

Weight Bias Internalization and Therapeutic Intervention in Outpatient Counseling

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## Abstract

In the United States, obesity increased from 30.5% to 42.4% and severe obesity rose from 4.7% to 9.2% from 1999 to 2018, a concerning statistic because research indicated being obese places people at risk for a plethora of obesity-related health complications (Hales et al., 2018).

Although a significant proportion of the U.S. population remains overweight, research has found a tremendous disdain and fear of fat people and the idea of becoming fat (Saguy & Ward, 2011). A less-studied risk factor to health and obesity was weight stigma and weight bias internalization (WBI). This research paper examined what is known about mental and physical health in relation to WBI and how it has been treated in the outpatient therapeutic setting. Few studies have examined the efficacy of therapeutic interventions intended to reduce internalized weight bias, and studies that have examined that relationship are severely limited by many factors.

Keywords: body acceptance, diet culture, fat, fatphobia, obesity, weight bias, weight discrimination, weight bias internalization, weight stigma

## Chapter One: Introduction to Weight Discrimination

The age-adjusted prevalence of obesity in the United States in 2018 was 42.4% for all adults (Hales et al., 2018). With such a large percentage of the population meeting the criteria for obesity, obesity warrants a discussion beyond the number on the scale. Although many people are obese, society views obese individuals disparagingly, a trend that has not waned as the population's proportion of obese individual has grown (Rubino et al., 2020). A study on weight-based discrimination found that discrimination towards obese individuals increased 66% in the 1990s (Puhl & Heuer, 2009). Statistics for discrimination in the U.S. based on weight are best understood within the socio-cultural context that created them. Before the turn of the 20<sup>th</sup> century, fat was a sign of wealth and privilege, a demonstration of good fortune and nourishing food, the absence of disease, and the lack of employment that required hard labor (Cooper Stoll, 2019). The prior standard of holding fat in high regard has become unfathomable, since diet culture became widely normalized. American culture has indoctrinated youth, especially young girls, with the desire to achieve health through the ideal thin body type (Myers & Crowther, 2007). What happens when a culture prizes something people cannot access in a healthy manner?

Gailey & Harjunen (2019) found a complex constellation of psychological, physical, social, cultural, and economic factors guiding the social construction of body size norms and judgment of the material body. Those who cannot achieve an acceptable body size may be subject to weight stigma, where people treat them differently or are compelled to comment on their bodies in many settings. Regardless of body size (large or small), evaluation of oneself based on the cultural preference for thinness and weight-based stereotypes has resulted in the creation of a relatively new term, weight bias internalization (WBI) (Hayward et al., 2018; Pearl

& Puhl, 2018). WBI occurs when people ascribe weight-based stereotypes to themselves, which negatively affect mental and physical health (Hayward et al., 2018).

Internalization of a societal ideal or the inability to meet such an ideal has been viewed as more nuanced and more problematic than overt slights by the public. Weight stigma has often been reinforced through many channels: unsolicited weight advice at the doctor's office when seeking care for other ailments, goals set at the gym based on size, social media focused on the weight loss journey, well-intentioned comments of loved ones, or even encounters with strangers (Fikkan & Rothblum, 2012). Internalizations about weight can go beyond public commentary and become an integral part of how people view themselves. WBI presents on a spectrum, resulting in a range of symptoms that can shape an entire lifespan (Emmer et al., 2020; Rubino et al., 2020). This paper reviewed existing research and therapeutic interventions that addressed WBI.

### **Statement of the Problem**

Why is it important to treat clients struggling with weight bias internalization and what therapies are most effective?

### **Significance of the Study**

Weight bias internalization (WBI) has been found to negatively influence mental health and quality of life (Pearl & Puhl, 2018). As obesity numbers continue to climb in the United States (Hales et al., 2018), more people have larger bodies than ever and live in a society that does not value those types of bodies. Understanding WBI and current treatments can benefit mental health practitioners with case conceptualization and treatment planning. As practitioners establish a better understanding of WBI and its associations, clients may have a better likelihood of getting treatment that serves them and their specific challenges.

## **Purpose of the Study**

The study aimed to synthesize available research about WBI in one paper. The focus was on research that discussed people's everyday experiences with WBI and research that addressed treatment options for the therapeutic setting. During the research process, gaps in the literature became apparent, and have been identified as areas for further investigation.

## **Definition of Terms**

*Body Mass Index (BMI)*: a measure created to categorize a person's weight, calculated by a person's weight in kilograms divided by the square of their weight in meters. BMI categories are underweight, healthy weight, overweight, and obese (CDC, 2020).

*Diet culture*: a cluster of cultural norms in the U.S. equated with health, and guided by food restriction, diet control, and exercising to obtain a particular normalized body size (thin) (Faw et al., 2021).

*Fat*: often used as a pejorative term, but for this paper, has been used to describe a large person. To say large instead of fat would take something away from the discourse. Fat as a descriptor has been derived from the discipline of fat studies that seek to understand the "cultural construction of material bodies" (Fahs & Swank, 2017).

*Fat stigma/ weight stigma/ weight bias*: describe negative attitudes and/or belief towards someone or a group based on weight, often expressed as stereotypes, prejudice, and discrimination (Puhl & Heuer, 2009). The fat scholarship does not coalesce around a singular term, and they are often used interchangeably.

*Liminal State*: the belief that fatness is temporary, which affects how people live their daily lives. Making life choices based on when a thin ideal body could be realized, contributes to weight bias internalization (Gailey & Harjunen, 2019).

*Obesity Epidemic*: commonly used to describe the increasing rate of obesity in the U.S. (Hales et al., 2018).

*Thin idealization*: the glorification of a thin and often unattainable body shape for women (Swami et al., 2010), prized for narrowness and lack of weight, rather than alternative larger or full body shapes (Polivy & Herman, 2004).

*Weight bias internalization (WBI)*: the extent to which people ascribe negative weight-based stereotypes to themselves because of their body, which can have negative outcomes for mental and physical health (Hayward et al., 2018; Pearl & Puhl, 2018).

### **Delimitations of Research**

The research was conducted June-August 2021 through UWL's Murphy Library via an electronic search function. No research or journal articles were found on internalized weight bias before 2008.

### **Method of Approach**

A brief review of weight bias internalization and current therapeutic interventions was conducted. A literature review was completed related to research, studies, and anecdotal evidence of how weight internalization has impacted mental and physical health, and how it has being treated in the outpatient therapy setting. Search terms included: weight bias, weight stigma, weight bias internalization, obesity, fatphobia, fat stigma, fat acceptance, mental health, physical health, Acceptance and Commitment Therapy, and Cognitive Behavioral Therapy. All searches for relevant sources were conducted via UWL's electronic search function available through Murphy Library. The findings were summarized and synthesized in Chapter 2 of this paper. Conclusions and recommendations are included in Chapter 3.

## Chapter Two: Review of Literature

### Weight Stigma

Weight Bias Internalization (WBI) cannot be understood without a precursory discussion of weight stigma. American history and culture have been saturated with the stigma against various populations (e.g., mental health stigma, racial stigma, socioeconomic stigma), and stigma categorized a person as feared or unacceptable based on their group, character, or body (Goffman, 1963). By Goffman's definition, intolerance and discrimination based on fatness was a grievance against the body understood to mean something about a person's character. Fatphobia has invoked tremendous hatred and fear of fat and was constructed from the view that thin bodies are the best (medically, aesthetically, and morally) (Saguy & Ward, 2011). In contrast, fat bodies are viewed as repulsive and avoided at all costs (Saguy & Ward, 2011). The discourse around weight stigma has been rooted in a narrative of choice and having the will power to change your destiny. Suppose an individual could not make a desired weight change. In that case, weight stigma would be attributed to their inability to change, to laziness, or gluttony, and they would be viewed as unattractive or undesirable (Gailey & Harjunen, 2019). These unfavorable characterizations have real-life consequences; one example was in a 2016 literature review that investigated weight stigma and eating behavior, and found associations between weight stigma, psychological and behavioral symptoms, and physiological stress (Vartanian & Porter, 2016). The day-to-day stigma of being overweight has been a widespread experience and largely inescapable per the cultural narrative on normal body sizes. Experiencing chronic stigma has been associated with maladaptive coping, which may mean things like eating additional calories, having low self-esteem, generalized body dissatisfaction, disordered eating, and engaging in less physical activity (Puhl et al., 2018). A 2017 study focused on hypothetical

weight gain, and by doing so, lent a granular understanding to the cognitive response of participants to weight gain. Participants were so repulsed by the idea of being overweight that the emotional reactions of participants were melodramatic and unrealistic, taking the emotional form of dread, disgust, terror, fear, abjection, and disability (Fahs & Swank, 2017).

Beyond stigmatization based on personal characteristics ascribed to fat, weight has been erroneously associated with a person's health and fitness level (Gaesser et al., 2015). Weight has been and remains a particularly unfair measure of health because overweight individuals can be in good health even though their Body Mass Index (BMI) score categorically labels them as overweight (Humphreys, 2010). BMI does not consider several factors: how having more fat in specific areas of the body can be less healthy than other areas of the body (e.g., excess fat around the abdomen has been shown as a risk factor for various diseases), differences in average percent of body fat based on racial differences, and difference in body fat based on weight for athletic individuals with high amounts of lean muscle mass (Humphreys, 2010). Alternative studies have demonstrated that cardio-respiratory fitness (CRF) not BMI or adiposity was a better moderator of mortality risk and indicator of overall fitness because weight has a strong genetic basis and the heritability of obesity was equivalent to that of height (Gaesser et al., 2015). The sociological study of weight stigma generally fits under the category of fat-studies, which has been a relatively new area of focus for researchers. Cooper Stoll (2019) argued for the inclusion of fat as a social justice issue and suggested further sociological research on weight stigma. Viewing weight through a sociological lens could help conceptualize cultural biases, supporting-structures, and the historical depth of the phenomena. Fat-studies could also inform how fat-based discrimination and stereotypes affect people at the societal and individual level. Current fat studies around weight stigma focused on America because of the obesity epidemic; however,

cross-cultural studies identified similar findings of culturally embedded weight stigma in other countries (Gailey & Harjunen, 2019).

Further consideration should be given to how weight stigma intersects with other forms of discrimination (racial, ethnic, gender, sexual orientation). An intersectional study by Ciciurkaite & Perry (2018) demonstrated that Hispanic women and those of lower incomes were more vulnerable to weight-based discrimination than white or more affluent women, which they attributed to limited access to resources and existing social structures. Obesity rates are higher in minority populations in the U.S., and in 2020, the CDC reported non-Hispanic black adults as having the highest prevalence of severe obesity (13.8%) (Hales et al., 2018). Regardless of obesity rates, most of the research on weight stigma used sampling from a primarily white participant pool (Himmelstein et al., 2017). The lack of diversity and representation in the research was especially problematic because while weight stigma appeared constant across groups, internalization and coping skills vary (Himmelstein et al., 2017).

### **Weight Bias Internalization**

When someone internalizes a stigma, they are agreeing with the stereotype, even if unconscious of the agreement. The extent to which someone internalizes an external message, such as a weight stigma, can vary based on person's unique characteristic and circumstances. Believing a negative, socially-constructed stigma about oneself has been shown as highly detrimental to psychological wellbeing (Durso et al., 2016). There are several theories about how external weight stigma becomes internalized. Acceptance and Commitment Therapy (ACT) and psychological flexibility theory explain how WBI leads to problems via a combination of cognitive fusion with stigmatizing thoughts (Levin et al., 2018). Someone experiencing WBI, has ascribed negative fat stereotypes to their individual person, which influences how they see

themselves within society, their value as a person, and how they participate in society. This kind of fusion could lead to maladaptive coping such as avoidance of activities and could become a constant evaluation measure. A narrative perspective conceptualizes weight stigma similarly but with more societal emphasis. Narratives can be understood as contributing to self-identity and agency, contingent on how a person perceived themselves and more importantly how others see them. Being assigned an oppressive narrative can damage social identity and become internalized (Ramos Salas et al., 2019). This process of internalization was termed infiltrated consciousness by Lindemann-Nelson (2001).

### **Weight Bias Assessments**

Because weight bias internationalization has been such a complex and relatively new concept, Durso and Latner (2008) created the first therapeutic assessment for WBI. The Weight Bias Internalization Scale (WBIS) was developed in 2008 to assess WBI through an 11-item Likert scale that assessed weight-related stereotypes and self-devaluation for overweight and obese populations (Pearl et al., 2020). Other assessments (Antifat Attitudes Questionnaire (AAQ), the Antifat Attitudes Test, and the Attitudes Toward Obese Persons (ATOP) were previously used to screen for WBI, but WBIS was an important development in the treatment of WBI because it identified the internalization of weight bias. WBIS was a foundational tool for identifying when someone believed a negative weight message about themselves, rather than how they generally viewed obese people. The initial validity testing of the assessment found a correlation between WBI and anti-fat attitudes, drive for thinness, and body image; relationships between WBI and self-esteem, mood concerns, and body image concern (Durso & Latner, 2008). WBIS scores, anti-fat attitudes, and BMI significantly predicted variables such as, mood, self-esteem, and binge eating. The most influential result from the development of the WBIS was that

the anti-fat attitudes a person held towards others was separate from WBI and does not necessarily align with BMI (Durso & Latner, 2008). Since the original testing of WBIS, research has shown better internal consistency of the assessment by making it a 10 or 9 item version (Durso et al., 2016). Another scale, Weight Self-Stigma Questionnaire (WSSQ), was created by Lillis et al. (2010) with two subscales (enacted stigma and self-devaluation). WSSQ was widely used because of its strong psychometric properties, providing another tool for assessment in clinical and research settings (Pearl et al., 2020). A 2013 study assessed WBI with an alternative measure, related to how participants viewed obese individuals, normal weight individuals, and themselves based on personality (Carels et al., 2013). This study assessed WBI as part of the social comparison and identity formation process. The goal was to determine if the social labels ascribed to fat people resonated with individuals of various body sizes and if that personal ascription could mediate the internalization of weight stigma. This study used the Obese Persons Trait Survey (Puhl, 2009) as published and in a modified capacity to assess views about obesity, normal weight, and self. The study found negative ratings of self and not of obese people were most aligned with WBIS scores, further validating WBI as a measure of internal stigma as opposed to external stigma (Carels et al., 2013). Assessment tools are essential for assessment, treatment, and tracking progress in a therapeutic setting.

### **Mental Health**

In the decade after the development of the WBIS, weight stigma and WBI caught the attention of academic researchers. Overwhelmingly, the body of research on WBI has demonstrated significant implications for mental health. Pearl & Puhl (2018) found a strong, negative relationship between WBI and mental health outcomes in their literature review of 74 studies, and their meta-analysis found 30 peer-reviewed studies on WBI and depressive

symptoms. Significant and positive associations between WBI and depressive symptoms were indicated for 28 of the 30 studies regardless of body size (Pearl & Puhl, 2018). This was an important finding because the earliest research on WBI focused solely on participants categorized with an overweight or obese BMI. Pearl & Puhl's (2018) research has been further validated since other studies confirmed BMI has no bearing on whether someone registers on the WBIS; it was more about the endorsement and internalization of the negative characteristic related to fat (Carels et al., 2013). Another large study (N = 2,036) by Hunger & Tomiyama (2018) contributed to research about the adverse psychological and physical health outcomes related to WBIS, regardless of BMI and specific to female participants who began the study as adolescents. Participants with various reported experiences of weight stigma were more likely than peers to express greater body dissatisfaction and drive for thinness at 19 years old than their peers (Hunger & Tomiyama, 2018). Similar to the depression findings, significant correlations between anxiety and WBI were observed in adults of varying weight statuses. In addition, correlations observed between WBI and anxiety have been documented in both community and clinical samples; several studies found that WBI predicted anxiety over and beyond the variance accounted for by participants' BMI (Pearl & Puhl, 2018). Research has found associations between WBI and other measures of mental health including body image concern/dissatisfaction, eating disturbance, binge eating symptoms, eating disorder pathology (drive for thinness, dietary restraint, emotional eating), and self-esteem (Carels et al., 2013; Durso et al., 2016; Durso & Latner, 2008; Griffiths et al., 2018; Hatzenbuehler et al., 2009; Pearl & Puhl, 2018; Puhl & Heuer, 2009). Considering the literature's linkage of WBI to a wide array of mental health symptoms, there was a justifiable case for researching how WBI could be addressed in a therapeutic setting. Early intervention could help someone with depressive

symptoms avoid a major depressive episode or similarly before a disordered eating symptoms warrant a full diagnosis.

### **Physical Health**

Public health entities committed a disservice to the public by oversimplifying the narrative around health and shaming those that cannot use willpower to make themselves slim (Ramos Salas et al., 2019). People's relationship with weight and health has been much more nuanced than putting down the doughnut. Daly & Sutin (2017) found that the perception of oneself as overweight (regardless of BMI) was prospectively associated with biological markers of poorer health, including unhealthy blood pressure, C-reactive protein, HDL cholesterol, triglycerides, glucose, and HbA1c levels. This finding was striking because it included people with a *normal* BMI. However, the debate on BMI's relationship with WBI continues to loom unanswered because of divergent research outcomes. In forty-two cross-sectional studies, sixteen studies found significant associations between WBI and BMI and seventeen found no significant associations (Pearl & Puhl, 2018). Weight bias also appears as inequities in healthcare (Pearl & Puhl, 2018) because weight bias remains an acceptable form of discrimination and obesity was deemed a curable and a temporary condition (Gailey & Harjunen, 2019). Unsurprisingly a study from 2009 found that participants' perceived weight discrimination was most often reported in public, insurance, and healthcare settings (Hatzenbuehler et al., 2009).

### **Behavioral Response**

In one study, the narratives of those affected by weight stigma demonstrated a behavioral response (avoidance and social isolation) that translated into a reluctance to pursue healthy behaviors (e.g., going to the gym or getting a wellness check) (Ramos Salas et al., 2019). WBI's direct linkage to behavior response was demonstrated in two studies when participants

underwent a controlled experience of weight stigma and saw increased food consumption over the control group (Major et al., 2014; Schvey et al., 2011). Schvey et al.'s (2011) research was particularly dramatic because overweight women who watched a stigmatizing video with weight stereotypes before eating ate three time more calories than their overweight counterparts that did not watch the video. Although these associations are not causation, evidence pointed to treating the system that perpetuates weight-based stigma and not the individual (Tomiyama et al., 2018). This behavioral response was important for more than just eating behavior because it shaped a person's ability to form and execute goals. One example occurred when educational outcomes of college-aged women and young girls were negatively impacted by weight (Fikkan & Rothblum, 2012).

### **Social Considerations**

The power and reach of weight stigma and WBI has been shown as important because of the influence on physical and mental health, and also on the ways it shapes how people organize their lives. Considering the role of weight stigma from a lifespan perspective was vital for understanding the importance of how weight-based self-perception shaped the trajectory of people's lives (Ramos Salas et al., 2019). Pila et al. (2018) followed a narrative methodological approach to explore lifetime protective and risk factors for body image concern, specifically addressing the gaps in the literature related to older females (50-65 years old). Semi-structured interviews were conducted and four themes were identified: enduring concern about body image, weight and appearance-based self-consciousness, social experiences that impact self-perception, and impact of weight bias, stigma, and discrimination (Pila et al., 2018). Gailey and Harjunen (2019) identified hyper(in)visibility as similar to the theme of appearance-based self-consciousness and social experiences (Pila et al., 2018). Both categories pertained to weight,

perception of weight, and how the perception influenced the way women interacted and were interacted with in the social sphere. Gailey and Harjunen (2019) found positive findings by exploring the liminal state of being fat, which was experiencing one's body as temporary until reaching an ideal body. Gailey and Harjunen (2019) and Pila et al. (2018) both found liminal narratives of waiting and putting off life (leisure activities, major life events, professional opportunities) until reaching the anticipated ideal body. Weight concerns affected self-determination (doing what they want without consideration of their bodies). The liminal state of mind was arguably identified as both a risk and protective factor as it often led to the pursuit of quick fixes (dieting to help reach the end goal), but it also helped people cope with their WBI by separating it from themselves (Gailey & Harjunen, 2019). Both studies suggested that WBI and weight stigma had lifetime negative implications for quality of life, if unaddressed.

### **Therapeutic Interventions**

Therapeutic interventions employed by mental health practitioners target presenting problems and diagnoses and are made from various vantage points, e.g., biomedical, cognitive, behavioral, sociocultural, and, or familial. Although there was a wealth of research supporting WBI as an important consideration for mental health, few evidence-based therapeutic interventions were specific to addressing WBI in a therapeutic context. There are randomized controlled trials that have focused on body dissatisfaction, however there are very few that specifically target WBI. One recent study supported reducing WBI by fostering self-compassion rather than focusing on weight or weight reduction (Forbes & Donovan, 2019). Hayward et al. (2018) found that people experiencing weight stigma and WBI were more likely than peers to report maladaptive coping than adaptive coping skills, suggesting that people did not have the tools needed to address their everyday experience with weight stigma and WBI. There was a

small number of studies that considered WBI and weight stigma, but they were primarily focused on group settings. These studies showed the possibility for interventions targeted at both the individual and group level. From previous research findings, interventions were recommended that focused on self-endorsement of positive traits (regardless of body size) as means to combat or even circumvent WBI (Carels et al, 2013). Fortunately, of the few researched therapeutic interventions for weight stigma and WBI, those studies targeted endorsing positive traits and self-acceptance.

### *Acceptance and Commitment Therapy*

Griffiths et al. (2018) found seven studies that treated WBI via therapeutic intervention and four of those studies (Fletcher 2011; Levin et al., 2018; Lillis et al., 2009; Palmeira et al., 2017) tested interventions based on Acceptance and Commitment Therapy (ACT). Acceptance and Commitment Therapy (ACT) has been theoretically based on a Cognitive Behavioral Therapy (CBT) that teaches self-compassion, psychological flexibility, and mindfulness, while employing common CBT interventions. Someone who was psychologically inflexible would try to control or avoid difficult internal experiences such as WBI. Psychological flexibility and weight self-stigma significantly predicted negative health-related quality of life (Lillis et al., 2011). Although ACT has been studied regarding weight management, there has only been one randomized controlled trial (RCT) (Palmeira et al., 2017) that addressed coping with weight stigma in a therapeutic context. The RCT included 84 participants in a weight loss program, where the treatment group received a one-day ACT workshop specific to weight self-stigma. Those receiving ACT improved their WBI, quality of life, psychological symptoms, and weight (Levin et al., 2018). Notably the RCT study focused on weight loss and tested ACT combined with a healthy eating program against treatment as usual (TAU). The ACT group reduced their

weight and WBI significantly compared to the control group, with reductions in WBI not attributable to weight loss per statistical analysis (Griffiths et al., 2018). Similar research found that ACT had a significant effect on WBI (not explained by weight loss) Levin et al., 2018; Palmeira et al., 2017). Another ACT study was adapted to utilize a self-help book and incorporated the guidance of a self-help coach. This was an interesting model, but the participant pool was homogenous and small (N =13), so further investigation would be needed to see if the improvements in weight-related psychological inflexibility would be generalizable to a larger sample utilizing the self-help model (Levin et al., 2018). An Acceptance and Commitment (ACT) randomized-controlled trial (RCT), without focus on weight loss and not recruited by targeting weight loss centric groups, could be an advantageous next step for considering ACT's efficacy for improving mental and physical health. Generally, the ACT studies suffered from small sample size, lack of diversity, no follow up, lack of control, reliance on self-report, and great variety in the duration of the interventions (Griffiths et al., 2018).

### ***Cognitive Behavioral Therapy***

Since publishing Pearl & Puhl's (2018) meta-analysis, there was an RCT published that utilized CBT to target weight bias internalization. The interventions were aimed at weight stigma-reduction and behavioral weight management. Results were mixed because WSSQ score decreased more than WBIS scores and there was a significant improvement to WBI in both the control and test group (Pearl et al., 2020).

### ***Narrative Inquiry Approach***

The Narrative Inquiry approach was based on the Narrative Repair Model (Lindemann-Nelson, 2001), which leveraged social narratives to influence how we identify groups and populations (i.e., social identity) and how individuals act (i.e., individual agency) (Ramos Salas

et al., 2019). The intention of the study was to develop counter-stories that challenged unjust assumptions and oppressive narratives, through elucidating the larger social dynamics and inequities of power based on fat via the deconstruction of experiences, beliefs, values, practices, and relationships (Ramos Salas et al., 2019). Although this was another intriguing model because of how well it translated to regular talk therapy (deconstructing narratives), the study sample size was small (N=10) and it was a singular study specific to WBI.

### ***Feminist Therapy***

A sociocultural approach, Feminist Therapy, targeted the power structures that have created and maintained weight stigma. Feminism could be an ambiguous and loaded term to those who are unfamiliar and may not be appropriate for all persons with WBI. Through this approach, consciousness-raising, social and gender-role analysis, resocialization, and fat activism are mechanisms to fight weight stigma at the personal and systemic level. Although a Feminist paradigm has the potential to empower and fuel growth, activism may be a more advanced step, inaccessible for those persons who do not understand their own internalizations (Ali & Lees, 2013). Feminist therapy does not promote weight loss because of the potential to reinforce weight stigma and has not been researched concerning WBI.

### **Summary**

Weight stigma has been a problem at an institutional and interpersonal level (Hatzenbuehler et al., 2009). Beginning with the recent creation of assessment tools in the late 2000s, there has been increased scholarship focused on weights stigma and WBI. Research has indicated clear associations between weight stigma/WBI and indicators of mental health (depression, anxiety, body dissatisfaction, eating disturbance, binge eating symptoms, eating disorder pathology, and self-esteem). WBI and its relationship to physical health has been

researched less. Understanding the role BMI plays in relation to physical and mental health, will help researchers decipher WBI's importance. The specifics of how weight stigma and WBI affect mental and physical health has been less clear because research has only showed associations. Important for weight stigma and WBI research has been the ability to control for other contributing factors such as mental health diagnoses, general life stressors, and other forms of discrimination.

Some encouraging associations were found in research that utilized CBT and ACT, and a future direction for research was found in the literature about Narrative Inquiry and Feminist Therapy. However, research on therapeutic interventions for WBI was limited by the number of total studies, the diversity of the participants, the small sample size, and the limited types of interventions tested. Recommendations based on the literature review are summarized in Chapter 3.

### **Chapter Three: Conclusions and Recommendations**

Future research on WBI may help mental health practitioners with case conceptualization and course of treatment because it could provide research-based foundation for understanding the interactions between weight stigma and self. In the hypothetical weight gain study by Fahs and Swank (2017), women focused solely on the negative factors of weight gain, did not imagine any advantages from gaining weight, and expressed very intense negative emotions about the idea of being fat. This dramatization of what it means to be fat, was a poignant demonstration of how culture fuels weight stigma and WBI. With such deep cultural infiltration, a responsive therapeutic context should use assessment to understand the severity of WBI for the individual before a treatment plan has been finalized. Responsible practice should identify the various levels (family, social media, medical establishment, etc.) of messaging and what aspect would be most salient for clients struggling with WBI. To help clients deconstruct their specific internalizations and move away from maladaptive narratives, there needs to be a larger and more consistent research base to draw upon. Future research could examine key factors affecting weight bias intervention. What are the protective factors that can moderate weight stigma and help prevent weight bias internalization? Why are some people more susceptible to these internalizations? What can reshape the personal narratives of those who struggle with their weight and lessen the lifetime toll of weight stigma? What adaptive coping skills could be useful?

Further research would be needed to parse out WBI as part of and/or distinct from other mental health concerns. The rising obesity rate, the universal theme of obesity as an undesirable and stigmatizing label, and the lifetime impacts of navigating a world that condones weight stigma leads to questions of how to improve the quality of life for people of all body sizes. The

future public health strategy should infiltrate all areas of society, including increased medical training, public education about true measures of health, (Tomiya et al., 2018), a cultural emphasis on wellness as opposed to weight loss, and mental health systems that acknowledge WBI as worthy of assessment and treatment. Elimination of weight stigma is an ideal preventive measure, but in the meantime, evidence-based interventions could help those struggling with WBI.

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