Portfolio 1: Major Research Project

Weight Stigma in Clinical Psychology: A Critical Discursive Psychology Analysis with Trainees

Kate Arnold

18000024

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Abstract

Background

Weight stigma is defined as negative attitudes towards and beliefs about others because of their weight (Andreyeva, Puhl, & Brownell, 2008). Biased views of fat individuals by professionals in physical healthcare and the stigmatising impact this can have on the quality of care they receive has been well documented (Phelan, et al., 2015). Mental health professionals ascribe more negative personal attributes to fat clients (Hassel, Amici, Thurston, & Gorsuch, 2001), rate fat clients as having more severe symptoms than thin clients (Hassel, Amici, Thurston, & Gorsuch, 2001; Young & Powell, 1985) and predict worse treatment prognosis and contribute less effort towards treatment of fat clients (Davis-Coelho, 2000). Although weight stigma has recently been studied in American Clinical Psychology training institutions and qualified professionals (Brochu, 2019, 2020) the topic has received little published research attention within the profession of Clinical Psychology in the UK.

Method

The current study used Critical Discursive Psychology (Edley & Wetherell, 2001, Wetherell, 1998) analysis to consider the way in which 12 UK trainee clinical psychologists constructed weight, bodies, and fatness during online focus groups; how they drew on and resisted existing repertoires, positioning themselves and others in relation to these; and the implications of this, clinically, professionally and in broader social and political ways.

Findings

Findings highlighted a disjuncture between trainees' reflections about 'fat-talk' with family and friends in their personal lives compared to talk in professional settings, including training programmes, clinical work and supervision. They offered

enthusiastic and detailed accounts of conversations about weight and body size in their personal lives, but reported limited and awkward talk in professional settings, and when speaking ‘as professionals’. Trainees drew on multiple repertoires to discuss weight, bodies and fatness, including weight as something that is controllable and should be managed (either by individuals or society), weight as a physical health issue, weight as a mental health issue, and weight as measure of worth. While showing some awareness of the impact of negative stereotypes, they were not immune to perpetuating, at times, powerful negative societal positionings of fat people in comparison to others, and in ways that underplayed the relevance of fat stigma. Further, their apparent awareness of how their internalisation of stereotypes was as odds with their values as trainee clinical psychologists appeared to have the paradoxical effect of closing down open discussion needed for learning and reflexive clinical work and supervision.

Conclusion & Implications

Trainees are in a powerful position to challenge weight bias, but to challenge it they must first be made more aware of it and the detrimental impact it can have on all people, but especially those in fat and marginalised bodies. Clinical implications are discussed to consider how trainees might be better supported to acknowledge and challenge their own biases about weight and fat individuals, including addressing weight stigma in their training and how supervisors might better support trainees to actively reflect on their own and other bodies.

Table of Contents

1. Introduction

1.1 Overview

This research takes a qualitative approach to explore the construction of weight and fatness in a professional group. It presents a Critical Discursive Psychology analysis of three focus groups held with trainee clinical psychologists, examining how constructions of fatness, weight stigma and anti-fat bias are taken up, resisted, and developed among those who will shape the next generation of Clinical Psychologists. It also examines implications for the people they are employed to work with. Through this, the study explores potential opportunities to challenge unhelpful constructions within professional groups.

This introductory chapter opens with an exploration of the researcher's relationship with the research and topic, detailing their theoretical and epistemological position. It then provides a consideration of the language used throughout the thesis and defines key terminology and concepts. Finally, an overview of the historical origins of fatness and societal fascination with fat bodies is provided before transitioning to a summary of existing research in weight stigma and anti-fat bias within society and physical and mental health professions.

1.2 Relationship with the research

Good qualitative research requires acknowledgment of the ways in which the researcher influences the research, not only as a theorist (epistemological reflexivity), but as a person (personal reflexivity) with their own biases, reactions, insights and understandings (Willig, 2008). Researchers should be explicit about what they are bringing to the process, interpretation, and associated outcomes (Berger, 2015). I (the researcher) will begin by providing an overview of the

perspectives I bring to the research and how this has contributed to my connection with and interest in the project.

1.2.1 Personal Position

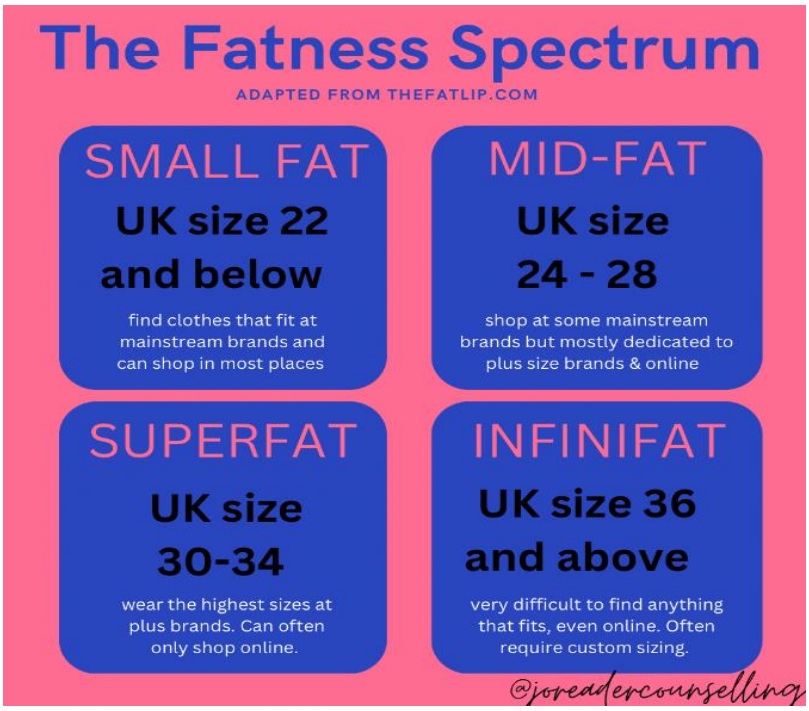
I have a connection to the community in which the research is being carried out and could be considered an insider researcher (Aiello & Nero, 2019). I am a trainee clinical psychologist exploring the construction of weight and fatness within my peer group. I also self-identify as a 'small-fat'[1] (Figure 1). My connection to this research is rooted in both my own journey and relationship with my body, as well as my passion for 'fat activism' and social justice for bodies of all sizes. It also comes with an awareness of the privileges I hold that protect me from the weight-based prejudice those in larger bodies experiences. These privileges include where my body currently sits on the fatness spectrum, but also being a white, able-bodied, middle class, educated, cisgender woman. It is my belief that although all members of society are negatively impacted by anti-fat bias (e.g., through 'diet culture'), those in fat and marginalised bodies are disproportionately impacted by it.

I aim to use my emotional and personal connection to fuel this research, however I acknowledge the importance of being transparent about this position and engaging in reflexive tasks throughout the research to consider how my own responses and biases may impact the project. In preparation for the research, I took part in a reflexive bracketing interview (Ahern, 1999) with a peer from my training cohort (extract available in Appendix A). Throughout the research process I kept

[1] The fatness spectrum is a set of terms created for and by the fat community to identify one's size. While not universally standardised, they offer a rough framework for gauging one's place on a spectrum of size/fat privilege

reflective diaries including one to note my responses/reactions to articles I read for the project (Appendix B) and a more general diary (Appendix C).

Figure 1. Infographic of the Fatness Spectrum (Reader, 2023)



1.2.2 Theoretical Position

My personal beliefs about 'fat'[2] bodies have influenced my choice of research topic. These beliefs fall within a social constructionist epistemological framework. Social constructionism considers how human experience is mediated (and shaped) by our historical and cultural contexts and the language we use (Burr, 2003). Our perceptions and experience are therefore not a direct reflection of the environment, but should be understood in the aforementioned contexts. Research from a social constructionist perspective seeks to identify ways in which realities are constructed

[2] Single use quotation marks will be used to indicate a construction *or* a contested word/phrase (*see section on Language)*. Double quotation marks will indicate use of a direct quote from a source, will appear in italics and be appropriately referenced in APA style

and to consider the cultural availability of these realities and the implications of these constructions for human experiences and practices (Willig, 2008). Within a social constructionist perspective 'fatness' is not viewed as a natural, objective, or inherent quality of the body, but as a social construct that is shaped by cultural and historical factors. Under this framework, I perceive 'fat' or 'fatness' not simply as being a matter of individual biology or genetics, but rather as a product of social norms and values around body size, health, and beauty. These norms are not fixed or universal but, rather, they vary across different societies and historical periods.

It is difficult to delineate how and when my approach to 'fatness' was shaped, but I was heavily influenced by Bordo's (2004) descriptions of the ways in which fatness has been constructed as a 'problem' in Western cultures. This construction is rooted in historical and cultural attitudes towards gender, race, class, and power. Bordo proposes that fatness intersects with other forms of oppression including (but not limited to) ableism, racism and (hetreo)sexism.

1.2.3 Methodological Position

Discursive psychology places language (discourses) at "*centre stage"* (Edley, 2001, p. 190) rather than treating it as a simple depiction of and 'route into' underlying realities or experiences of the world. There are multiple modes and methods of discourse analysis as a qualitative method, but the commonality lies in focusing on the relationship between language and the social world. The analysis of discourse conceptualises language as constructive and functional (Willig, 2008) so analyses both *how* people say things, the impact on the audience, and how society can influence language and communication. Discourse analysis focuses on how this language, in various forms of communication (e.g., written down, spoken), sends a message (rather than what the messages within the text might be) (Harris, 1952).

The current thesis aims to explore how weight and fatness are viewed in the profession of clinical psychology. The use of discourse analysis will tap into how these concepts are constructed through sociocultural discourses and underpinned by a social constructionist epistemology.

1.3 Language

As a constructionist approach to language is used in this research, the language used in this dissertation is acknowledged to actively construct a position and have a social impact. It will however need to use culturally available language that is available in common discourse. An example of this is the Body Mass Index (BMI) which is a term used to construct a person's body within a medical framework - something that, in modern Western culture at least, has become almost axiomatic or hegemonic (with many personal, social and political implications) (Gutin, 2018). This thesis will seek to highlight (and at times challenge) the constructive work of language in this field.

1.4 History of Fat Bodies and Origins of Weight Stigma

1.4.1 Definitions and construction of 'fat(ness)' and 'obesity'.

The following section will outline constructions which will be used throughout the thesis. It primarily centres on constructions of bodies but will also provide an overview of some of the cultural repertoires which are widely available, and some which may be perceived as 'alternative' approaches.

Bodies will primarily be described in the thesis in ways which align with a fat-activist[3] stance. This includes the use of the word 'fat' as a neutral descriptor for predominantly plus-sized individuals. The word fat is perhaps typically used as an insult (to bodies of all sizes) but many involved in fat activism have reclaimed it as "*objective adjective to describe our bodies, like tall or short"* (Gordon, 2020, p. 8). Fat as a neutral description of a body stands in opposition to more medicalised language to describe fat bodies, such as '*obesity'*, which is a classification determined by the Body Mass Index (BMI; described later in this section). The Latin origins of this word (*obestus*) translates into devouring oneself or to eat oneself away (Aronson, 2003). It is recognised by many fat people and activists as a pathologizing, derogatory slur. As such it will only be used in this thesis when specifically referenced by another sources. Non-fat bodies will also be described in ways which align with an inclusive, social justice-oriented language, including the use of the word 'straight-sized' (typically used to described body sizes that are small through large).

The Body Mass Index (BMI) is a numerical figure calculated as body weight in kilograms divided by the height in metres squared (Engin, 2017). The origins of this measure and a critique are provided later in the chapter. The BMI is a popular measure of health in Western countries, with the National Health Service (NHS) using it to determine access to specific care, including IVF (NICE, 2010) and gender-affirming surgery (NHS, 2023). In North America it is also used to calculate individuals' eligibility to access insurance policies, whereby people who have higher

[3] Fat activism: Fat-centric activist theory that specifically demands a radical dismantling of the system of valuing (thin) and devaluing (fat) bodies (Cooper, 2016)

BMIs have reduced access to policies/services and are charged more for access to medical care (Bhattacharya & Sood, 2011).

Perspectives of fat bodies in a Western context seem to be inextricably connected to our understanding of health[4]. A critique of health models is that they correlate weight and health without a nuanced understanding of the pathways through which weight might be associated with negative outcomes, many of which might not imply biological mechanisms, but rather societal ones that stem from 'diet culture' (defined below) itself and broader internalised negative attitudes towards fatness. Critical weight science challenges assumptions underlying this dominant perspective of the relationship on weight and health (Bacon & Aphramor, 2011). Critical weight science challenges notions that fatness is always unhealthy (Tomiyama et al., 2016), dieting as an effective tool for long-term weight loss (Mann, et al., 2007), and the belief that weight is controllable (Solomons et al., 2013).

'Diet culture' refers to a set of socially constructed and conditioned beliefs in which thinness is synonymous with health, beauty, and moral virtue (Jovanovski & Jaeger, 2022). It promotes weight loss as a method of obtaining a culturally prescribed body type and to achieve health and happiness. Common beliefs associated with diet culture include weight loss being a moral obligation and a physical manifestation of self-discipline and willpower (Leahey et al., 2014). Long-term success rate of diets for maintaining weight loss over five years is between 5% to 10% (reviewed in Gaesser, 2009) with two-thirds of people regaining more weight

[4] The construction of 'health' is beyond the scope of this thesis, it is commonly defined as "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"* (Svalastog, Donev, Kristoffersen, & Gajović, 2017, p. 432)

than they initially lost (Byrne, 2002; Mann, et al., 2007). A meta-analysis of 31 studies concluded that there was no evidence to support dieting to achieve significant sustainable weight loss (Mann et al., 2007). Diets not only fail in their primary aim (to reduce body size), but can lead to permanent difficulties with body and food preoccupation, body dissatisfaction, increased stress, disordered eating, eating disorders, lowered self-esteem, depression (Tylka, et al., 2014) and ultimately result in weight gain (Lowe, et al., 2013).

Weight stigma is defined as a negative attitude towards, and beliefs about others because of their weight (Andreyeva et al., 2008) and can include an individual experiencing abuse in the form of verbal or physical aggression (Wu & Berry, 2018). These biases fit under the umbrella term of anti-fatness/anti-fat bias to describe attitudes, behaviours and systems that serve to exclude, oppress, and marginalise fat bodies (Gordon, 2020). The intersection of weight stigma and racism are explored in Sabrina Strings '*Fearing the Black Body'* (Strings, 2019) and Harrison Da'Shaun's '*Belly of The Beast'* (Da'Shaun, 2021).

1.4.2 History of fat bodies and origins of weight stigma.

This section details an overview of fat history and weight stigma, primarily focussed on Western viewpoints and lenses (though historical contexts will undoubtedly include a broader range of cultures and perspectives). Fatness has been associated with laziness, success, poverty, prosperity, slovenliness, unattractiveness, and voluptuousness (Sermo, 2015). Historical and sociological writings provide us with a sense of how fat bodies have been viewed through different time periods and some of the traits attributed to them.

The framing of fat bodies has been explored in the palaeolithic era; one study examined statues from this period and fat bodies were far more frequently

represented than those labelled as ‘skinny’ or ‘normal weight’ (Józsa, 2011). The researcher considered how widespread famines were during this period and deemed it unlikely that the proportion of fat statues was an accurate representation of a typical body type during this time. Instead, he concluded that the over-representation of fat bodies in these statues was more likely a sign that fatness was expressed as a beauty ideal.

In Medieval Britain, body fat was associated with access to meat and luxurious foods, and so was a body type attributed to the upper class of society whose reportedly leisurely ways were set apart from the poor who faced food scarcity and gruelling physical labour (Brown, 1993). Fat bodies were respected as a status symbol and viewed as a sign of wealth and good health. The ‘Renaissance’ (14th-17th Century) is synonymous with a voluptuous aesthetic observed in artwork of the period.

The 17th century seems to be a turning point for perspectives on fat bodies. During this period fat bodies appeared to become less respected, accepted and began to be feared. Strings (2019) attributes this shift to the transatlantic slave trade and rise in Protestantism “*Racial scientific rhetoric about slavery linked fatness to “greedy” Africans. And religious discourse suggested that overeating was ungodly”* (Strings, 2019, p. 6).

In 1832, Adolphe Quetelet, an academic interested in astronomy, statistics and sociology, began creating a formula to assess weight, using a population study of White French and Scottish males (Eknoyan, 2008). Quetelet associated the average individual from these calculations to be the ideal, and those who deviated it were a “*monstrosity”* (Quetelet, 1991).

Modern day discourses about fat bodies have at least in some part been driven by neoliberalism and the development of health insurance companies (Knox, 2019). Health insurance companies became popular in Western Europe around the early 1880's and began appearing in North America around 1900, with an agenda to simultaneously reduce the number of sick workers, and profit from the use of and access to medical services (Starr, 1982). Analysts at insurance companies concluded that workers who deviated from the average[5] range of weight-to-height ratios had the biggest mortality risk (Brumberg, 2000). An epidemiological longitudinal study found a U-shaped relationship with weight and mortality, individuals who were exceptionally slim and exceptionally heavy had the highest risk of mortality (Keys, 1980). Keys stated that although '*obesity'* did not cause heart disease, he found fat people "*disgusting"* and "*ethically repugnant"* (Blackburn & Jacobs 2014). He rebranded the Quetelet Index as 'the Body Mass Index' (Keys, et al., 1972). It became a popular measure of health in Western countries, along with the proposition that people with higher BMIs were at greater risk of disease and early mortality (Jutel, 2008; Oliver, 2006).

1.5 Weight Stigma in Society

The following section will review research which considers weight stigma in society, weight stigma in physical health and weight stigma in mental health professionals

Although discrimination is typically considered to threaten values of inclusion and equality (Brownell et al., 2005), prejudice against fat people appears to be

[5] The average worker at this time was White, male and middle class (Springs, 2019)

widely observed and tolerated (Pont et.al., 2017). Anti-fat bias can be viewed as an acceptable prejudice, or 'soft bigotry', often held or condoned by people who identify as '*progressive"* and otherwise typically present as more willing to tackle oppressive structures (Daisey, 2020; Scoenfielder & Weiser, 1983). Bodies that deviate from the norm are viewed as disobedient (Foucalt, 1979) and become oppressed and marginalised. Individuals with fat bodies are frequently deemed as culturally undesirable and deviant (Chan & Gillick, 2009).

Attribution theory provides a framework for understanding how weight-based prejudice and fat oppression might operate (Weiner, Perry & Magnusson, 1998); people discriminate against fat individuals because they believe their weight is controllable (Crandall & Moriarity, 1995; Musher-Eizenmann et al., 2004; Puhl & Brownell, 2003). The more a disease[6] or health related outcome is perceived as being a result of individual choices and control, the more it becomes stigmatised. The perception that bodyweight is under individuals' control benefits the previously discussed multi-billion-dollar weight-loss industry and is therefore a strongly upheld belief in society. However, there are more complicated and nuanced explanations and theories that challenge this belief; Stunkard et al., (2018) concluded that body weight is affected by an interplay of biological and environmental factors and estimated that around 70% is determined by genetic factors.

Hatred of fat people in Western countries is not only permissible but is viewed as justified and expressed through both macro and micro mechanisms (Morgan,

[6] The 'disease model of *obesity*' (De Lorenzo et al., 2019; Rosen, 2014) sees '*obesity'* and fatness as a "*real pathology"*, in this model '*obesity'* is seen as a debilitating condition (Müller & Geisler, 2017).

2011). Part of the justification for explicit expressions of anti-fatness seems in part connected to ideas about fat-shaming, a practice where fat individuals are purposefully made to feel ashamed of their bodies (Rinaldi, Rice, & Kotow, 2019). Fat-shaming is sometimes framed by its users as a way of supporting fat individuals to lose weight (which again is framed in this context as a positive and necessary thing). American late night television host, Bill Maher dedicated a segment of his HBO show in September 2019 to encourage fat-shaming to make a "*come back"* as, he explains, shame had been an effective tool to reduce smoking, to get people to wear seatbelts, to stop littering and to stop being racist[7] (Lee, 2019). Shame, Mahere claims, is the "*first step in reform"* (Casey, 2019). The use of shame to promote weight loss has also been suggested in public health awareness as an "*edgier strategy"* (Callahan, 2013, p. 34). There was a significant rebuttal and critique to Callahan's proposal and there is more empirical support to suggest that fat-shaming is not only ineffective at encouraging weight loss but may lead to weight increase (Derricks & Earl, 2019; Tomiyama & Mann, 2013; Wellman, Araiza, Newell, & McCoy, 2018).

Fat individuals are stereotyped in Western societies as inferior, incapable of self-control and requiring surveillance and policing (Braziel & LeBesco, 2001). They can face economic discrimination (Brownell et al., 2005; Ernsberger, 2009), with fat women being particularly susceptible to lower occupational attainment and lower earnings than other size groups (Cawley, 2004). Weight stigma can lead to fat

[7] Lee (2019) challenges Mahere's claims that shame was an effective tool in these acts, especially as littering and racism is still rampant

individuals facing social exclusion and isolation across the lifespan (Arias Ramos, et al., 2018; Hajek & König, 2018).

There is a dominant discourse that fat individuals face social, psychological and physical health difficulties as a result of their fatness (Blair & Nichaman, 2002; Gkastaris, et al., 2020; Wyatt, et al., 2006). However, the direction of this relationship has been challenged: whereas these negative outcomes have frequently been attributed to individuals' fatness, there is mounting evidence that these negative outcomes are related to the weight stigma and prejudice fat individuals face. A meta-analysis exploring the association between weight stigma and mental health which used data from over 59,000 participants from 105 studies concluded that higher perceived weight stigma is significantly associated with diminished mental health (Emmer, Bosnjak & Mata, 2019).) A limitation of this meta-analysis is that all the studies included were cross-sectional in design, making it difficult to ascertain the direction of effect between weight stigma and mental health. However, another systematic review of the physiological and psychological health outcomes of weight stigma (Wu & Berry, 2017) identified two longitudinal studies, the findings of which suggest a direction of effects of weight stigma increasing negative health outcomes (Jackson, Beeken, & Wardle, 2014; Sutin & Terracciano, 2014).

Fat individuals who live in societies where higher weights are stigmatised (as evidenced above) are therefore exposed to stressors that might compromise their physical and mental health (Brownell et al., 2005; Puhl & Brownell, 2003). Fat individuals also might not be protected by in-group favouritism observed in other marginalised groups and fat individuals engage in weight stigma to the same extent as average weight individuals (Schwarts et al., 2006). In the United States, the National Association to Advance Fat Acceptance (NAAFA) and the International Size

Acceptance Association (ISAA) aim to respond to discrimination and encourage fat activism, but it is difficult to locate similar groups or organisations within the United Kingdom.

1.6 Weight Stigma in Physical Health

Biased views of fat people by professionals in physical healthcare and the impact of stigma on the quality of care they receive has been well documented (Phelan et al.,2015) for nurses (Merrill & Grassley, 2008), physicians (Ferrante et al., 2009, Huizinga et al., 2009) in reproductive care (see Ward & McPhail, 2019 for review), and in eating disorder treatment (Phul et al., 2014). The prejudice fat people are exposed to in medical settings can contribute to delays, and in sometimes, complete avoidance of care seeking in physical health settings because of concerns they will be judged, shamed because of their bodies, and their concerns dismissed (Alberga, Edache, Forhan, & Russell-Mayhew, 2019).

Fat individuals who seek medical care report high incidents of weight stigma from medical doctors, stating interactions with these professionals are one of the most common sources of weight stigma in their lives (Puhl & Brownell, 2006; Puhl, Himmelstein, & Pearl, 2020; Puhl, Lessard, Himmelstein, & Foster, 2021). There has been a history of prejudice against fat patients from doctors; one study described doctors listing '*obesity'* as a condition they would rate more negatively than drug addiction, alcoholism and mental health difficulties and were more likely to associate fat patients with noncompliance, dishonesty and poor hygiene (Klein, 1982). In a study of American medical students, although implicit weight-bias (unconscious preference for thin over fat people) decreased, explicit bias (conscious preference for thin over fat people) increased between their 1st and 4th year of training (Phelan et al., 2015). This could result from negative attitudes towards fat people being

modelled by qualified/senior doctors and academics providing training to medics (Kenny et al., 2003).

There is a lack of equipment available in healthcare settings for fat bodies, such as blood pressure cuffs (Dobson, 2003), pelvic examination instruments (Phelan et al., 2015), and body scanners such as Computed Tomography (CT; weight limit 450lbs) and magnetic resonance imaging (MRI; weight limit 350-550 lbs) (Hammond, 2013). The lack of available appropriate equipment further contributes to poor healthcare outcomes for fat individuals, as they do not receive the same access to physical healthcare as their straight-sized counterparts. The consequences of this, alongside weight stigma among medical professionals, can results in fat individuals receiving delayed diagnoses (Fontaine, et al., 1998), misdiagnosis (Graham, et al., 2022; Scott, et al., 2012) and not receiving diagnoses (APA, 2017).

Medical understandings of fat bodies are further complicated by a lack of good quality research involving fat bodies (Aphramor, 2010) with fat people frequently being excluded from research unless it is in relation to an intervention that specifically targets body size. This leads to fat people having reduced access to medication. Emergency contraception (commonly referred to as ‘the morning after pill’) is less effective for individuals weighing over 155 pounds, has reduced ‘potency’ in those weighing over 165 pounds and does not work at all in people weighing over 175 pounds (Glasier, 2013). Vaccines can be less effective for those in fat bodies, including the flu and COVID-19 vaccine (Popkin et al., 2020), with no current attempt to provide alternative options for those wishing to access these life-saving preventative measures. Correlations between individuals in fat bodies and higher rates of hospital admission with poorer health outcomes and higher rates of mortality during the COVID-19 pandemic (Public Health England, 2020) has led to “*shame,*

blame and moral outrage" which has been directed at fat people (Dolezal & Spratt, 2022, p.4).

Overall, a lack of training, knowledge and understanding about fat bodies, alongside practitioner bias may lead to pathologizing fat bodies. Fat individuals experiences of physical healthcare is that professionals are primarily concerned about making their bodies smaller by encouraging weight loss, despite the costs to their physical and mental health these directions might have (Paine, 2021; Ward & McPhail, 2019). In physical health, fat people's lives appear to be viewed as inherently less valuable and more risk-able than people in straight-sized or small bodies.

1.6 Weight Stigma in Mental Health

Physical and mental health professionals may have distinct roles in promoting overall well-being. Where physical health primarily deals with diseases, injuries, surgeries and medical procedures related to body's physiological system, mental health can focus on understanding and addressing psychological and emotional challenges that individuals (and systems) face. There can be overlap between these disciplines (e.g., mental health professionals working in physical healthcare) but in general, mental health professionals seem to have a different remit for working with service users than their physical health colleagues. Treatment approaches, education and training, and epistemological and ontological approaches may also differ for these groups. It is therefore important to separately consider the presence and impact of weight stigma in mental health professionals.

It is likely that mental health professionals will work with individuals with diverse body types, including fat and marginalised bodies. The relationship between weight and mental health difficulties is complex and multifaceted. Research indicates

a relationship between weight and mental health, but the direction of causality and the factors involved appear unclear; some studies indicate a bidirectional relationship between fatness and mental health diagnoses including depression and anxiety[8] (Gariepy, Nitka, & Schmitz, 2010; Luppino, et al., 2010). However, as previously explored, the stigma and discrimination fat individuals experience can negatively impact their mental health. Weight stigma contributes to feelings of low self-esteem, social isolation and increased psychological distress (Puhl & Heuer, 2009; Vartanian, Pinkus, & Smyth, 2014).

Research on weight stigma in mental health professionals appears more limited than in physical health professionals. Findings from studies that are available found that mental health professionals assigned more negative personal attributes to fat clients (Hassel et al., 2001), rated fat clients as having more severe symptoms than thin clients (Hassel et al., 2001, Young & Powell, 1985) and predicted worse treatment prognosis and made less effort in treatment of fat clients (Davis-Cohelo et al., 2000). Findings from these studies demonstrate that mental health professionals may have similar, perhaps unchallenged, negative views about weight and fatness. It has been acknowledged that there is a lack of training in weight-based prejudice in mental health professionals (Rothblum & Gartrell, 2019)

1.6.1 Weight stigma in clinical psychology

Weight stigma has recently been explored with trainee clinical psychologists in the USA (Brochu, 2019). These studies presented findings of the biases trainees

[8] The construction of these mental health diagnoses is contested but beyond the scope of this chapter to fully explore. Diagnoses are used as a way of highlighting discourses which link mental health with individuals' weight

may have towards fat individuals and attempts to reduce weight stigma through educational interventions. There is limited peer-reviewed research exploring weight stigma in clinical psychology, however, some doctoral thesis[9] have contributed to this area. One thesis explored the effects of service-user '*obesity'* on clinical judgments made by trainee clinical psychologists; in an online experiment 151 UK trainees were found to hold moderate degree of weight stigma towards fat service-users (Carter, 2018). Trainee and qualified clinical psychologists were considered to have negative implicit biases towards fat individuals and did not explicitly express any neutral or positive biases towards fat individuals[10] (Blencowe, 2017).

Clinical psychologists in the USA and UK share similarities in terms of their training and professional roles, but there are some notable differences due to variations in healthcare systems, training programs and regulatory bodies. Many UK clinical psychologists are trained to work as scientific-practitioners with a strong emphasis on using 'Evidence-based practice' (EBP), which implies that the process of making clinical decisions encompasses clinical expertise and experience, patient preferences, and presentations, and importantly integrates research evidence (Spring, 2007). Promotion of dieting and weight-loss remains a treatment goal within psychology (Akoury, Schafer, & Warren, 2019)and a Cognitive Therapy book (Beck, 2012) epitomises the idea that weight loss is an achievable goal. Given the previously reviewed evidence on the ineffectiveness of diets for weight loss (Mann, et al., 2007) and the negative impact dieting and restriction can have on mental

[9] Part of the course requirement for the Doctorate in Clinical Psychology is the submission of a research thesis, the scope and presentation of these varies by training institutions.
[10] As they did to other marginalised groups considered in the study

health and wellbeing (Tylka, et al., 2014), encouraging or endorsements of diets could be viewed as a highly unethical practice for clinical psychologists (Chrisler, 1989; McHugh & Kasardo, 2012) and against the professions' commitment to EBP.

Clinical psychologists are likely to incorporate beliefs that are dominant within the society they live in and, without specific training to challenge societal and medical bias around fat bodies, they are at risk of perpetuating oppressive structures which can damage the mental and physical health of fat service users (Tomiyama, 2014; Tomiyama, Carr, Granberg, Major et al., 2018).2018) as well as impacting more broadly on wider populations.

Training to become a clinical psychologist in the UK takes place across 30 institutions, with most places currently funded by the NHS. Trainee clinical psychologists enrolled on a three-year Professional Doctorate which involves clinical placement learning and assessment, research training, personal study, and academic assessment (ACP, 2020).

1.7 Rationale for current study

There is a current gap in research and understanding about weight stigma in the profession of clinical psychology, and more specifically, in the UK. The current study aimed to explore the presence of weight stigma within clinical psychology through a qualitative approach. Trainee clinical psychologists are rather uniquely placed within the profession as they receive clinical and academic training throughout their degree. They are required by the BPS to engage with material regarding diversity in teaching and to continue these reflections and applications whilst on clinical placement. As such, it was determined that exploring weight stigma in trainees would offer the opportunity to consider current training they have received on weight stigma and working with fat bodies, and what the cultural and societal

discourses around weight and fatness they may perpetuate and challenge. The British Psychological Society (BPS) have not made specific guidelines for training centres about the inclusion of weight stigma in diversity training and do not appear to consider it when assessing diversity of its trainees, staff, or NHS service users (BPS, 2019). Trainee clinical psychologists are the future of the profession and workforce and thus may hold power to shape the evolution of professional cultures and practice around weight stigma.

Systematic Literature Review

1.8 Overview

The introductory chapter of this thesis presented evidence of weight stigma in healthcare professionals, as well as a burgeoning interest in anti-fat bias and its negative consequences. To the author's knowledge, there has been no published review that has synthesised empirical research focusing on weight stigma in mental health professionals. A search of the international prospective register of systematic reviews (PROSPERO) (Schiavo, 2019) did not find any past or current studies focussed on weight stigma in mental health professionals.

Systematic literature reviews (SLRs) provide opportunities to critique and synthesise existing evidence and literature (Siddaway, Wood, & Hedges, 2019). Existing systematic reviews have explored weight-based prejudice in exercise and nutrition professionals (Panza, et al., 2018), dieticians (Jung, Luck-Sikorski, Wiemers, & Riedel-Heller, 2015) and healthcare professionals' (Budd, Mariotti, Graff, & Falkenstein, 2011; Lawrence, et al., 2021). Many studies which examine weight prejudice in healthcare settings have grouped physical and mental health professionals together (Harvey & Hill, 2001; Vallis, Currie, Lawlor, & Ransom, 2007; Wise, Harris, & Olver, 2014). These professions typically have different areas of expertise, focuses of concern, treatment approaches, setting of practices, and educational/training routes. Therefore, systematically reviewing studies examining weight-based prejudice in mental health professionals may distinguish similarities or differences between the professions.

The introductory chapter provided an outline for the importance of language in relation to bodies. Puhl (2020) reviewed 33 studies examining preferences for

weight-related terminology and findings suggested that neutral terminology (e.g., weight or unhealthy weight) is preferred to words that were viewed as more medicalised and/or stigmatising (e.g., "*obese").* Given that words can further contribute to stigmatising, pathologizing and dehumanising fat bodies, the current review attended to the language used in the publications.

The current review was also interested in how demographics of the mental health professionals (e.g., sex, ethnicity, and age) involved in the study were considered. Although it is difficult to estimate the demographic profile of mental health professionals globally, the qualified clinical psychologists in the UK are overwhelmingly White (88.2%) and female (79%) with an average age of 42 (Longwill, 2015). Weight-stigma in physical health professionals has also considered qualification status; in a study of medical students, implicit weight-bias decreased over the course of their training, whereas explicit bias increased (Phelan et al., 2015). This may have been a result of negative attitudes towards fat people being modelled by qualified/senior doctors and academics providing training to medics (Kenny et al., 2003). The review will consider the qualification status of mental health professionals in the studies to investigate whether weight stigma is perceived among both trainees and qualified professionals.

A previous unpublished SLR (part of a doctoral thesis) exploring weight stigma in mental health professionals (Carter, 2018) identified eight studies. The justifications for completing a similar SLR are:

1. Increased interest/empirical research in weight stigma in the past five years (Flint, 2022; Rubino, et al., 2020) may result in identification of additional studies, providing a more up-to-date review of the literature.
2. The previous SLR focussed on how negative beliefs and attitudes about fatness impacted clinical judgement of mental health professionals, the current SLR explores weight stigma in mental health professionals with a focus on language

3. The previous SLR remains unpublished and poorly accessible to researchers and mental health professionals. This current, updated SLR will prioritise publication to offer access to the academic and clinical community (Dowd & Johnson, 2020).

1.9 Review Questions

The systematic review of empirical literature aims to answer the following overarching question:

What does the literature tell us about weight stigma in mental health professionals?

Exploratory research question:

What language do the studies use to describe fat bodies/individuals and weight stigma?

1.10 Systematic Literature Review Process

1.10.1 Search strategy method.

The SPIDER tool (Cooke, Smith, & Booth, 2012) (Table 1) was used to identify the guiding question. The searches for the systematic review were conducted in April 2023 using the following bibliographic databases, accessed via the University of Hertfordshire; Scopus, PsycArticles, PubMed, Cohrane Library and CINAHL plus. These databases represented a range of disciplines including psychology and medicine. Previously identified key papers in the area were reviewed to establish potential search terms and several pilot searches were used to further capture terms and relevant articles (Appendix D).

Table 1: SPIDER Tool for Search Strategy

Sample	Mental Health Professionals
Phenomenon of **I**nterest	Weight stigma
Design	Questionnaire, surveys, interventions, interviews, focus groups
Evaluation	Views, experiences, beliefs
Research Type	Qualitative, Quantitative, Mixed Method

Appendix E provides the concepts and associated search terms used to conduct the search. The researcher broke the topic into concepts to create search terms (Siddaway, Wood, & Hedges, 2019). Article titles, tags and keywords were used to identify further terms, in addition to the thesaurus function of the database. Search terms were truncated and both UK and US spellings were utilised to yield a higher number of papers and terms were combined using Boolean operators 'AND/'OR'. Inclusion and exclusion criteria are outlined in Table 2.

Table 2. Inclusion and Exclusion criteria

Inclusion criteria	Exclusion criteria
Article available in English	Article not available in English
Article is an original empirical study (using quantitative, qualitative or mixed methods)	Article is not an empirical study (e.g., commentary or reviews of literature)
Study involved Mental Health Professionals (MHPs)	Study does not include MHPs ***or*** study does not separate MHPs from other health professionals
Study involves some element of weight-based prejudice/weight bias	Study does not include any element or mention of weight-based prejudice/weight bias
Study is published in a peer-reviewed journal	Study is not published within a peer-reviewed journal

1.10.2 Review process.

The following procedure was followed to complete the SLR (Table 3), following guidance from Siddaway et al., (2019).

Table 3. SLR Steps to identify final collection of articles

Step 1	Search results were exported from bibliographic databases to Covidence (systematic review management tool) (Veritas Health Innovation, 2023)
Step 2	Duplicates removed
Step 3	Titles then abstracts screened according to inclusion and exclusion criteria: records were removed if the title included a profession name that was not a mental health professional (e.g., dietician, medical student). If the title included 'Healthcare Professional' the abstract was checked to see if this included mental health professionals; if no MHP included, article screened out, if MHP included *or* unsure from abstract, article was included for full text review.

Step 4	Articles which did not meet the inclusion criteria were removed
Step 5	Review borderline cases (studies which are near misses for inclusion/exclusion criteria)
Step 6	References of final articles hand-searched for any potential missed relevant articles *(Step 3-6 repeated with these articles*)
Step 7	Final collection of articles established

A flow diagram summarising the literature searching and shifting process using Preferred reporting items for systematic reviews and meta-analyses (PRISMA) (Page, et al., 2021) was produced (Figure 2).

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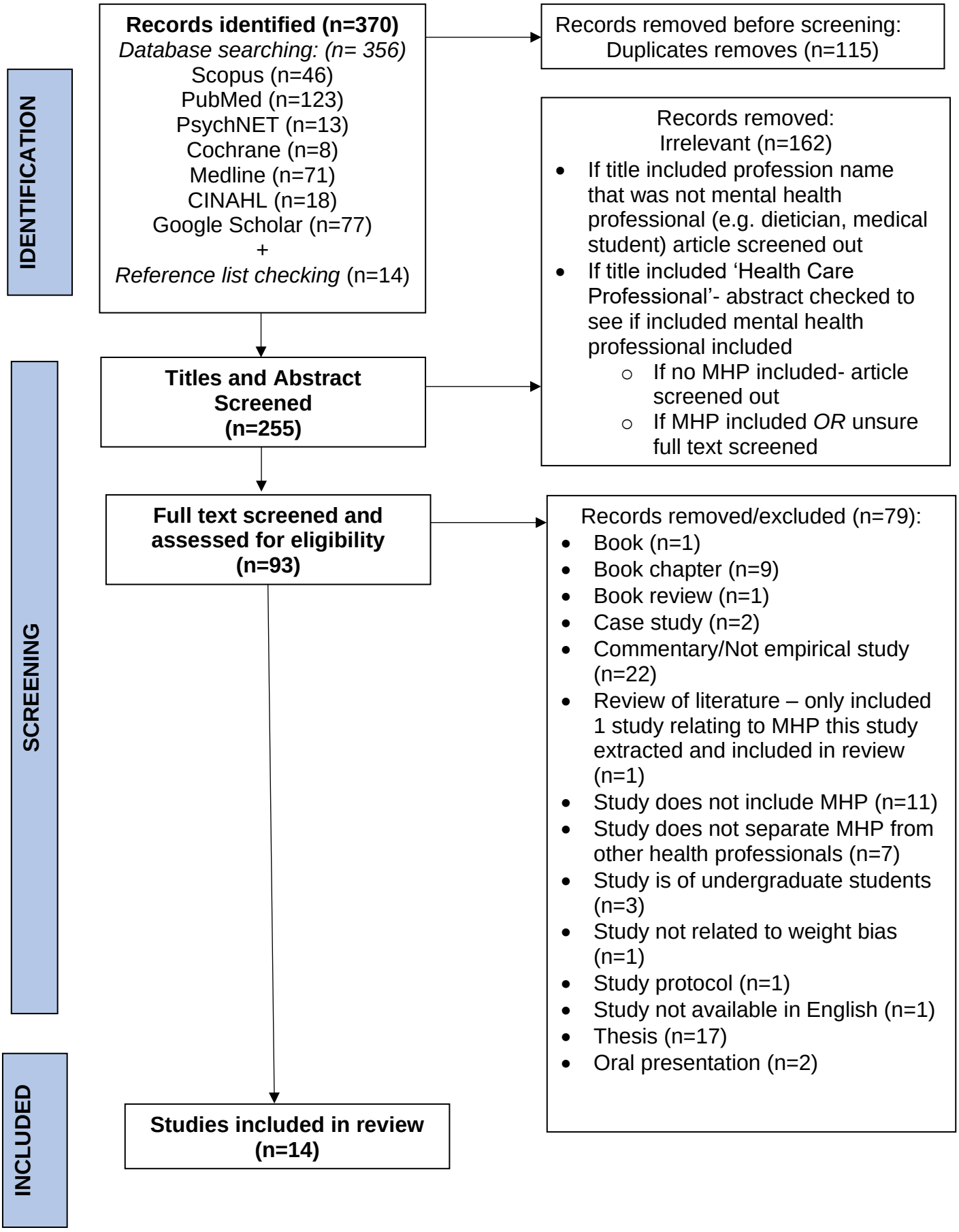
Figure 2: PRISMA literature searching and final paper identification summary



1.10.3 Quality assessment of studies.

Studies were assessed for their quality using appraisal tools to consider the robustness of the methodology and credibility of the findings (Boland, Dickson, & Cherry, 2017). All studies were rated separately by an independent rater, discrepancies were discussed and resulted in a shared agreement by both raters.

The 10-item Critical Appraisal Skills Program (CASP, 2018) is commonly used for quality appraisal in health-related research and recommended by the Cochrane Collaborative (Noyes, et al., 2018). CASP was used to evaluate the qualitative study selected as part of the review. As the quantitative studies did not fit the framework (e.g., not randomised control trials, case control or clinical predictions) alternative tools were identified for these studies.

The 11 quantitative cross-sectional studies were appraised using the Appraisal tool for Cross-Sectional Studies (AXIS) (Downes, Brennan, Williams, & Dean, 2016). This 20-item assessment evaluates the study's various components including introduction, methodology, results, discussion, and ethical approval. One intervention study was assessed using the Quality Assessment Tool for Quantitative Studies, developed by the Effective Public Health Practice Project (EPHPP; Thomas, Ciliska, Dobbins, & Micucci, 2004). Ratings consider study design; data collection and intervention integrity and an overall methodological quality rating is provided.

The Quality Assessment of Mixed Methods Study Appraisal Tool (MMAT; (Hong, et al., 2018) was used for one study. This assessment considered the qualitative and quantitative elements of the research, as well as the rationale for mixed-methods and integration of the components.

1.11 Systematic Review Results

Figure 2 provides a summary of the SLR. Of 370 articles identified, *n*=115 were removed due to duplication, *n*=162 were removed due to irrelevant title and/or abstract and *n*=79 were removed following a full text and eligibility screen for not meeting inclusion/exclusion criteria. Fourteen studies were included.

1.11.1 Articles included in the review.

Table 4 provides brief summaries of articles selected. Demographic information reflects available information from the study. If participants were described as ‘female’ or ‘male’, demographic information was listed as gender, if ‘woman’ or ‘man’ is used, demographic information was listed as sex.

Table 4. Summary of SLR Studies

#	Author (Year)	Title	Location	Sample	Research Methodology
1	Agell & Rothblum (1991)	Effects of clients' obesity and gender on the therapy judgements of psychologists	USA	**N=** 282 psychologists **Recruited:** Membership of APA **Gender:** 34% female, 66% male **Ethnicity:** 90% White	Quantitative
2	Bleich et al., (2015)	US health professionals' views on obesity care, training and self-efficacy	USA	**N=** 500 US health professionals –nutrition, nursing, behavioural/mental health, exercise, pharmacy (*n*=100 from each) **Recruited:** Medical Market Research Panel, USA **Gender:** *(of behavioural/mental health)**: 69% female, N/S male, **Ethnicity*:** 82% White	Quantitative
3	Brochu (2020)	Testing the effectiveness of a weight bias educational intervention among clinical psychology trainees	USA	**N=** 45 clinical psychologist trainees **Recruited:** Attendance of mental health training program **Sex:** 62.2% women, 35.6% men **Ethnicity:** 62% White, 18% Hispanic or Latinx, 11% Asian, 4% multiracial, 2% Black	Quantitative
4	Cravens et al., (2016)	Marriage and Family Therapy Students' views on including weight bias training into their clinical programs	USA	**N=** 35 marriage and family therapy (MFT) and medical family therapy(MedFT) trainees **Recruited:** Accredited master's and doctoral programs **Gender:** 68.6% female, 25.7% male **Ethnicity:** N/S	Qualitative

5	Davis-Coelho et al., (2000)	Awareness and prevention of bias against fat clients in psychotherapy	USA	**N=** 200 psychologists and psychotherapists **Recruited:** APA's Divisions of Clinical Psychology & Counselling Psychology, Psychotherapy and Psychologists in Independent Practice **Gender:** 38.5 % female, 61.5% male **Ethnicity:** 94% White, 6% 'Non-White'	Quantitative
6	Forristal et al., (2021)	Fatmisia and Clinical Counseling Decision-Making in Master's-Level Counselor Trainees	USA	**N=** 113 counsellor trainees **Recruited:** N/S- participants were from training programmes accredited by the Council for Accreditation of Counselling and Related Educational Programs **Gender:** 73.5% female, 26.5% male **Ethnicity:** 66.4% White, 15.9% Black, 6.2% Latinx, 5.3% Biracial/multiracial, 0.9% Native American, 0.9% Pacific Islander	Quantitative
7	Hassel et al., (2001)	Client weight as a barrier to non-biased clinical judgement	USA	**N=** 163 mental health professionals **Recruited:** Meetings and conventions of professional psychological associations and graduate schools **Sex:** 53% women, 47% men **Ethnicity:** 79.8% White, 8.6% African American, 4.9% Hispanic, 4.3% Asian American, 2.5% 'other'	Quantitative
8	Pascal et al., (2012)	Perceptions of Clients: Influences of Client Weight and Job Status	USA	**N=** 74 mental health graduate students **Recruited:** Mental health graduate programs **Gender:** 80.3% female, 17.1% male	Quantitative

				Ethnicity: 77.6% White, 6.6% Latino/a American, 5.3% African American, 3.9% Asian American, 2.6% multiethnic, 2.6% did not respond	
9	Pratt et al., (2014)	Marriage and Family Therapists' Perspectives on Treating Overweight Clients and Their Weight-Related Behaviours (WRB)	USA	**N=** 108 marriage and family therapist trainees and qualified/professionals **Recruited:** Master's, doctoral and post-degree certificate program directors contacted and placed on Association of **Gender:** 80.6% female, 19.4% male **Ethnicity:**75% White, 25% 'Other'	Mixed Methods
10	Pratt et al., (2016)	Marriage and Family Therapy Trainees' Reports of Explicit Weight Bias	USA	**N=** 162 marriage and family therapist trainees **Recruited:** Email sent to accredited master's and doctoral program directors to circulate to trainees **Gender:** 83.9% female, N/S male **Ethnicity:** 69.1% White	Quantitative
11	Stapleton (2015)	Beliefs about Causes of Obesity: A Comparison of Australian Doctors, Psychologists and Community Members	Australia	**N=** 271 doctors (*n*=41), psychologists (*n*=66) and community members (*n*=98) **Recruited:** Social media and newsletters of professional societies **Gender** (*of psychologists)**:** 89.4% female, 10.6% male **Ethnicity*:** 90.9% White Australian, 7.6% European, 1.5% Arab-Chinese	Quantitative
12	Van der Voorn et al., (2023)	Weight-biased attitudes about paediatric patients with obesity in Dutch healthcare	The Netherlands	**N=** 555 Healthcare Professionals (HCPs) including mental health professionals (*n*=39, 7%) **Recruited:** HCPs throughout the Netherlands invited to participate through their professional associations or public health services	Quantitative

		professionals (HCP) from seven different professionals		**Gender** (*total sample)**:** N/S females, 7% males **Ethnicity*:** N/S	
13	Veillette et al., (2018)	What's Weight Got to Do With It? Mental Health Trainees' (MHT)Perceptions of a client with Anorexia Nervosa Symptoms	USA	**N=** 90 graduate-level mental health program students **Recruited:** Graduate-level mental health program social media sites, email & flyer dispersal at a university in the southeastern region of USA **Sex:** 90% women, N/S men **Ethnicity:** 62% White, 18% Hispanic/Latinx, 7% Multiracial, 6% African American, 4% Asian, 3% declined to respond	Quantitative
14	Young & Powell (1985)	The effects of obesity on the clinical judgements of mental health professionals (MHP)	USA	**N=** 120 Mental health professionals **Recruited:** Public and private nonprofit clinical centres in Virginia, USA **Gender:** N/S **Ethnicity:** N/S	Quantitative

1.12 Quality assessment findings

A full evaluation of the quality of each article following AXIS (Downes, Brennan, Williams, & Dean, 2016), EPHPP (Thomas, Ciliska, Dobbins, & Micucci, 2004), MMAT (Hong, et al., 2018) and CASP (CASP, 2018) are included in Appendix 1-4. Quality appraisals were completed for cross-sectional studies (Articles 1,2,5,6,7,8,10,11,12,13,14), an intervention study (Article 3) a mixed-methods study (Article 9) and a qualitative study (Article 4). An overview of the findings will be provided here.

1.12.1 Quality appraisal of cross-sectional studies.

Table 5. Studies appraised using AXIS

#	1	2	5	6	7	8	10	11	12	13	14
Author(s) (**Year**)	Agell & Rothblum (1991)	Bleich et al., (2015)	Davis-Coelho et al., (2000)	Forristal et al., (2021)	Hassel et al., (2001)	Pascal et al., (2012)	Pratt et al., (2016)	Stapleton et al., (2015)	Van der Voorn et al., (2023)	Veillette et al., (2018)	Young et al., (1985)

The overall quality of the cross-sectional studies included in the SLR (Table 5) was deemed acceptable (Appendix F). There were some notable exceptions to this; only two studies (Articles 2 & 6) justified the sample size. Those studies that did not provide a justification (Articles 1,5,7,8,10,11,12,13,14) may lead to biased estimates, low statistical power, and increased sampling error, minimising the validity of results (Faber & Fonseca, 2014). None of the studies considered why individuals did not participate in the study, which was typically discussed in the context of sampling methods. The findings of the studies are still thought to make a valuable contribution

to the understanding of weight stigma in mental health professionals but will be interpreted considering these limitations.

1.12.2 Quality appraisal of intervention study.

Brochu (2019) was deemed to have a 'Strong' global rating (Appendix G), the study was not randomised as all participants (trainee clinical psychologists) received the educational intervention and the study was deemed to have good intervention integrity. The findings of the study can therefore be included with confidence.

1.12.3 Quality appraisal of mixed-method study.

The evaluation of Pratt et al (2014) using the MMAT (Hong et al., 2018) indicated that there was a clear research question with appropriate data collection to address the question, making it suitable to be screened for its mixed methods (Appendix H). Although the study had positive ratings for both qualitative and quantitative elements, the paper did not provide a clear rationale for the use of mixed methods, the different components were not effectively integrated, and the combined outputs not addressed.

1.12.4 Quality appraisal of qualitative study.

CASP was used to evaluate Cravens et al., (2016) and found the methodology and design to be appropriate for the research question (Appendix I). The researchers commented on the limitation of the delivery of a weight bias training seminar given by the same individuals who facilitated the focus group to collect data. However, there was no further consideration of the relationship between researcher and participant, with no indication of researcher reflexivity and transparency. Despite this, the study was considered to make a valuable contribution to the research area.

1.12.5 Summary of quality appraisal.

The use of four quality appraisal tools highlighted that, although there were some limitations across the studies, none were of such poor quality that the findings should be considered with caution. Where there are discrepancies between studies, individual study quality will be considered.

1.13 Summary of study characteristics

The following section will summarise key features of the studies included in the systematic literature review including study aims, participant characteristics, study designs, study findings, and future research proposed in the literature

1.13.1 Summary of included study aims.

Several studies included in the review aimed to investigate whether mental health professionals hold negative stereotypes about fat clients, and whether these views have a negative impact on assessment, prognosis and/or delivery of therapy (Articles 1, 5, 6, 7, 8, 13, 14). Three studies (Articles 2, 11, 12) aimed to explore perspectives of different healthcare professionals (including mental health) on their understanding of the causes of '*obesity'.* Two studies aimed to examine the efficacy of using seminars to raise awareness of weight stigma to reduce anti-fat beliefs/attitudes (Article 3) or consider how to integrate this work into training curriculums (Article 4).

1.13.2 Summary of study design.

The procedures and study designs of the studies included in this review can be grouped as follows, experimental designs, questionnaires/surveys and studies which included a weight-bias seminar (these studies were an intervention and focus group design).

Experimental design studies.

Seven of the included studies used vignettes of fictional clients in which weight and sometimes other demographics were manipulated (Articles 1, 5, 6, 7, 8, 13, 14). Four included a photo or picture of the client which had also been manipulated to represent different weights (Articles 5, 6, 7, 14). The studies are summarised in Table 6.

Participants in these studies were randomly assigned to different conditions and asked to complete measures pertaining to their views on the client including prognosis and expectations around their use of therapy. Vignettes of fictional clients were written as a referral to the professional, or from the client's perspective. All the vignettes described white women, although two studies (Articles 1 & 7) included a white man to compare the impact of client gender presentation on therapists' judgement.

Table 6. Experimental study summaries

#	Author (Year)	Research Methodology	Measures	Findings	Strengths & Limitations
1	Agel & Rothblum (1991)	Quantitative study: Between subjects' design, of fictional case history models; 8 experimental conditions (2xcase models, 2xweight, 2xgender)- fictional case history models. Participants read case histories that were manipulated by weight and gender.	***Person Perception Inventory*** adapted from Worsely, (1981) 28 items from 7 semantic differential-style scale, including personality attributes (e.g., dependent/independent, dull/lively) physical attractiveness attributes and social attractiveness ***Case History Questionnaire*** Rated client using 7 point Likert scale on questions relating to participants opinions including severity of targets problem, motivation to change, therapists treatment interest, prognosis for client, expected treatment duration/ number of sessions and whether client would be referred elsewhere (and to whom)	Psychologists were negatively influenced by a client's weight. They rated '*obese'* clients more negatively on appearance. Negative impression of clients' appearance did not generalize to more negative diagnosis or treatment recommendations	+ sample size allowed adequate manipulation of the case study in different conditions + study aimed to consider the impact of psychologists' bias and stereotype impact on diagnosis, treatment, and prognosis - no indication of participant own relation to weight/body size and how this might impact findings - study over 30 years old;
5	Davis-Coelho et al., (2000)	Quantitative Independent measures, experimental design. Two hypothetical clients. Participants given a self-reported history of the clients and a photograph. Histories were identical but weight of the client was manipulated in the photograph.	**Global Assessment of Functioning (GAF)** *-not described in study: this measured how much a person's symptoms affect their day-to day life on a scale of 0 to 100* (Jones, Thornicroft, Coffey, & Dunn, 1995) **Questionnaire** (*no specific measures listed in study)* Included questions assessing recommended treatment modality, provisional diagnosis, prognosis, client effort client motivation	Female psychologists predicted worse outcomes for the fat client Diagnoses influenced by client weight- psychologists were more likely to suggest a diagnosis of an eating disorder for the fat client than for the non-fat client Treatment goals influenced by client weight- psychologists indicated that "improve body image" was significantly more	+ study provides implications and recommendations for psychologists to try and reduce weight bias + study provides real life actions therapists can take to support fat clients (e.g. ensuring physical environment is supportive) -Limited generalisability as sample from one area of the US - self report data which is subjected to reporting bias.

				likely to be a treatment goal for the fat client	
6	Forristal et al., (2021)	Quantitative Independent measures, experimental design. Participants were randomly assigned to one of three groups (control- unaltered photo of model; overweight -slightly altered photo; '*obese'* heavily altered photo)	**Fat-Phobia Scale- Short Form** (FPS-SF; (Bacon, Scheltema, & Robinson, 2001) Based on Robinson et al (1993)50-item Likert-style Fat Phobia Scale (FPS). The FPS-SF uses 14 items to rate participants beliefs of fat people on a scale of 1-5 (e.g., from lazy to industrious, from self-indulgent to self-sacrificing) **Weight Bias Internalised Scale** (Durso & Latner, 2008) Self-report questionnaire measures internalized negative stereotypes and negative self-statements about '*overweight'* and '*obese'* persons (e.g., "*I hate myself for being overweight")*	Counsellor trainees held negative beliefs about fat people Counsellor trainees rated fatter clients as having more severe levels of depression but no sig. differences in clinical recommendation by condition but after controlling for FPS-SF, WBIS and self-reported BMI, significant effect of group assignment on clinical rec. for diagnosis.	+utilized a standardised vignette to ensure consistency across participants +comparatively diverse sample - Potential social desirability bias in self-report measures -single vignette may not fully capture complexity of clinical decision-making related to weight bias
7	Hassel et al., 2001	Quantitative Between subjects, 4 conditions (m/f average weight/ overweight), 4 participant groups (m/f, Christian, non-Christian). Participants given a clinical vignette accompanied by a picture depicting a therapy scene of a client sitting on a couch. Client was either male or female and either '*overweight'* or of '*average'* weight	**DSM-IV (1994) Diagnoses List** Participants asked to select from 10 DSM-IV diagnoses (1994)which were grouped into Major Depression, Anxiety Disorders, Adjustment Disorders & Relational Problems **Attitude Scale** (*adapted from* (Harris, Walters, & Waschull, 1991)Participants rated client according to 22 adjectives on 7-point likert-scale with an overall attitude score calculated; the higher the participants total score, the more negative attributions they had of the client **Attitudes Toward Obese Patients Scale (**ATAOP**;** (Bagley, Conklin, Isherwood, Pechiulis, & Watson, 1989) Assess attitudes toward '*obese'* patients	Mental health professionals ascribed more pathology and negative attributes to *'obese'* clients than to average-weight clients. They were almost twice as likely to be given an adjustment disorder. Diagnoses of depression and anxiety given at similar rates for '*obese'* and '*average'* weight clients. Mental health professionals judgments of GAF scores for '*obese*' clients were lower than for *'average'* weight clients.	+standardized vignette used to assess effect of client weight on clinical judgement which aimed to control for variability across different clinical scenarios + insights into potential impact of weight bias on clinical judgement and highlights need to address biases in training. - Just over 9% of the Sample were participants whose highest qualification was an undergraduate BS or BA degree in psychology or related topic…not really MHP

			Global Assessment of Functioning (GAF) (Jones, Thornicroft, Coffey, & Dunn, 1995)		-no clear justification for Christian compared to other religious affiliation.
8	Pascal & Kurpius, (2012)	Quantitative Experimental, between subjects; 2(client weight) x 2(job status) factorial design. Trainees randomly assigned to 1 of 4 treatment conditions/vignettes. Female client described as either '*obese*' or '*normal'* weight and as a bookkeeper or executive.	**Fat-Phobia Scale- Short form (**FPS-SF; Bacon et al., 2001) **Personal Efficacy Beliefs Scale (**PEBS; (Riggs, Warka, Babasa, Betancourt, & Hooker, 1994)Evaluates attitudes about the participants perception of the client's ability and confidence in their job skills	Mental Health Trainees perceived more negative personal characteristics about '*obese'* client than the '*normal'* weight client but no differences regarding client weight and perceived work efficacy. For '*obese'* clients, personal characteristics correlated with ratings for work efficacy (more negative perceptions of work efficacy related to more negative perceptions of client's personal characteristics) but not for '*normal'* weight clients. '*Obese'* clients were more likely to be viewed as lacking self-control, as someone who overeats, having low self-esteem and as being unattractive than '*normal'* weight clients. 'N*ormal'* weight clients more likely to be rated as having endurance and will-power.	+ examines biases using validated measures + implications are contextualised in a training context - only explicit biases measured (social desirability bias?) -lack of gender and racial diversity in the sample
13	Veillette et al., (2018)	Quantitative Between subjects' experimental design. Participants randomly assigned to read one of three vignettes where weight of client was manipulated.	**Diagnostic Question** Open ended question: "*What would your diagnosis of Susan be?"* **Number of treatment sessions recommended for client**	Participants in the "overweight" condition were less likely to assign a diagnosis of anorexia nervosa or atypical anorexia nervosa.	+ supportive of previous findings in a novel group of MHT + clear outline for training needs for MHT working in eating disorders and future research

			Fat-Phobia Scale- Short form (FPS-SF; Bacon et al., 2001) **Attitudes Toward Obese Patients Scale (**ATAOP**;** Bagely et al., 1989)	Participants in the "underweight" condition were more likely to assign a diagnosis of anorexia nervosa or atypical anorexia nervosa. Participants recommended fewer treatment sessions for the client when she was "overweight" than when she was "underweight" Participants more strongly endorsed weight stereotypes in their perceptions of the client when she was "overweight. Participants reported similarly positive attitudes toward the client regardless of BMI	- self-report explicit weight bias, subject to bias and respondent effects - generalizability of findings outside ED?
14	Young & Powell (1985)	Quantitative Between- subjects' experimental design. Participants randomly assigned to read one of three vignettes where weight of client was manipulated.	**Questionnaire** (*modified from* (Settin & Bramel, 1981) Measured participants responses to specific client variables; assessed clinicians willingness to work with client, belief that therapeutic intervention would be useful, belief of a favourable prognosis.	Mental health professionals rated '*obese'* patients as having more severe symptoms of depression, anxiety and low self-esteem, and more likely to recommend hospitalization and medication than '*average'* weight clients. Mental health professionals clinical judgments and treatment recommendations were affected by the patient's weight, with the obese patient being perceived as having more severe symptoms and requiring more medical intervention and less psychotherapy.	+ one of the first studies to look at weight bias in MHP + included measure of participant's weight - Study conducted in mid 1980's and may not reflect current attitudes and beliefs about '*obesity'* in MHP - self-report explicit weight bias, subject to bias and respondent effects

Table 7 provides an overview of how clients in the vignettes were described or visually represented. Two of articles (5, 14) included a pilot study to ensure pictures of clients represented distinct body sizes.

Table 7. Description of fictional clients used in studies

		Client Descriptions/Images			
#	**Author(s) (Year)**	**'Underweight'**	**'Average-weight'**	**'Over-weight'**	**'Very-Over weight'**
1	Aggel et al., (1991)		**Weight**: 135lbs **Height**: 5ft, 7 inch	**Weight:** 190lbs **Height:** 5ft 7 inch	
5	Davis-Coelho et al., 2000		**Weight**: 130-139lbs **Photo:** unaltered	**Weight:** 170-179lbs **Photo:** Altered with theatrical makeup and padding	
6	Forristal et al., 2021	**Photo:** altered by professional graphic artist using photoshop	**Photo:** unaltered	**Photo:** altered by professional graphic artist using photoshop	
7	Hassel et al., 2001		**Picture**: how body configured not stated	**Picture**: how body configured not stated	
8	Pascal & Kurpius, 2012		**Weight:** 135lbs **Height:** 5ft, 5 inch		**Weight**: 235lbs **Height:** 5ft, 5 inch
13	Veillette et al., 2018	**BMI:** 16.6	**BMI**: 21.3	**BMI**: 29.5	
14	Young & Powell, 1985		**Photo:** unaltered	**Photo**: altered to appear 20% weight increase	**Photo**: altered to appear 40% weight increase

Questionnaire/survey studies.

Five of the studies used cross-sectional survey designs to obtain participants' reported attitudes and beliefs about working with fat clients (Articles 2, 9, 10, 11, 12), see Table 8 for study summaries.

Two studies focused on professionals' current practices, training and beliefs related to working with fat clients on '*weight related behaviours'*, including weight loss (Articles 2 & 9). One of the studies specifically focused on current practices, training, and beliefs (Article 9). Another asked participants' to assess how important they felt biological, patient-level and social/environmental factors were as contributing factors to '*obesity'* in their service users, their quality of training around

working with weight management and their confidence on helping '*obese patients'* achieve weight loss (Article 2). The remaining studies (Articles 10, 11, 12) focused on assessing participants' attitudes and beliefs about fat people and clients.

Table 8. Questionnaire/Survey study summaries

#	Author (Year)	Research Methodology	Measures	Findings	Strengths & Limitations
2	Bleich et al. (2015)	Quantitative study: Cross-sectional internet-based survey Participants sent an online survey with questions relating to causes of '*obesity*', training they had received in weight management, their confidence in providing '*obesity*' care	**Beliefs about causes of obesity** Assessed by asking '*How important is each of the following possible causes of obesity for your patients?'* Falling into biological, patient-level and social/environmental factors **Quality of weight management training** Assessed by asking '*how would you describe the training you received regarding 'obesity' care and weight loss counselling during…degree or…training'* **Self-efficacy** Assessed by asking *'how confident are you in your ability to help your 'obese' patient…achieve...weight loss?'*	Nutritionists were more likely to identify genetics or family history as an important factor contributing to '*obesity*' than nursing or mental health professionals. Individual-level behavioural factors were overwhelmingly identified as important causes of *'obesity'*, with nearly all participants citing insufficient physical activity, overconsumption of food, lack of will power, and lack of information on good eating habits. About one third of each professional group had additional training in '*obesity*' and stigma	+ Comparing MHP with range of other health professionals working with fat people (*but separated by profession)* + rigorous methodology involved a thorough literature review to inform development of the survey -Study's focus is not specifically on weight prejudice, more aimed at 'weight management' (though question on bias was included) - Self-report measures
9	Pratt et al. (2014)	Mixed Methods Cross sectional online survey design. 20 quantitative items measuring current practices, training and beliefs and two open-ended qualitative questions asking about	**Current weight related practices** Seven Likert-scale items which assessed participants' current weight-related practices with clients in the past year. **Training to work with clients on Weight Related Behaviours (WRB)** Five Likert-scale items to assess participants training experiences in working with overweight clients and their WRB	Most MFTs reported they frequently work with overweight clients but feel only somewhat competent in treating weight-related issues. They tended to view '*overweight'* and '*obesity'* as complex issues involving multiple factos (including psychological,	+ insight into the perspectives and practices of MFT and importance of addressing weight prejudice + valuable information on challenges and barriers MFTS face which can help inform future training and education

		conceptualizing MFT theory and successful outcomes.	**Beliefs about working with clients on WRB** Nine Likert-scale items assessing participant's beliefs about working with clients on WRB	social, cultural and environmental). MFTs generally agreed that weight stigma and discrimination are common problems that these clients face and the importance of addressing it in therapy	- self-report data, subject to bias and might not accurately reflect practice - study did not explore impact of therapist characteristics (e.g. gender or weight) on which might be relevant to understanding current findings
10	Pratt et al., (2016)	Quantitative Cross sectional online survey design. Participants sent an online survey with questions about their attitudes toward and beliefs about fat individuals and anti-fat attitudes	**Attitudes Toward Obese Patients Scale (**ATAOP**;** Bagely et al., 1989) Assess attitudes toward '*obese'* patients **Beliefs about '*obese'* person scale** (BAOP; Allison et al., 1991) Measures explicit beliefs regarding '*obesity'*, specifically around the perceived causes of '*obesity'* **Anti-fat attitudes questionnaire** (AFA; Crandall, 1994) Measures personal dislike of overweight or '*obese'* individuals (explicit weight bias)	Marriage and Family Therapy trainees reported moderate levels of explicit weight bias, male trainees reported higher levels of explicit weight bias. Trainees who reported personal experiences with weight bias had higher levels of explicit weight bias. Trainees with higher BMI scores had lower levels of explicit weight bias. Older trainees had lower levels of explicit weight bias than younger ones	+ well validated measures +demonstrates explicit weight bias among MFT trainees which has implication for quality of care and training on working with fat clients - self-report data, subject to bias and might not accurately reflect practice - didn't examine relationship between explicit weight bias and actual clinical practice
11	Stapleton et al., (2015)	Quantitative Cross sectional online survey design Study measured beliefs about the causes of obesity. Medical doctors, psychologists, and members of the general public completed questionnaires.	**Attitudes Toward Obese Patients Scale (**ATAOP**;** Bagely et al., 1989) Assess attitudes toward '*obese'* patients **Anti-fat attitudes questionnaire** (AFA; Crandall, 1994) Measures personal dislike of overweight or '*obese'* individuals (explicit weight bias) **Beliefs about '*obese'* person scale** (BAOP; Allison et al., 1991) Measures explicit beliefs regarding '*obesity'*, specifically around the perceived causes of '*obesity'*	The study found that individual behavioural factors, such as overeating or lack of exercise, were the most commonly attributed causes of '*obesity'* across all participant groups. These behavioural causes were more frequently cited than biological, psychological, or social factors, indicating that the perception of '*obesity*' being within an	+comparison of different professions and community members -lack of gender and racial diversity in sample - self-report data, subject to bias and might not accurately reflect practice

				individual's control was prevalent	
12	Van der Voorn et al. (2023)	Quantitative Cross sectional online and paper survey design. Healthcare professionals (HCPs) throughout the Netherlands invited to participate	**Attitudes of Health Care Providers about Treating Patients with 'Obesity' scale** (Puhl et al., 2014) 22 items comprising four subscales: 1) negative attitudes toward patients with '*obesity*', 2) perceived frustrations in treating patients with '*obesity*', 3) perceived confidence and preparedness in treating patients with '*obesity*', 4) perceived weight bias by colleagues	Paediatricians and GPs reported the highest number of negative weight-biased attitudes, including more negative attitudes, more perceived frustrations, less confidence and preparedness in treating patients with '*obesity*'. Paediatricians and GPs perceived more weight bias by colleagues compared to other professionals. Dieticians reported the lowest number of negative weight-biased attitudes, including less negative attitudes, less perceived frustrations, and more confidence and preparedness in treating patients with obesity compared to the other groups of HCPs	+ Novelty: limited research on weight bias among HCP in the Netherlands + implications for practice (training and educations) and future research around weight bias in Dutch HCP - small sample size per HCP subgroup (couldn't study potential impact of personal characteristics on reported weight-bias) - self-report explicit weight bias, subject to bias and respondent effects

Studies using weight-bias seminar: intervention or focus group.

Two of the studies included in the review used a weight-bias seminar as part of their procedure (See Table 10, Articles 3 & 4). Brochu (2020) used the seminar as an intervention, measuring participants' attitudes to fat individuals and fat clients pre- and post-seminar. Cravens et al., (2016) piloted and evaluated a weight-bias training programme by inviting participants to a focus group following the seminar.

Table 9. Weight bias seminar study summaries

#	Author (Year)	Research Methodology	Measures	Findings	Strengths & Limitations
3	Brochu (2020)	Quantitative: Repeated Measures; Pre-test-post-test intervention design. Participants were sent measures to complete 1 week before and 1 week after a weight-bias seminar.	**Anti-fat Attitudes Questionnaire** (Crandall, 1994; Quin & Crocker, 1999) Willpower subscale to measure weight controllability beliefs and dislike subscale to measure anti—fat attitudes. **Attitudes toward fat clients** Measure of attitudes toward fat clients, scale consists of 12 items	One week after the weight bias seminar, participants reported. • weaker weight controllability beliefs • weaker anti-fat attitudes. • less negative attitudes toward fat clients • anti-fat attitudes weakened from pre-test to post-test Weight controllability beliefs significantly mediated reduction in negative attitudes toward fat clients from pre-test to post-test	+ important contribution to the field- challenging weight bias evidenced in the profession with use of intervention based on attribution theory +study design provided opportunity to explain for change in reported beliefs - brief follow up period: unknown if weight bias reduction is sustained longer than a brief period - demand compliance might impact findings, difficult to test without use of control group
4	Cravens et al., (2016)	Qualitative: 1 hour weight bias training followed by a focus group Participants attended a 1-to-2-hour training on weight based prejudice based on experiential activities published by Pratt & Cravens (2014). Participants then attended a focus group lasting between 30 min to 1 hour inquiring about student's impression of the training	No measures were used; Data analysed using focus group methodology (Krueger & Casey, 2009)	Four themes identified 1. Training feedback 2. Challenges to the field of MFT 3. Self-of-the-therapist challenges 4. Knowledge about the systemic aetiology of weight loss and gain Each theme contained information that reflected deficits in MFT training related to weight bias and working with clients who are overweight	+ bottom up approach to feedback about weight bias training + novel insights into weight bias in MFT -Sampling self-selection bias; invitations to participate extended to all accredited couple/marriage and FT programs, programs that responded and students who attended might be more likely to see it as an important topic than those who did not participate. - limitation of design: participants might not have felt comfortable offering reflections in front of their peers

1.13.3 Summary of study samples.

All the studies took place in Western countries, primarily the USA (*n*=12, 85.7%) apart from two studies which were conducted in Australia (Article 11) and the Netherlands (Article 12). Study participant numbers ranged from 35 (Article 4) to 555 (Article 12). Studies with more participants tended include a range of healthcare professionals (Articles 2, 11, 12). Seven of the studies asked participants for some description of their own bodies (Articles 2, 3, 6, 7, 9, 11, 14). Table 10 provides a summary of the descriptions provided of participants' bodies.

Table 10. Participant bodies/satisfaction with

Participant **(Pax)** body size/weight/satisfaction with body				
#	**Author(s) (Year)**	**BMI** (or other height: weight index*)	**Scale to rate or categorise body** 1 (lower body weight) to 7 (higher body weight)	**Satisfaction with weight/ Desire to lose weight**
2	Bleich et al., (2015)	49% Pax. categorised as '*overweight*' or '*obese*'		35% '*seriously trying to lose weight*'
3	Brochu (2020)		MD 3.77 (SD=1.24), just above average	
6	Forristal et al., (2021)	Pax. placed selves in categories: normal weight (38.8%), obese (28.9%) overweight (27.3%), underweight (5%)		
7	Hassel et al., (2001)			16.6% '*completely satisfied*' with weight, 79.1% desire to lose weight
9	Pratt et al., (2014)	Average BMI 27.5 ('*overweight*'). 44% of Pax identify as '*overweight*'		
11	Stapleton et al., (2015)	Range: 18.07-52.03 (MD 25.77, '*overweight*')		
14	Young & Powell., (1985)*	23% categorised as '*overweight*'		

Ten of the studies reported higher percentages of female participants than male (Articles 2, 3, 4, 6, 7, 8, 9, 10, 11, 13) ranging from 53% (article 7) to 90% (Article 13). Articles 1 and 5 were the exception to this, reporting higher percentage male participants (66% and 61.5%) compared to female participants (34%, 38.5%). One article did not report on female participant percentages, listing male as 7% of

the sample (Article 12) and one study did not report on gender or sex of participants. Studies primarily used binary classifications for gender, apart from Forristal et al., (2021) who specified the inclusion of cis and transgender female identifying participants in their sample (Article 6).

Reporting on participant race and ethnicity was limited in many of the studies, which frequently listed groups as 'White' and 'Other' (Articles 1, 2, 5, 7, 8, 9, 10). Studies which did include more detailed demographics (Articles 3, 6, 11, 13) were dominated by White participants (62%, 66.4%, 89.4%, 62%). Three studies did not report race or ethnicity of participants (Articles 4, 12, 14).

Studies included a range of different mental health professionals. Some studies used quite broad terms such as '*psychologists'* (Articles 1,11), '*Behavioural and mental health professionals'* (Articles 2, 7, 12, 13, 14), '*mental health graduate students'* (Article 8). Other studies included participants from specific professions such as Marriage & Family Therapists (Articles 4, 8, 9), Clinical Psychologists (Article 3) and Counselling Psychologists (Article 6). One study used participants from a range of mental health professions including Clinical Psychologists Counselling Psychologists and Psychotherapists (Article 5).

1.13.4 Summary of findings reported in the literature.

Sex

Most studies which explored sex (Article 3, 5, 7, 11, 14) analysed participants' responses by sex, whereas one study (Article 1) investigated whether respondents' perceptions of weight changed according to the sex of the client in the vignette. Several of the studies (Articles 1, 5, 11, 14) concluded that female and male participants rated fictional clients differently. Compared to male mental health professionals, female mental health professionals rated clients as sadder, tenser,

more depressed, harder, crueller; they also rated male clients as more angry than male psychologists (Article 1). Female participants were found to give worse prognoses to fat clients (Article 5), ascribe more pathology (including addiction, OCD behaviour, self-injurious behaviours) and more negative attributes to '*obese'* clients than male participants (Articles 7 & 14) and reported greater fear of fat (Article 10).

In contrast, small sex differences in the other direction were observed in one study, with male professionals reporting more negative attitudes towards '*obese'* clients and more perceived weight bias by colleagues compared to female professionals (Article 11). Article 11 included a high number of participants (*N=271)* including doctors, community members, and mental health professionals. Thus, the difference in findings may be attributable to the profession of the participants.

Two studies did not identify differences based on sex of participants (Articles 3 & 7). One study did not find any difference in the proportion of female and male professional endorsing weight controllability beliefs, anti-fat attitudes or attitudes towards fat clients (Article 3). There were no differences in the proportion of male and female professionals describing patients as 'obese' compared to 'average' weight, nor in the levels of pathology ascribed to patients of different weight in terms of diagnosis (Article 7).

Overall, the studies presented mixed findings of the impact of gender, though more indicated that there may be differences in how female and male participants respond to fat clients, and that female mental health professionals may be more critical towards fat clients than their male counterparts (Articles 1,5,7,10,14). Some studies hypothesised that these differences might be due to greater exposure to societal expectations about body size and internalised weight bias in women than men (Articles 7,10,14).

Ethnicity

Two studies (Article 2 & 9) explored if differences emerged as a function of professionals' ethnicity. One found no significant differences in endorsement of weight controllability beliefs, anti-fat attitudes or attitudes toward fat clients based on participant race (coded as White versus '*non-white'*) (Article 2). Article 9 observed differences; with '*Non-White'* Mental Health Professionals expressing stronger beliefs that '*obesity'* is outside of an individual's control. These findings should be interpreted with caution, given the limited diversity of participants in these studies, it is uncertain whether they would have the power to calculate these differences (Faber & Fonseca, 2014).

Body Size

Although several studies asked participants for some measure of body size/weight/BMI as part of their demographic information (Articles 2, 3, 6, 7, 8, 9, 11) few included this in analyses, and those that did reported mixed findings. Some found that mental health professionals' weight was not associated with weight controllability beliefs, anti-fat attitudes or attitudes toward fat clients (Articles 3 & 7). When mental health professionals desire to lose weight was measured, there were no effects found for the amount of weight they reported wanting to lose on the diagnosis, GAF scores, ratings or attitudes towards fat clients (Article 7).

Two studies (Articles 6 & 14) observed differences which they inferred were related to participant body size: one identified that '*overweight'* mental health professionals were less critical of '*obese'* clients than '*normal weight'* professionals (Article 14). One study observed that professionals who did not identify as overweight, had weaker beliefs about '*obesity'* being within an individuals' control than those who identified as overweight (Article 10). Mental health professionals in

this study were more likely to report a fear of fat if their BMIs were categorised as '*overweight'* compared to professionals with BMIs in the '*healthy'* range.

Profession

Three studies explored differences in weight bias of mental health professionals compared with other healthcare professionals (Articles 2, 11, 12). One study including doctors, psychologists, and members of the community (Article 11) concluded that beliefs regarding the psychological causes of '*obesity*' were more prevalent among the community sample than doctors and psychologists in the study.

Differences were observed in American healthcare professionals (nutritionists, nurses, behavioural/mental health, exercise professionals and pharmacists) in their beliefs about factors contributing to '*obesity'* (Articles 2). Nutritionists placed greater emphasis on genetics or family history, while exercise professionals highlighted physical disability as an important factor. Nurses and nutritionists were also more likely to place greater emphasis on social and environmental influences which might contribute to '*obesity'*.

Medical doctors exhibited higher levels of anti-fat bias than other healthcare professionals, including higher amounts of perceived frustration at fat clients, less confidence and preparedness when treating fat clients, and higher incidents of observing weight bias from colleagues (Article 12).

The studies included in the review were balanced in their use of qualified professionals (Articles 1,2,5,7,12,14,11) and graduate students/ trainee mental health professionals (Articles 3,4,6,8,10,12), with one study (Article 9) using both qualified professionals and trainees.

1.14 Weight Stigma in Mental Health Professionals

The following section will address how the studies included in the review addressed the main research question, "***What does the literature tell us about weight stigma in mental health professionals?"*** considered in relation to anti-fat attitudes, attitudes towards fat clients and implications on diagnosis and treatment of fat clients by mental health professionals.

1.14.1 Anti-fat attitudes and beliefs about causes of '*obesity*'.

Some studies investigated anti-fat attitudes in general (not just toward clients), including beliefs about the causes of '*obesity'* (Articles 2, 3, 11, 12). Participants in one study (including members of the community) held rather neutral attitudes to fat individuals, not expressing highly negative attitudes, but also not holding particularly favourable ones (Article 11).

Behavioural factors such as insufficient physical activity, overconsumption of food, reliance on restaurant/fast food options, consumption of sugar-sweetened beverages, lack of willpower, and inadequate knowledge of healthy eating habits were widely acknowledged to make important contributions to '*obesity'* (Article 2). Mental health professionals in this study rated these factors as more important than genetics, family history, social/environmental factors (including access to healthy food and lack of safe exercise locations). Similarly mental health professionals in another study (Article 11) demonstrated strong beliefs about behavioural causes of '*obesity'* (e.g., eating too much, not exercising enough), with beliefs about the social factors contributing to '*obesity'* being the least reported.

Attempting to reduce anti-fat attitudes in mental health professionals, one study tested attitudes before and after a weight-bias seminar (Article 3). Professionals had fewer negative attitudes towards fat clients and anti-fat attitudes

one week after the seminar and that there was a reduction in weight controllability beliefs.

1.14.3 Judgement about fat clients.

The studies included in the review shed light on professionals' perceptions of and attitudes toward fat service-users. Fat clients were rated as more physically unattractive and embarrassed compared to straight-sized clients, they were also perceived to be softer and kinder (Article 1). One study found that 46% of mental health professionals reported they had witnessed other mental health professionals make negative comments about fat clients (Article 12). The study also reported that almost 30% of the mental health professionals held beliefs that fat clients were often non-compliant with treatment recommendations.

Mental health professionals were reported to rate fat clients as having more negative personal characteristics (Article 8,13), viewing fat clients as '*lacking in self-control'*, more likely to over-eat, have lower self-esteem and to be less attractive than straight-sized clients (Article 8). Fat clients were also evaluated more harshly than clients described as '*normal'* (Article 14).

Some studies found areas in which mental health professionals did not differentiate between fat and straight-sized service-users; clients of all body sizes were described as self-sacrificing, strong, and industrious (Article 8). Positive attitudes and positive treatment attitudes were found to be similar regardless of service-users perceived BMI (Article 13).

1.14.4 Diagnoses and treatment.

Some studies explored whether mental health professionals reported different diagnoses (and severity of symptoms) based on client body size (Articles 5, 6, 7, 13). No differences in diagnoses of depression and anxiety were observed based on

service-user body size (Article 6 and 7) though more severe levels of depression were assigned to '*overweight'* clients than '*thin'* clients (Article 6).

Diagnoses of adjustment disorders were more likely to be given to '*average-weight'* clients then '*obese'* clients (Article 5). The authors postulated that this might be an indication that '*average-weight'* clients are more likely to be perceived as having a '*disturbance'* outside of their control impacting their mental health, whereas '*obese'* clients were more likely to be diagnosed with a relational disorder.

One study compared mental health professionals' responses to clients with different body sizes presenting with symptoms of an eating disorder (Article 13). Clients described as '*overweight'* in this study were less likely to be given a diagnosis of anorexia nervosa and offered fewer therapy sessions than clients who were '*underweight'*. Paradoxically, another study found mental health professionals were more likely to suggest a provisional diagnosis of an eating disorder for fat clients than non-fat clients (Article 5). Differences in these findings might be attributable to several factors; Article 5 had more participants (N=200) than Article 13 (N=90) which indicates the authors had greater power in their statistical analysis, potentially giving more weight to their findings. There were also differences in the studies samples, those in Article 5 were qualified professionals and had a lower percentage of female participants (38.5%) than Article 13 participants who were graduate trainees and predominantly female (90%). Recency should also be considered; Article 13 was published much more recently (2018) than Article 5 (2000) which may reflect a more accurate representation of current attitudes towards diagnoses of eating disorders in mental health professionals.

Difference in treatment recommendations for fat and non-fat service users were considered by some studies (Article 1, 5, 7). Two studies found no differences

for recommendations of therapy type or duration based on client weight (Article 1& 7). Another study found mental health professionals were more likely to indicate that treatment goals of improving body image and increasing sexual satisfaction (despite no mention of sexual difficulties in the vignette) would be attributed to fat clients than non-fat clients (Article 5).

1.15 Exploratory research question

This section will explore how the studies addressed the additional exploratory research question around the use of language.

1.15.1 Language used to describe fat individuals and weight stigma.

Most of the articles included in the review used words relating to '*obesity'* either within the article itself, or the measures/vignette used in the methodology of the study. Notable exceptions were Article 3 and 5 which both used the word 'fat', though Article 3 also refers to '*obese patients'* within their study measures section. Article 6 initially used '*obese'* and '*obesity'* before discussing the political reasons for choosing to use fat in the introduction (which is then used through the remainder of the article). Article 7 was noted to have used a broader range of language, but primarily centred around different constructions of '*obese'* (e.g., '*obese people', 'obese persons').* Many of the articles also used '*overweight'* and '*obesity*' interchangeably (Articles: 1, 4, 7, 9, 10, 11, 12, 13, and 14). Straight-sized individuals were referred to through the studies as '*average weight'* (Articles 1 and 7), '*nonobese'* (1), '*non-fat'* (5) and '*normal-weight'* (Articles 8 and 13).

Weight stigma was described using a range of words and phrases throughout the included studies. Earlier studies seemed to struggle to describe this phenomenon more so than recently published ones, for example, Article 14 (published in 1985) used the following descriptions (not an exhaustive list); "*social*

rejection of the obese" (p. 234)*, "biases and attitudes towards the obese"* (p. 234)*, "negative perceptions of the obese" (*p. 235*)*.

Several studies used "w*eight bias"* (Articles 3, 4, 10) with some containing "*stigma"* in the context of either '*obesity'* (Articles 1 & 11) or weight (Article 12). Two articles described '*discrimination'* against "*overweight people"* (Article 7, p.147), "*fat discrimination"* (Article 7, p.147) and "*discrimination against obese individuals"* (Article 8, p. 349). One study (Article 5) referred to "to "*fat bias"* (p. 682) and "*fat oppression"* (p. 683). The rather novel phrase of "*fatmisia"* (p. 336) is used in Article 6 as the authors challenge the use of "*fatphobia"* (p. 336) for its ableist language and the appropriation of mental health diagnoses (phobia) to explain and potentially perpetuate discrimination of fat individuals.

1.16 Key Topics Identified in the Selected Studies

The systematic review, conducted in accordance with Siddaway et al. (2019) synthesized the findings of 14 papers. After becoming familiar with the papers, the researcher identified prominent and recurring themes to derive patterns of meaning related to weight bias in mental health professionals. The researcher identified central and recurring concepts that were subsequently categorized and discussed in the following three sections:

- **The need to recognise weight as an unexplored area of diversity**
- **The need for additional training and interventions on weight stigma for mental health professionals**
- **The need to understand weight-bias in mental health professionals**

1.16.1 The need to recognise weight as an unexplored area of diversity.

Six of the studies included in the review discussed the importance of mental health professionals addressing their own biases and ethical codes against

discrimination, and how weight appears to be an unexplored area of diversity (Articles 3,4,6,7,8,10). Participants in Article 4 make reference to the absence of weight when they have received diversity training;

"…*we don't learn about it in diversity; it's just something that we are so unaware of to the point that it's not in any textbooks or nobody's researched about it. I think that is huge and it should be talked about more and highlighted for everyone to learn about*" (p. 215).

The paper discusses the importance of having a code of ethics that explicitly addresses anti-discrimination practices and that weight bias and discrimination are often overlooked and not adequately addressed in diversity classes and research. This is supported by Article 7 whose authors identify that therapists have yet to face their own prejudices towards fatness, even when they have attempted to challenge other areas of discrimination. One study noted that discrimination against fat individuals is widespread and should not be ignored but further contributes to it being absent from diversity training (Article 8).

Two of the studies (Articles 9 & 10) were conducted by the same authors who discussed the importance of diversity and sensitivity training in Marriage and Family Therapy. They propose that this training should prioritise oppressed populations, whilst acknowledging that this rarely includes body size and weight bias. An absence of diversity classes that train mental health professionals how to address weight and fatness to prevent bias is discussed.

1.16.2 The need for additional training and interventions on weight stigma for mental health professionals.

Nine studies emphasised the need for addressing weight stigma and promoting a more inclusive approach by including it on graduate courses for

students who are training to be mental health professionals, wanting to work therapeutically and/or interested in psychological research (Articles 1,2,3,4,5,6,8,10,11)

Brochu (2020) highlights the importance of training in critical weight science and attribution theory so that therapists can support and gently challenge clients who are interested in weight loss, (e.g., by providing psychoeducation about the limited success of diets for weight loss) and understanding the causes and factors associated with '*obesity*' (e.g., reducing individual blame and responsibility). This finding in the studies was highlighted over thirty years ago (Drell, 1988) that being fat is still viewed as the person's own fault and still seems to be a view held by many of the mental health professionals featured within the review.

Cravens et al., (2016) stresses that these issues relating to weight bias and body size should not be limited to diversity classes at the doctoral level, but rather integrated throughout training. Davis-Coelho (2000) suggests that undergraduate and graduate programs provide an opportune time for training so that it is something therapists hold in mind from the moment they start working with a client. Forristal et al. (2021) suggest that therapists should examine their own attitudes towards diverse body sizes and their own bodies. Pascal & Kurpius (2012) point out that curricula often overlook perceptions of clients' weight and occupations, despite the prevalence of discrimination against obese individuals. Pratt et al. (2016) recommend training therapists to be unbiased and recognize and address their own weight biases. Stapleton (2015) emphasizes the need for tertiary education programs to teach about anti-fat attitudes and the multifaceted causes of obesity.

Two studies highlighted how beneficial individuals found just participating in the research as it had given them the opportunity to explore the topic for the first

time, some having either never heard of weight bias or reporting that they had never had the space to explore or talk about it before (Article 3, Article 4).

Addressing weight bias on training courses/within graduate schools would address a consistent finding throughout the identified studies, that younger mental health professionals are more likely to hold stigmatizing views and beliefs about fat clients and were more likely to differentiate between '*obese'* and '*non-obese'* clients than older mental health professionals (Article 1, Article 5, Article 11, Article 14).Davis-Coelho (2000) suggests interventions specifically for training programs, recognising that younger mental health professionals and those with fewer years of experience may exhibit greater bias against fat clients. This bias may be influenced by internalised fat oppression, which tends to be more common in younger clinicians.

Articles selected for review in the SLR emphasise the importance of addressing existing weight stigma of mental health professionals through interventions. Brochu (2020) highlights some challenges that have been encountered in reducing weight bias, with certain prejudice reduction interventions proving ineffective when applied to weight bias (Gloor & Puhl, 2016; Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003). However, other researchers have achieved greater success in this area. Cravens et al. (2016) developed interventions based on previously published experiential activities by Pratt & Cravens (2014).

1.16.3 The need to understand weight bias in mental health professionals.

The studies included in the review provide insights into mental health professionals attitudes, beliefs, and treatment approaches concerning weight bias and fat clients. While some studies focused on weight bias towards clients, others examined anti-fat attitudes and beliefs about *'obesity'* in general. Bleich et al. (2015)

found that mental health professionals emphasised individual factors, such as overconsumption of food and lack of willpower, as important causes of obesity. Stapleton et al. (2015) reported strong beliefs among mental health professionals about behavioural causes of obesity, while beliefs about social causes were weaker. Interventions, such as weight-bias seminars, have shown some success in reducing negative attitudes towards fat clients and weight controllability beliefs (Brochu, 2020).

Perceptions and attitudes towards fat clients varied across the studies. Aggel and Rothblum (1991) found that obese clients were perceived as physically unattractive and embarrassed, yet also seen as kinder. Pascal and Kurpius (2012) noted negative stereotypes and perceptions of lower self-control and self-esteem among obese clients. Mental health professionals made more negative stereotypes about larger clients and evaluated them more harshly (Veillette et al., 2018; Young & Powell, 1985). However, some positive attitudes were observed regardless of client body size (Pascal & Kurpius, 2012; Veillette et al., 2018).

Diagnosis and treatment practices varied as well. Diagnoses differed based on client body size, with adjustment disorders more likely assigned to average-weight clients and relational disorders to obese clients (Hassel et al., 2001). No differences were found in diagnoses of depression and anxiety. Mental health professionals showed different responses to clients with eating disorder symptoms based on body size, with a tendency to overlook or minimize symptoms in overweight clients compared to underweight clients (Veillette et al., 2018). Davis-Coelho et al. (2000) found that mental health professionals were more likely to suggest a provisional diagnosis of an eating disorder for fat clients and attributed treatment goals of improving body image and increasing sexual satisfaction to them.

1.17 Strengths and Limitations of the SLR

The following section will consider the limitations of the SLR. Firstly, it will provide an overview of the limitations of the studies included in the review. It will then offer a broader critique of the current review.

1.17.1 Limitations of studies included in the review.

A review of weight stigma in mental health professionals who are White American Women (?)

The studies included in the review primarily centred on White women, both in terms of the participant demographics, and in terms of fictional clients featured within the vignettes. This is problematic in trying to understand and identify weight stigma in other populations and leads to whiteness being the dominant narrative in the research area. Where gender and racial diversity was explored there did appear to be some differences, though even these studies held very binary views on gender and race (e.g., grouping participants into '*white'* and '*non-white'* categories). Future research should ensure that a broader range of perspectives are included.

The studies were primarily located in the USA, apart from one which was conducted in Australia (Stapleton, 2015) and one in the Netherlands (van der Voorn, 2023). This limits the generalisability of the findings and leaves a gap in our understanding of weight stigma in other countries.

Do vignettes accurately predict real-life practice?

Half of the studies used vignettes of fictional clients, where weight was manipulated to identify whether differences could be found between mental health professionals who were assigned to a group with a straight-sized or fat client (Articles 1, 5, 6, 7, 8, 13, 14). Given the dominance of this methodology in this

research area, it is important that we consider how accurate vignettes are at predicting real-life practice of mental health professionals.

While vignettes can provide valuable insights and help researchers and educators explore specific aspects of practice, there are limitations in their ability to predict real life behaviour. Vignettes often simplify complex real-life situations and remove nuances and contextual factors that mental health professionals may encounter in their actual practice (e.g., client history, personal dynamics, emotional engagement, therapeutic alliance) that can significantly influence decision making and behaviour.

The self-report measures and responses used in these studies are also susceptible to social desirability bias in which participants may have responded in ways that they deem to be socially acceptable or desirable which might lead to different behaviours and responses than in real-life practice (Brenner & DeLamater, 2016). In addition, there is weak evidence to suggest the applicability of our self-reported attitudes to the way our behaviour is measured and how we may act in the real world (Dang & Inzlicht, 2020).

Despite these limitations, vignettes can be a valuable tool for research and generating insights into professional decision-making processes and potential weight-bias. The vignettes used within this review have highlighted areas of improvement needed in the field (e.g., better understanding of critical weight science and the causes of '*obesity*'), but it is important that future research in the area broadens out the research methods to provide more nuanced and contextual understanding of weight bias within mental health professionals and how this might impact the therapeutic experience for fat clients.

1.17.2 Critique of the SLR.

As previously discussed, assessing the quality of studies may improve confidence in the findings. As such the current systematic literature review was assessed using CASP for Systematic Review (CASP, 2018). A full breakdown of the appraisal can be found in Appendix J. In summary the literature review met most criteria to be considered of good quality.

Only studies available in English were included, which is a major limitation of this SLR. It is possible that relevant studies were not included in the review. During the review process, one paper (Woetzel, Sikorski, Schomerus, Luppa, & Riedel-Heller, 2014) was identified which had an English abstract and appeared to be relevant (weight related stigma of '*obese'* individuals in somatic and mental healthcare settings) but was only available in German and could not be used due to language restrictions. Attempts made to locate an English language copy of the paper (through University of Hertfordshire library requests and contacting the authors) were unsuccessful.

In addition, unpublished research (e.g., masters and doctoral theses) were not included which might add a valuable contribution. Future research could specifically focus on unpublished and grey research to consider what these sources have to say about weight stigma in mental health professionals.

1.18 Future Research

The earliest study included in the review (Young & Powell, 1985) identified the importance of therapists challenging their anti-fat attitudes, both in general and those they held about their clients. Almost forty years later, training opportunities on mental health graduate courses that challenge weight bias appear to be limited. The studies featured in the review all addressed this but there was no exploration as to *why* it

remains an area of diversity that is not explored or examined. Some participants even shared with researchers that they enjoyed participating in the research projects as it was the first time they were either learning about weight bias or had the opportunity to discuss it on training (Articles 3 & 4).

Future research should aim to unpick the reasons behind the chasm between identifying the need for mental health professionals to reflect and evaluate their relationships with their own and diverse bodies and the absence of its place on training. Crandall (1994) hypothesised that prejudice against '*obese'* people was easier to hold than explicit prejudice against other marginalised groups, as it does not have the negative social connotations (in that it is still acceptable to make fun of fat people). As weight-stigma can impact everyone in society (Brown, Finlt, & Batterham, 2022) it is important that this is addressed, especially for those in marginalised bodies (clients and therapists alike).

As identified in the limitations above, it is imperative that future research include a broader range of perspectives, including mental health professionals from the global majority and with marginalised identities. Given that only four of the studies were published in the last five years, it is important to continue reviewing weight stigma in the profession to consider if it has changed or evolved in any way.

1.19 Conclusions of Systematic Literature Review

The current systematic review identified fourteen articles that were published in peer-reviewed journals which met the inclusion criteria set out by the researchers. Overall, the studies highlighted the need to address weight bias, challenge negative stereotypes, and ensure unbiased diagnoses and treatment for fat clients. Intervention efforts and training programs can play a crucial role in reducing weight stigma among mental health professionals. The review stresses the importance of

reframing weight in clinical practice as a social justice issue, aside from a purely medical approach (Brochu, 2019; Forristal et al., 2021). Gaps in the current literature included understanding how weight stigma and fat bodies are constructed by mental health professionals and the existence of weight stigma in UK-based clinical psychologists.

2. Methodology

2.1 Overview

This chapter provides a description of the qualitative methodology used for the current study. A rationale for choosing to use focus groups and analysing the data using Critical Discursive Psychology is provided, followed by an overview of participant recruitment, participant demographics and the process of the focus groups. Information on the use of Expert-By-Experience Consultants and ethical consideration of the study is included.

The current study aimed to explore how trainee clinical psychologists (‘trainees’) talk about and construct conversations around weight, body size and fatness. The broader aims of the study are underpinned by a social constructionist epistemology (See next section) that language matters and the belief that how we talk about and construct phenomenon and experiences matter as it impacts the way we interact and treat others. Specifically, the way trainees talk about weight, body size and fatness and interact with this topic impacts the way all people are treated, but especially those in marginalised and fat bodies. Language does not just represent some form of reality; it actively constructs and reconstructs versions of reality. When we use certain types of reality, we maintain that reality, but language can open new possibilities for living, it can create new realities that people can step and live in to (Edelman, 1985; Gergen, McNamee, & Barrett, 2001). Review of existing literature highlighted a need for more in-depth understanding of how weight bias manifests within mental health professionals (see Chapter 2); hence qualitative methodologies were selected to address this.

2.2 Epistemology and Positionality

2.2.1 Ontology.

This study sits within a critical realist framework; it recognises that whilst there may be multiple (varying) perspectives, there is an underlying reality that exists independent of human beliefs and perceptions (Fletcher, 2017; Jeppesen, 2005). This ontological approach maintains that there are objective structures and power dynamics that underpin social phenomenon. It recognises that societal structures, norms, and power dynamics contribute to the stigmatisation of fat people. A critical realist approach to this research in this area would seek to uncover mechanisms that produce anti-fat bias and examine how social structures perpetuate this.

2.2.2 Epistemology.

Chapter 1 refers to the positioning of this study within a social constructionist epistemology. It recognises that like race and gender, body size and ideals are not inherent or universal but constructed and shaped by social, cultural, historical, and political structures. Weight bias is understood from this lens, not as an individual attitude but a product of broader social structures, norms, and power dynamics. As this position calls for a critical examination of the underlying social and cultural factors that contribute to weight bias, research in this area should critically examine social and cultural factors that contribute to weight bias, with the aim of challenging and transforming the discriminatory beliefs, practices and policies that perpetuate such prejudice.

2.3 Experts-By-Experience Consultation

The researcher used Twitter to try and identify potential Expert-by-Experience Consultants (‘consultants’) for the project. The aim was to involve service-users who identified as fat and had experience of working with a clinical psychologist in the UK

(Figure 3). Through this method, one consultant was found to support the project. This consultant was extremely valuable in contributing to early discussions about the project and tasks were discussed and identified throughout the research project (Table 11).

Figure 3. Social Media request for Experts-By-Experience Consultation

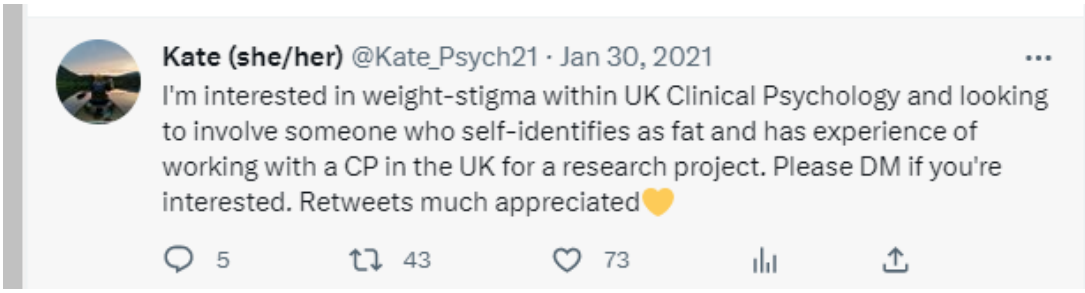


Table 11. Expert-By-Experience Consultant(s) Identified Tasks

Stage	Input
Planning	• Discussed ideas around the project: consultant encouraged researcher to consider how would a clinical psychologist with no knowledge/awareness of weight stigma realise they were being biased, what language might they use? Explored what service-users should be able to expect from clinical psychologists and how their bodies might be written about
Method	• Review interview schedule • Review participant information sheet • Review Study Advertisement Poster:
Analysis	• Read through one complete transcript • Access to other two transcripts • Discuss extracts of transcripts in consultant team meetings • Discuss stages of analysis/findings
Discussion	• Discuss clinical implications and assist with recommendation development
Dissemination	• Assist with dissemination
Reflections	• Discussions around researchers' and consultants reflections

Following an attendance of a 'Weight stigma, fatphobia and diet culture in the therapy room' workshop (Chappell & Reader, 2023) in February 2023, the researcher contacted two counselling therapists who identified as fat and showed

interested in consulting on the project. From this point, the consultation group met on a regular basis to attend to the consultation tasks.

2.4 Consideration of Qualitative Methodology: Why Critical Discursive Psychology?

Several qualitative analyses were initially considered for the study, mainly Grounded Theory, Narrative Analysis, Thematic Analysis and Critical Discursive Psychology. This section will review the analysis as methods for the current study.

Grounded theory was considered due to its focus on social processes (Charmaz, 2014) and as an appropriate methodology when a phenomenon is under-researched (as weight bias in trainee clinical psychologists is). It involves the collection and analysis of data where theory is ‘grounded’ in progressive identification of categories of meaning from the data (Willig, 2009). However, as there was no intention to develop a grounded theory or model from the data set, it was discounted as a possible analytic tool for the current study.

Narrative analysis focuses on the stories people construct about their experiences, and how these stories organise and bring order to personal and wider social understandings (Squire, et al., 2014). Narrative analysis might have provided the opportunity to examine how trainee clinical psychologists construct meaning around weight and body size, the stories they tell about weight in their personal and professional lives and how they make sense of these experiences. It can be a useful way to uncover ideologies embedded in stories and the larger culture that creates the narratives (Asaba & Jackson, 2011).

Thematic analysis is a flexible and widely used qualitative analysis method that involves identifying, analysing, and reporting patterns (themes) within the data (Braun & Clarke, 2012). This approach would involve a close examination of the

focus group transcripts and systematically coding and categorising segments of the data related to weight and body size constructions. By organising the codes into meaningful themes, an insight into the way trainees construct and discuss these concepts would have been developed. Although thematic analysis would have provided a clear structure for analysing data and identifying patterns, the descriptions of the data may not have engaged deeply enough with underlying power dynamics and discourses.

Critical Discursive Psychology analysis (CDP; Edley & Wetherell, 2001, Wetherell, 1998) was chosen to analyse the data as the best fit for the aims and theoretical under-pinning of the project. CDP is one of many approaches that sits within discursive research, but helpful here in its fusion of some more-established approaches; namely post-structuralist discourse analysis (e.g., Foucauldian discourse analysis, (Foucault, 1981)) and discursive psychology (Edwards & Potter, 1992; Wiggins & Potter, 2017), adopting a social constructionist epistemology, allowing a focus on how the social phenomenon of weight-stigma is drawn on and (re)constructed (Gonzalez Johansen, 2020). This approach considers individuals to be both the "*product and the producers of discourse"* (Edly, 2001, p. 190).

CDP is inherently political in its nature; it draws from Foucauldian-inspired Discourse Analysis (e.g., Willig, 2008) to consider how sociocultural available discourses shape our understanding of the world through the interplay of discourse, power, and subjectification. It considers the dominance of particular discourses and who is served by the creation and maintenance of these discourses. Through discursive psychology influences (e.g., Edwards & Potter, 1992), it recognises that individuals actively construct their versions of reality and discursive resources are used as a tool to achieve (and demonstrate) different social actions. Solomons et al.

(2023) describe CDP as valuable in considering the constructions of topics which may be '*contested'* or '*difficult'*, especially in situations in which challenges to the dominant positions come from marginalised voices. It was thus considered to be an appropriate analysis for this study as talking about weight and bodies (regardless of size) can be a difficult experience, whilst the dominant societal constructions are of fat bodies being unhealthy, unattractive, wrong and bad (Cooper, 2010; Kwan & Graves, 2013)

2.5 Methodology

A focus group research method was used to collect data for the study. Focus groups operate by exploring interactions between the group participants that develop based on a topic or questions set by the researcher (Morgan, 2002; Willig, 2013). During early stages of the project, there was some consideration about using 1:1 individual interviews due to the potentially sensitive nature of the topic. However, as one of the aims of the study was to explore how trainees construct weight and fatness, it was hoped that the open discussions generated in a focus group might allow for the presentation, exploration and challenging of different viewpoints. In addition to this, trainees frequently participate in group discussions (e.g., multi-disciplinary teams), it was therefore considered a format that would create opportunities for more naturalistic discussions about the subject area.

Krueger & Casey (2000) suggest focus groups should contain between six and eight participants, though Willig (2013) proposes that involving more than six participants in a discussion reduces the ability of participants to remain active and can make transcription of the discussion difficult, mini-groups can have four to six participants (Greenbaum, 1988). Previous research on the participant number for online focus group seems to be limited, with some researchers recruiting four to six

participants (Matthews, Baird, & Duchesne, 2018). The number of focus groups to generate sufficient data is suggested to be between three and twelve (Krueger, 1994).

Given that some doctoral students can experience difficulties in recruitment for research projects, the number of participants and the number of focus groups aimed to meet minimum criteria for focus groups as described above. The aim was for four to six participants to be recruited for three focus groups; this would have involved a total number of between 12-18 participants. Due to face-to-face restrictions at the time of the data collection because of the Covid-19 global pandemic, focus groups took place on an online video platform.

2.6 Ethical Considerations

Ethical approval was granted on 06/07/2021 from the University of Hertfordshire, Health, Science, Engineering and Technology ECDA, Protocol number: LMS/PGR/UH/04606 (Appendix K). Data collected for the study was kept and stored in accordance with the Data Protection Act 2018 (UK Government, 2018). Transcription documents were anonymised, and any identifying information was removed, pseudonyms used throughout.

Informed consent was collected from participants and their rights regarding participation in and withdrawal from the study were fully outlined (Appendix L). A potentially challenging ethical issue was identified in the planning of the project pertaining to the use of a focus group to collect data related to removing participant data if requested (Sim & Waterfield, 2019). This issue was addressed by making it explicitly clear in the consent process that participants retained the right to withdraw from the group at any time during the discussion, they were also given the opportunity to request that their data not be quoted in the study report. It was

explained to participants, given the nature of the methodology, that withdrawing data following data analysis might not be possible. This was discussed sensitively with the participants prior to the focus group and within the debrief.

The recruitment for the study did not explicitly advertise it as a project interested in anti-fat bias within the profession. It was framed as a study of trainees' views on service-user weight. The critical stance to weight stigma, approach of the researcher, and the analysis method was not disclosed to participants prior to the group as it could potentially bias those who might be interested in the topic and could alter discussions of trainees within the focus group. This was highlighted as an ethical issue as participants were not fully aware about the study's aims and they might not have chosen to participate if they had known.

The topic of weight and fat bodies might be viewed as a sensitive topic for participants. Given that over a third of UK adults felt anxious or depressed because of concerns about their body image (Mental Health Foundation, 2019), participants may have experienced discomfort and dissatisfaction with their own bodies and such thoughts might have been prompted by discussions of weight. Participants who identify as being fat and/or experience disordered eating might find these discussions particularly distressing, though their voices within this area should not be excluded.

Participants who have not contemplated the oppression and weight stigma associated with fat bodies might have felt shame, regret, guilt, or defensiveness during the discussions. The wellbeing of the participants was considered throughout the design of the interview schedule and the debrief and appropriate support was sign-posted following the study.

2.7 Recruitment Process

Participants were recruited through purposive sampling (Thompson, 1999) by contacting the 30 Clinical Psychology training programmes in the UK. The pilot group indicated that some participants felt somewhat uncomfortable expressing views that might come across as prejudicial against fat people, or challenging some of the points as they were aware of researchers' views and position on the material. The decision was therefore made to not recruit from the researchers' own training programme. It was hoped this would limit the likelihood of participation from trainees who the researcher had close contact with, who might be aware of the lens and biases they brought to the topic.

Courses were contacted either through administrative assistants, course tutors or course directors (depending on which contact details were available on university websites) on the 23rd of July 2021. A request was made for a brief email (Appendix M) to be circulated amongst current trainees in their programme, this email included the research poster. No additional incentives were offered in exchange of participation in the study

Trainees who were interested in the study were invited to contact the researcher to register interest in the project and were provided with a participant information sheet (Appendix N). If participants were interested in taking part, they were sent a consent form and participant demographic information. Once the criteria for a focus group had been met (4-6 participants) a doodle poll was sent with potential dates for the groups. When the minimum criteria for a group was met, a focus group was arranged. Participants were invited to attend alternative groups if they could not attend, the exception for this being those recruited for the final group.

Supplementary recruitment strategies were planned through the use of social media (e.g., Facebook groups, Twitter, WhatsApp) using the recruitment poster (Appendix O) and any contacts who might be able to promote the study. Recruitment methods were recorded for each participant.

2.8 Participants

2.8.1 Inclusion criteria.

Inclusion criteria for participants was primarily that the person was a trainee clinical psychologist at a UK University at the time of the focus group. There are no upper age limits for training to be a clinical psychologist in the UK, therefore there were no upper age restrictions within the current study. Criteria for entry onto the Doctorate in Clinical Psychology typically includes a '*good level'* of proficiency in both written and spoken English for those candidates who do not speak English as a first language, with courses often requiring demonstration of this through an English Language Qualification certificate. It was therefore assumed that all potential participants would be proficient English speakers to be able to take part in the focus group.

2.8.2 Potential participants.

A total number of 25 trainees got in contact with the researcher requesting more information from 11 of the contacted universities. Only one of these had any previous familiarity with the researcher and they decided to not participate, therefore none of the final participants were known to the researcher.

Of those who originally contacted the researcher, 18 returned consent forms and demographic information. Those who did not end up participating in the study either withdrew (*n=2)*, were unable to make the scheduled dates for the focus groups (*n*=1) or did not respond to availability requests for the focus groups (*n*=1*).* Fourteen

trainees were invited to the focus groups and confirmed their attendance on a first-come-first-serve basis; four were invited to attend the first focus group (*n*=1 did not attend), six were invited to the second focus group (*n=1* did not attend), and four were invited to the third group. In total 12 trainees participated.

2.8.3 Participant profile.

Participants completed demographic information prior to attendance of the focus group (Appendix P). Names of participants have been anonymised using pseudonyms of fat women from history (Appendix Q). Additional demographic information was collected to ensure participants met screening criteria, assess how many training courses were represented within the study, explore what year of training they were as well as their gender, ethnicity, nationality, and self-description of participant body size. These were all left as questions to write a response to, ensuring trainees could provide an accurate reflection of their own identity if they chose to. A summary or participant profile can be found in Table 12; to maintain confidentiality and protect participant anonymity; universities, ethnicity and nationality description will be discussed separately.

Table 12. Participant Pseudonyms, Age, Description of body

Group	Name	Age	Participant self-description of body size
Group 1	Beth	28	Slightly above average
	Hilda	26	M-L
	Denise	33	UK Size 10
Group 2	Cass	29	Tall, healthy body weight, average build
	Pam	26	Slight
	Ella	28	Medium(ish) build
	Henrietta	26	Size Medium or UK 10-12
	Martha	27	Average
Group 3	Stephanie	27	Healthy
	Julia	34	Athletic tall
	Lucielle	28	Normal BMI - size 6
	Aubrey	30	Obese BMI

2.8.4 Participant demographics.

All the participants identified as Female (*n*=11) or as a Woman (*n*=1). No men expressed an interest in participating in the study. Secondary recruitment strategies specifically highlighted the need for male participation but there were no uptakes to this request. Age ranges of participants were 26-34 years old (mean=28.5). Participants primarily reported to be White (*n*=11) with one participant choosing to not disclose their ethnicity. Participants described their nationalities as British (*n*=6), British-Brazilian (*n*=1), Finnish (*n*=1), Italian (*n*=1), Northern Irish (*n*=1) and Scottish (*n*=1). Within the transcripts, some participants discussion of their country of origin and nationality have been changed to further protect anonymity.

Participants were asked *"How would you describe your body size?"* (Table 12) providing an opportunity to write an open-ended answer and an interesting insight into the terms, phrases and adjectives used to describe bodies. These descriptions were characterised by use of the BMI, referring to clothing sizes, healthiness, and comparisons to an '*average*' body. It was difficult to group these descriptions together due to the variety of terms, and some having multiple descriptions that might have been grouped under different body size description. One participant identified as having a '*Slightly above average body*' and one participant identified as having an '*obese BMI'.* Most descriptions (*n=10*) could be described as '*straight sized*'.

The participants attended nine different clinical psychology training courses from the UK; Bath (*n=1),* Leicester (*n=1),* Newcastle (*n=2),* Queen's University of Belfast (*n=1)*, Royal Holloway (*n=2),* Sheffield (*n=1),* Southampton (*n=1),* Teesside (*n=1)* and UCL (*n=2)*. Trainees from second year were the largest group from the

participants (*n*=7, 58%), followed by first year trainees (*n*=4, 33%) with one third year trainee in attendance.

2.9 Data Collection

2.9.1 Resources.

A semi-structured interview schedule was used to facilitate discussions in the focus group (Appendix R). The interview schedule was established by reviewing literature in the area, and in discussions with the consultant. In addition, the schedule was piloted amongst five trainees from the researcher's own training cohort. The semi-structured interview centred on the trainees' views on fatness, experiences of working with fat service users and their knowledge around the '*obesity epidemic',* critical weight science and fat justice/activism.

Focus groups were conducted online using a laptop and recorded through Zoom (a video conferencing platform) and an encrypted dictaphone. Following each focus group, the researcher wrote in their reflective journal to capture some of the thoughts about the groups and ideas that arose during the discussion. The researcher transcribed all the interviews into Word, where initial responses of the texts were recorded before inputting the data into NVivo 12 software (QSR International, 2018) to fully analyse the transcripts.

2.10 Running the Focus Groups

The focus groups were more difficult to arrange than had been anticipated and an added complication was inviting enough participants to ensure a minimum of four but not going over the maximum of six advised (Greenbaum, 1988; Matthews et al., 2018). For instance, four participants were invited to the first group, but one person did not attend. The trainees had generously given up their time to attend the group, so the decision was made to go ahead with the group, despite having less

participants than expected. Five participants were invited to attend the second focus group but due to two participants having last minute unavoidable scheduling difficulties, one participant joined late, and another left early. Five participants were invited to the third group, but one participant did not attend.

The focus groups all took place between September and November 2021 using Zoom and lasted between 60-90 minutes. Attendees were sent an email with a link to the session and password to access the focus group at least a week before the meeting, with reminders sent the day before the meeting. Participants were asked for their verbal consent for the recording of the group (in addition to consent being given in writing on the consent form) on Zoom and an encrypted Dictaphone. Participants were encouraged to leave their cameras and microphones on wherever possible to ensure as many verbal and non-verbal cues were available to the facilitator and other participants. None of the participants were in a group with trainees from their own training universities.

At the end of the focus group, trainees were offered a space to ask any questions they had about the study or if they would like to offer any reflections on the group. All participants were immediately emailed a debrief sheet at the end of the focus group (Appendix S).

2.11Transcription

Audio and video-recordings were transcribed verbatim, with attention to discursive features (e.g., pauses, interruptions, emphasis, volume) using transcription conventions in line with those developed by Potter & Wetherell (1987) which can be viewed in Table 13. Adaptations included rounding seconds up (instead of using half seconds) and the addition of some descriptors (e.g. smiling)

available from the video recording, to aid in the preservation of the delivery of speech.

Table 13 - Transcription conventions used (Potter & Wetherell, 1987)

Transcription symbols	Example	Explanation
[square brackets with text]	**A**: [I wonder] **B:** [again there's] something	Represents overlapping speech
= equals sign	**A:** we're not allowing other people to come in= **B:**=yeah because I feel like	Represents 'latching' where there is no perceptible gap between the end of one person's speech and the beginning of another's.
(2), (.), (#)	**A:** I said earlier about (1) like (#) how we've all said that (2) when we've got lots on it's harder	Numbers in brackets represent pauses in seconds. (#) represents a pause of 0.1> to <1 seconds.(.) represents a brief pause of 0.1 seconds, like a catch between words.
Hyph-	**A:** like keep up ex-ex-exercise	A hyphen indicates a broken off utterance or a stutter.
: colon	**A:** they have changed how they look so::: dramatically	One or more colons indicate an extension of the preceding sound.
Italics, CAPITALS, *asterisk	**A**: but very *unhelpful* for other people **A:** I'm SCARED to say it but I kind of agree **A:** I've never heard of a *fat phobia*	Italics indicate an emphasis on the word. Capital letters indicate words spoken louder than surrounding talk. An asterisk preceding the word(s) indicates it is spoken quieter than surrounding talk.
.hh, hh	**A:** I was going to do *medicine* and moving to London.hh A: I'm.Hh going to sound like a massive fan	A full stop preceding a word indicates an intake of breath. .hh indicates an in-breath. Hh indicates an out-breath. Number of h's indicate length of breath.
.?!,	**A:** it's very different isn't it?	Punctuation marks indicate intonation rather than grammar
"speech marks"	**A:** it's kind of usually in the framework of "oh well it's better for someone's health"	Speech marks indicate the speaker imitating another person
(xxx)	**A:** how interesting the (xxx) would be if you had someone from a different society sharing that	Indicates inaudible speech
((double brackets))	**A:** Yeah I think ((clears throat)) mine was really similar	A non-speech element such as laughter or a descriptor. Can include facial description from visual recording e.g. ((smiling))

2.12 Data Analysis

Transcribed data was input to NVivo (Dhakal, 2022) and coded in line with the stages of Critical Discursive Psychology (CDP) outlined by Locke & Budds (2020) (see Table 14). Although these stages might appear linear, the process is inevitably more complex. Appendix S includes examples and extracts of transcription and stages.

Table 14. Stages of Analysis for Critical Discursive Psychology (Locke & Budds, 2020)

Stage	Task
1. Familiarisation with the data and initial coding	Researcher thoroughly familiarised self with the transcripts by listening through the audio recordings several times. Researcher than immerses self in data and performs a line-by-line coding focusing in on what is being said, what categories are being invoked and how they are invoked. Analysis moves from description and 'noticings' in the data to more detailed interpretation
2. Discursive constructions	This stage involves identification of the constructions of the topic and building on the coding that has been performed in stage 1. Analysis continues as analyst identifies prevalent themes/ways of talking in the discourse and how these key words or repeated themes can be grouped together. The focus is to attempt to understand what the words and themes are 'doing'.
3. Interpretative repertoires	Here the analysis considers the pervasive constructions of the discursive objects through the identification of interpretative repertoires (Wetherell & Edley, 2014). It seeks to understand what kind of reality is being constructed and what constructions are being resisted.
4. Subject positions	How the speaker is positioned and positions themselves and others in the discourse (Davis & Harré, 1990). During this stage the analyst focuses on the positions that are made available through the interpretative repertoires that are in operation.
5. Discursive accomplishments	At this stage the focus shifts to micro levels of analysis to examine the action orientation of the discourse by looking at ways in which the accounts are put together to achieve interactional effects.
6. Practice	Combines all the different aspects of the analysis and returning to a more 'macro' level of considering what this means for the topic under investigation. It attempts to demonstrate of what is ideologically achieved by drawing on repertoires, using particular subject positions and resisting others.

3. Analysis

3.1 Overview

This chapter provides a Critical Discursive Psychology (CDP) analysis of three focus groups of 12 trainee clinical psychologists (‘trainees’) in a discussion of weight, body size and fatness. The research questions were (1) how do trainees construct weight and bodies in discussions with other trainees, (2) how do trainees position themselves in relation to societal ideas around weight, bodies and fatness? In line with CDP, the analysis considered how participants drew from societal discourses but also demonstrated power to produce new discourse(s) (Edley, 2001) with the overall aim of understanding the "*social and political consequences of [this] discursive patterning*" (Wetherell, 1998, p. 405) among these trainee mental health professionals.

Acronyms of focus groups will be used e.g., Focus Group 1 (FG1). Extracts will be referred to in parenthesis (e.g., E1). The trainees self-described body size will be included in italics in parenthesis. In written text, it is easy to obscure the visible markers of the body that in the trainees’ group discussion, would have been apparent; speakers’ bodies will have a bearing on what they may feel able to say, make claims for and how this may be received (Fisanick, 2007).

3.2 Findings

Throughout their discussions, trainees drew on and resisted common repertoires of fat that had implications for the positioning of fat people, themselves, and others. Additionally, both in the discursive content and the flow of the talk there appeared a further theme of *difficulty* or ‘*trouble’* (Jefferson, 2015) in talking about fatness, particularly in professional contexts, something that has implications for professional practice.

3.2.1 "It made by stomach flip a little bit": Trouble talking about fatness in professional settings.

How trainees spoke about weight bodies and fatness in professional contexts suggested a discomfort with the topic. This section will explore some of the difficulties portrayed in both the content and mechanics of talk displayed, and what the social and political implications are.

"that's awful but…": the trouble with talking about fat.

The focus groups began with a warmup question to orientate trainees to the space (Krueger, 2002) in which the facilitator asked, *"If I say the word fat, what does it make you think about"?*. Perhaps unsurprisingly, given the study's advertisement and participant information, trainees' talk quickly focused on fat bodies - but not without some difficulties

The 20 second pause observed (E1) was a common feature of responses to this question. Long silences in conversation are considered indicative of awkwardness, difficulty in continuing the flow of conversation (Khademi, 2022) and a sign of 'trouble talk' (Jefferson, 2015). Even allowing for politeness at the start of a group, not wanting to interrupt others, and time needed to understand a question or

Extract 1: FG1

Kate: …if I say the word 'fat' what does it make you think about
(20)

Hilda: Initially I kind of, ummmm, my mind almost automatically goes to kind of like fat bodies, umm (3) yeah that was the first thing that came up for me

Beth: yeah I think ((clears throat)) mine was really similar, I like thought, I thought fat bodies, and then I thought unattractive and I uhhh caught myself thinking that and was just, told myself off a bit, like that's awful, but that's where my mind went.

Denise: I was ummm thinking of subcutaneous fat minus (#) versus the other one, which I don't remember the name was because I was looking at some video and there were kind of different types according you know what happens in terms of health outcomes depending what type of fat you have. Then I kind of just went ah, it's an adjective like any other

think of specific examples, pauses of this length are unusual and uncomfortable (Koudenburg et al., 2011).

Early talk gives indications of trouble constructing responses. Hilda (“*medium-large”)* and Beth (“*slightly-above-average”)* describe ‘automatic’ or initial thought process that then require reflection and evaluation, positioning themselves as aware of how powerful societal tropes influence them, yet also that such tropes are problematic. These provide early examples in which trainees’ preferred positions (either personal or professional) of being non-discriminatory and non-judgmental might be transgressed. The comments that follow indicate what the difficulty in this topic might be, and why the trainees require some time to respond in their preferred way, or perhaps, how they feel they should respond as psychologists. Beth chastises herself for her first thought, describing “*catching”* herself constructs thinking about this as something bad that should be hidden from others, perhaps indicates discomfort at positioning herself as someone who judges fat bodies. She simultaneously brings a common repertoire of fat as something that is “*unattractive*” on a body whilst challenging this, describing it as an “*awful*” thought, re-positioning herself as someone who is trying to be a good person and say the correct thing but who is fallible, and might get it wrong.

Denise (*“UK Size 10”)* positions herself as someone who is thinking rather differently. She takes up a more medical perspective of different *“types”* of fat which suggests she allows for a more neutral construction of the “*adjective*” in contrast to Beth’s more troubling emotional tone.

Extract 2: FG2

Cass: …umm(.)actually made me feel something before I thought something umm it made my stomach flip a little bit umm(2)I think the thoughts that came up were words umm(2)associated with maybe some shame and(4)th-

like(3) and disgust is kind of a feeling that came up of what that word is associated with often
(7)

Kate: Thanks Cass
(9)

Martha: Yeah I think similar to Cass initially I felt kind of a physical reaction compared to kind of(.)a thought process umm(1)and yeah a similar thing initially there was kind of quite a negative association to it that that was kind of my first thought and then(1)umm a bit of a oh well a there doesn't need to be((chuckles))a negative association but it was it was interesting that the first one was negative I guess

Henrietta: I think I had a similar reaction of(3)questioning what my first thought was about it so you know I thought a fat person and what that person is and who they are and then I was like but wait it could be anything((chuckles))but then was like questioning myself after

Ella: Yeah I feel like I don't have anything really to add other than(3)yeah when you hear the word it's just a n- it's just a negative word isn't it? Just because of kind of how it's socially perceived I think umm(1)so yeah just kind of that negative thought like yeah you just get that immediate reaction to the word don't you which(3)I guess is what we've been taught.

Cass ("*tall, healthy body weight, average build")* shares a physical response to the opening question typically associated with nervousness or anxiousness "*it made my stomach flip"*, which she linked to emotions of "*shame"* and "*disgust"* (E2). This is met with silence, the long pauses suggest further trouble for the trainees, in which they may need to carefully consider how to safely respond. When Martha ("*average"*) contributes, she offers reassurance and alignment building with Cass, *"Yeah I think similar".*

A pattern of responses follow, trainees are at first hesitant to talk, showing an awareness of the trouble associated with the topic. This is followed by an acknowledgement from most trainees that they are firmly influenced by "*negative"* views of fat and fatness, even sharing some visceral reactions of disgust. The trainees appear to be concerned by these responses. Perhaps their professional identities are at the forefront during the start of the groups as they are aware of being amongst a group of trainees discussing fatness and having/sharing responses they

feel they should not have as mental health professionals. More emotionally neutral medical discourses of fat are acknowledged, though most talk falls back into negative discourses of fatness. Their own "*awful"* judgements are partially understood by acknowledging that all the trainees are reflecting powerful societal discourses "*what we've all been taught"* (Ella; "*medium(ish) build"*). This positions trainees as human and products of their society, lessening potential accusations of blame, but raises questions about whether trainees are positioned as having agency or power to challenge these discourses.

Extract 3: FG3

Julia: It(#)makes(#)me(#)think(#)about umm a((chuckles))anatomical blob of fat on a table like a medical(#)something that's been taken out of someone(1)which is probably very gruesome(#)sorry guys((laughs))

Julia's ("*athletic tall"*) response frames fat as an inanimate object that has been removed from someone (E3). She describes her contribution as "*very gruesome*", pulling on repertoires of fat being disgusting, and apologises for even sharing this image. Her response comes with an almost rhythmic hesitation and non-verbal cues of laughter could be interpretated as nervousness or discomfort around the topic, or that she genuinely finds the thought humorous. She may be positioning herself as a joker to reduce tension and invite other trainees to contribute.

Extract 4: FG3

Lucille: …I think of(2)maybe a middle aged woman like GP surgery or something like that kind of I don't know(3)with some(1)pain problem maybe in her knee::s(2)or(2)yeah maybe something(1)that's kind of the image that comes to my mind

Stephanie: Yeah I would say ((clears throat)) for me I zoomed in in an image of(2)someone's stomach area that's where it kind of brought up for me like a stomach area that was large so that was where(1)my mind went to(3)a body part…

Lucille (“*normal BMI- size 6”)* constructs fat in several ways; she shares an image associated with the word fat, of a middle-aged woman seeking medical attention due to pain in her body (E4). In this way, Lucille medicalises fatness, equating it with something unhealthy requiring professional support from a doctor. However, she uses qualifiers *“I don’t know…yeah maybe something”*. Hedging her responses in this way may be a discursive attempt to reduce the force and minimise the perceived negative effect of her statement (Johansen, 2020).

“Umm I think…it does potentially come up”: the trouble with talking about weight and bodies on training.

Trainees were asked to discuss times in which weight and body size had been integrated into their clinical training. When trainees were unsure or could not think of examples, the facilitator encouraged them to consider specific teaching directed at weight and body size, or times it had been integrated in clinical vignettes or research. Here there begins a construction of the distinction between informal conversations among trainees as peers, and conversations ‘as trainees’. Martha in FG2 shares how “*informally in the cohort there’s constant conversations about it”, and Ella takes this up:*

Extract 5: FG2

Ella: I can’t think of it really any examples umm I think within our cohort it does potentially come up(3)umm(3)my cohort is all really active though they do triathlons and all sorts((laughs))umm so I feel like it probably *has* come up but I can’t think of like any specific examples umm probably more just like general(3)conversations maybe and I don’t know about at work either like on placement or anything I can’t(1)can’t *remember* ever being involved in any(1)conversation

There is some systematic vagueness “*umm I think…it does potentially come up”* where she has not ruled out the possibility of these conversations, but no specific examples are provided. She shares that her cohort is very physically active and

laughs about this. Whilst not explicit, by immediately discussing physical activity, Ella has drawn on recognisable repertoires that exercise and weight are connected, with the implication that individuals who exercise are unlikely to be fat and/or concerned about their weight and body size. Similar experiences were shared by Lucille (FG2) who states that these conversations have not occurred, connecting this to how "*conventionally attractive"* her cohort are.

Regarding more formal teaching, trainees spoke about how weight and body size had been discussed as part of eating disorder teaching, but none could provide other examples. This signifies how weight and body size may be pathologized and problematised in training, without apparent consideration of additional perspectives relevant to mental health training (e.g., the impacts of weight-based stigma on wellbeing) Implications of this will be discussed later.

"The wheel of privilege and the social graces": trouble with talking about body size in conversations about diversity.

A discussion that presented in all three of the groups, without prompting by a direct question, was the absence of weight and body size in the diversity teaching the trainees had received (illustrated in E6).

Extract 6: FG1

Denise: …we've seen the sort of wheel of privilege like so many times by this stage, but I've never really seen anything about(1)*body* composition on it erm(1)and we've sort of had Social Graces seminars and(1)reflective spaces and for, well at least for the group I was in they kind of just translated to being discussions about racism…

Beth: Yeah I thought the point you made about like the wheel of privilege and the Social Graces was like(1)like so spot on though… *but* I would agree that that the only one that sort of relates to your body is sort of *disability* I think in the Social Graces or whatever …and I just think there's nothing in there about like(2)yeah like, body *size*…

Training on the Social Graces[11] (Burnham, 2013) was discussed in all three groups. The trainees share a realisation that although some aspects of this were discussed during training (e.g., race), their experience is that body diversity had not been explored. Beth shares *"that the only one that sort of relates to your body is sort of disability"*, further drawing on discourses of body sizes being medicalised and pathologized.

Trainees acknowledged that bodies should be included in diversity training We might, therefore, have expected some consideration as to how members of this community may raise pride in their identity as we would expect in discourses of other marginalised communities. Alternative repertoires that recognised a challenging of this oppression were limited. Some trainees, notably Henritta and Aubrey, introduced discourses about body positivity (E7), but framed this through a neoliberal lens, of an individual learning to love and accept their own body, rather than a political resistance to oppression. Notably, none of the trainees considered the intersectionality of any of the '*Graces'* with body size.

Extract 7: FG2

Henrietta: …I'm(3)*more* on the side of(2)I suppose the body positivity movement that you see on Instagram and things like that where it's like " oh but we all have *amazing* bodies and they're all *brilliant* " and whatever and then I'm like(2)bigging myself up about it and being like "YEAH I've an *amazing* body" or whatever …

[11] The Social Graces mnemonic (Appendix V) is a tool to describe different aspects of personal and social identity through which individuals can experience power, privilege and oppression and is used to support trainees to explore aspects of similarities and differences between themselves and others (Nolte, 2017).

"definitely never": Trouble with talking about [one's own] weight and bodies in supervision.

Trainees were encouraged to think of examples where they had brought up weight or body size in clinical supervision, whilst on placement. Some trainees discussed situations where they had brought-up a service-user's body in supervision, either in relation to unrealistic weight loss goals, or concern about management of low body weight and alongside therapeutic work. If it did not arise naturally, the facilitator then prompted trainees to consider times they had reflected on their own body in supervision (E8).

Extract 8: FG1

Beth: ((smiling))I have definitely never reflected on my own body size in supervision...

Later in transcript

Denise: ...like you Beth it's never come up in supervision...I don't have time to bring myself into supervision and only with certain supervisors that I would(1)trust(2)and there's this feeling(1)I feel like when you start placement there's this thing that you know you should just entrust your supervisors and you know share your personal reflections and you're kind of like 'no I'm sorry trust needs to be earned and so far you haven't shown me anything that makes me think that you're trustworthy with this information'(2)ermm=

Beth: =I I think there's something as well like with the power dynamics of supervision and I guess like(#)the pressures of the course and like(#)knowing that they are marking you at the end of it that like(1)I very rarely wo::uld(2)like I will talk about cases and stuff that have impacted me personally and what not but like I would very rarely(#)like reflect on myself in a way that would make me vulnerable in that like supervisory relationship...

In her use of the words "*definitely never"*, Beth creates an impactful statement of complete certainty that she has not reflected on her own body in supervision – something fellow trainees could be expected to understand as potentially important in a profession that stresses the value of reflexivity. Beth's statement seems to have

made an impression on the other trainees as later Denise refers back to it in agreement. The discussion that follows frames reflecting on one's body as something that might make one feel vulnerable or unsafe in supervision. This, along with repeated talk of the need for trust and safety in supervision, suggesting a fear of weight stigma among qualified professionals – which clearly raises questions about how weight stigma might influence clinical encounters with service-users. The clinical implication of the absence of these discussions in supervision and training would make it very challenging for trainees to have the language or skills to have these discussions in their work with service-users.

"I'd be worried about putting my own judgement on them": trouble with talking about fatness in clinical work

Trainees were asked about their experience of working with fat people and whether conversations about weight or body (regardless of service user body size) had arisen during clinical sessions. Trainees shared that it was a common experience to work with people in "*larger bodies"* (E9). Cass categorises most service-users she has encountered as fat. In drawing on discourses of there being an "*average"* weight, she constructs weight and bodies as something that can be measured and compared against a norm, and that in her experience, service-users are likely to be above this expected level. There is a long pause following Cass' contribution, suggesting again some potential 'trouble' - but when Martha does respond, it is with agreement.

Martha discusses her experience of working with service-users in whose weight increased "*dramatically"* due to medication. She connects a past state of happiness with people's bodies prior to weight gain, constructing bodies as something that individuals have relationships with and an accepted assumption that

weight gain would negatively impact this relationship. Martha speaks to not wanting to bring up weight with service-users unless they bring it, in fear of "*putting my own judgement"* on to them. This suggests that Martha might have some negative judgement of bodies but is positioning herself as someone who would not want to unnecessarily express it to others.

Henrietta ("*size medium or UK 10-12"*) agrees with members of her group and shares that it is a common experience for her that service-users will discuss weight in relation to their "*self-esteem".* It is unclear in this discussion how trainees support their service-users who describe a struggle with their self-esteem in relation to body size or weight, or whether this would be challenged during their sessions. This might imply that people in fat bodies are expected to struggle with lower self-esteem because of their weight. The lack of discussion around this might draw on discourses that for fat people to improve their self-esteem, they must lose weight.

Extract 9: FG2

Cass: Yeah lots I think(1)umm(5)majority I would say of the patients I have worked with would probably be categorised as(1)overweight or obese umm I can think of very very few people who would be considered in the average or normal uh boundary or underweight even

(9)

Martha: Yeah I'd say the same as Cass that umm(1)yeah majority would be kind of thought of as larger bodies umm.Hh I guess therapeutically sometimes it's come up because when I worked in forensics there was lots of like patients on clozapine and that can enc- increase weight really dramatically over a really short period of time umm so people who(1)were quiet happy in themselves suddenly started taking(1)clozapine and their body changed so dramatically…I guess it depends on on the person in front of you if that feels important to you to give some space to then I would umm but I guess I wouldn't bring it up((chuckles))myself umm because(.)I'd be worried about putting my own judgement on them because they could be really happy umm with how they look and that's good((chuckles))that's what you kind of want isn't it? So yeah

The repeated instances of trainees struggling to talk about weight and fatness in professional contexts perpetuates repertoires that it is inherently wrong to discuss. Possibly the trainees acknowledge a need for sensitivity with this topic in professional settings as they have not learnt how to talk about weight, bodies, and fatness. Likewise, they do not want to feel exposed or vulnerable in talking about their own bodies in supervision as it does not appear to be a common practice in their experiences. The clinical and political implications of not addressing the difficulties with this topic in professional mental health settings, will be more fully explored in the discussion.

"It's never ever ever come up": the differences in talking about weight in professional and personal settings.

A noticeable difference was observed across the transcripts; in contrast with repeated constructions of the difficulty talking about fat, weight and body size within professional teaching and supervision contexts, there were enthusiastic and detailed accounts of conversations about weight and body size in the trainees' personal lives, This was well highlighted previously by Ella (E5) , here she expands on this observation (E10).

Extract 10: FG2

Ella: I'm just thinking(.)similar to what I said before it's never ever *ever* come up and now that's making me think that actually that just maintains the idea that umm talking about weight or is(1)a negative thing or(1)umm yeah somebody presenting as(3)I don't know I feel like now that(#)the fact that we've *not* spoken about…it's *never* come up in case study or I mean we've not had any teaching…but the fact that we've *never* been supported to even think about it, consider it just yeah does it just maintain that idea that this is something that we *don't* talk about because of the shame that's maybe attached to it?

Ella uses extreme case formulation (Pomerantz, 1986) and repetition to stress how absent conversations about weight and body size during her formal training experiences have been. She has recognised how potentially problematic the lack of conversations about weight and body size are in perpetuating the "*shame"* associated with the topic.

3.2.2 "[it]comes up all the time": Talking about weight and bodies in personal contexts

If trainees do not talk (much) about weight and bodies in professional contexts, an obvious question would be, 'is it just a taboo topic generally?' However, as already hinted at when these trainees mentioned less formal talk with fellow 'trainees-as-peers', this is not the case – and, when asked, trainees appeared very comfortable reporting conversations from their personal lives about weight and bodies.

Extract 11: FG1

Kate: …could you tell me about the last time you had a conversation with friends or family about weight or body size

Beth: ((smiling))for me it was really recently because I just went on a like to a lodge hot tub with like some of my girlfriends((chuckle))and so we were all saying like, ah like, you know, like lockdown or whatever we're all going to be ummm chunky dunking instead of like skinny dipping like sort of thing, ummm, so like, in a bit of a jokey way, ummm, quite recently, like in the last few weeks.

Hilda: Yeah I'd say similar with the lock down theme, umm, it's my birthday soon and so I've been trying to get like a dress and things and I was talking to friends and I was like 'oh god I'm going to have to go running' like in order to get rid of the lockdown weight, ummm, so yeah a lot, a lot of conversations about change in body size due to the lockdown.

Beth immediately launched into a story about recent conversation with her friends (E11), with apparent ease to her demeanour in her fast flow and non-verbal cues (e.g., smiling) . Beth describes a situation where she was joking with her friends

about their own bodies. This could be viewed as an example of 'normative discontent' (Rodin et al., 1984) a term used to describe widespread dissatisfaction with weight; it suggests that displeasure with one's own weight and body is so prevalent that it is the norm, satisfaction is the exception.

Hilda builds consensus with her response, demonstrating alignment with Beth that she has had similar recent conversations with friends; about gaining weight during COVID-19 UK Lockdown restrictions. She concludes that there are "*a lot"* of conversations about this, constructing conversations about weight as something that happens frequently in her personal life.

Extract 12: FG2

Ella: I feel like(4)umm yeah weight and body image just comes up *all* of the time in *all* conversations like it just(1)no matter what I think it just *always* turns into like even when you go out for a nice meal with friends like I did on Sunday and then it's that "oh god I've ate so much crap this week I need to go a diet tomorrow" it's that constant(3)*all* of the time(1)... uhh yeah it's just like a *constant*(3)*thing* in *every* social event that just comes up and then we talk a lot about how(2)we don't like our *bodies* it's just yeah it's *always* there I think

(5)

Cass: Yeah same I'm my aunt and mum and I are in a group message and my aunt sent a podcast this morning about calories(2)umm from(2)Dr Chatterjee's podcast ... the whole narrative is yeah similar to what Ella was saying that I just seem to talk about it all the time it's like verbal diarrhoea in the sense that.Hh I don't want to talk about it because I don't want to perpetuate the problem that it's talked about so badly but then I can't help myself it's like addictive...

Ella and Cass (E12) quickly provide examples of recent conversations they have had about weight or body size. Ella frames her response to be related to 'body image', despite this not being asked, demonstrating a construction of bodies as something we have a relationship with that are viewed by others, and ourselves. Her use of extreme case formulation (Pomerantz, 1986) "*comes up all of the time in all conversations like it just (1) no matter what"* legitimizes her claim. The examples that

Ella provides, the stress she places on the regularity of these conversations and the dominance of them indicate that she might be speaking to the "*(wrongness) of a practice"* (Pomerantz, 1986, p. 227).

Cass's response to this "*yeah same"* aligns with Ella's use of extreme case formulation "*I just seem to talk about it all the time".* Cass positions herself as someone who has limited agency over these conversations, they spill out of her. There is an acknowledgment of her power in these situations in perpetuating the *"problem*" by talking about it, but she justifies her inability to control this through describing the discussions as "*addictive"*. The language here cements a discourse of conversations about weight and body size as something that Cass has no control over and does regularly, perhaps to a point where it could cause her harm.

Extract 13: FG3

Aubrey:	I think I- I can remember mine it was quite recently(2)umm I was sharing with a friend who is also on the course(1)erm and weight's something we talk about a LOT(1)I would describe us both as fat people on a course of(2)a lot of thin people umm(1)and we've both struggled with eating before erm(3)and I was discussing like my sort of journey with(1)my body and and trying to see you know maybe being overweight as neutral… so yeah it's something that maybe I talk about MORE frequently than I would hope to…I don't know if that's other people's experiences?
Kate:	Hmmm [nodding her head. Smiling]
Stephanie:	I think that's quite interesting I think(3)Aubrey umm(1)it's not something that's talked about that much on my course umm(2)and almost like joining today(3)was something I was quite interested in that this is the kind of conversation that's happening in Research and(2)Kate but(3)I do(2)agree with uh you Aubrey says I do have a lot of these conversations in my personal life it's something kind of uh(1)yeah a very(1)I can remember a very recent conversation but with multiple people in my life…

Extract 13 replicates a pattern of responses observed in the other focus groups, that recalling conversations about weight and body size is an unchallenging task due to the recency and frequency. Aubrey ("*obese BMI"*) positions her and her friend as fat, in contrast to her thinner peers. Her earlier hesitation *("I think I- I")* might be at the uncertainty of how others in the group might respond to this identification or a discomfort in using it to describe herself. The word fat is often avoided, especially by straight-size people, as it has been weaponised and used as an insult against people of all sizes (Gordon, 2020). Aubrey uses her positioning as a fat person to consider if this is why she has had so many conversations about weight and is curious if others in the group have had similar experiences. Stephanie ("*healthy"*) shows interest and softly disagrees with Aubrey "*it's not something that's talked about that much on my course"*, sharing it was something that drew her to wanting to participate in the study.

"there's a commonality": talking about weight as a way of connecting with others.

A pattern of talking about weight as a way of bonding with others was created by the trainees; Cass (FG2) suggests there is a shared experience of talking about weight loss, "*I'm sure other people have this experience".* The idiomatic use of certainty here allows Cass to express the commonality, whilst also ensuring the responsibility does not lie completely with her (E14).

Extract 14: FG2

Cass: …I don't want to be that person but I just it's so(1)yeah it's addictive to talk about it and also it's quite(3)well there's a commonality because I I'm sure other people have this same experience where they feel like they're talking about it so it's something common to talk to you know(2)a a sense of connection to talk to people about it or you know what diet have you tried or like what gym class are you going to umm (2)

> and also people comment on that all the time you know "oh have you lost weight you're looking well"

Conversations about weight loss and bodies as a way of connecting or bonding with others were observed in the focus groups themselves. Across the focus groups, these discussions were frequently met with verbal and non-verbal responses of consensus, alignment building and reassurance giving such as *"yeah I'd say similar", "I DEFINITELY can agree with Lucille", "Yeah I completely agree"*. At the end of groups, trainees were asked about their experience of the session. Hilda and Beth acknowledged a slight discomfort at the start of the group which developed into a comfortable space for discussions (E15). Perhaps attributable to the ways the trainees connected and shared similar experiences.

Extract 15: FG2

Hilda: I personally have really enjoyed it((smiles))umm(3)it's been a really interesting umm conversation to have and I think umm all of you have made me feel really safe and comfortable to talk about these things … I wonder what it would have been like if there had been(2)men in this conversation? Maybe that would have would have made things a bit different?

Beth: I was thinking the…I found it(2)easier to just speak more freely I suppose as a conversation's gone on like ummm(1)because of that like sense of safety in the group…I don't know what I would have been like if there was(2)men

The trainees flagged the importance of considering the representation of gender in the group, and how conversations might have been different if men had been present. What is unsaid here might be that conversations about weight and body size are a way of connecting for women. The trainees in this group all identified as white women and were all a similar age. This experience might not be representative or translatable to different groups of people.

The implications of the commonality of these conversations indicates how much space this topic may take up in the trainees' lives. It is presented as something that is always there and trainees positioned themselves and others as powerless to this. Curiosity around how entrenched these topics are pointed toward the bombardment of messages about weight and body size in the media but was not critiqued or challenged by the trainees in the groups.

3.2.3 Repertoires of weight and bodies

Trainees spoke about weight, bodies and fatness using a range of recognisable repertoires. This section will outline some of the primary repertoires, subject positions, possibilities (and constraints) for action, judgement and implications which were presented and challenged during the focus groups.

"I've heard that weight is controllable": weight as controllable.

The discourse of weight being controllable and therefore something that should be managed either by individuals or society, was frequently drawn on throughout the focus groups.

"The narrative is then that you can control your weight": weight as something to be controlled by the individual.

Trainees advocated for individuals (including themselves) to take responsibility for their own weight. Body weight as a consequence of lifestyle choices, and therefore an individual's responsibility to manage, is a culturally and clinically dominant discourse (Greener, Douglas, & van Teijlingen, 2010; Saguy & Riley, 2005). Trainees were asked about any recent news coverage that resulted in a conversation about weight or bodies. In FG1, trainees discussed the recent introduction of calorie labelling on menus (Kaur, Briggs, Adams, & Rayner, 2022).

Extract 16: FG1

Hilda: Yeah I, I've had quite a lot of conversations about you know they said they were going to put calories on menus(1)ummm(1)strangely it coincided with when we had our lectures about eating disorders as part of the course, ummm, so a lot of us were already kind of thinking about eating disorders and thinking about the impact it might have, ummm, and yeah, that then, that then came out … lots of people sort of saying like they felt it was a really bad idea and, and not agreeing with it at all, hmmmm(3)and I don't agree with it either, I don't think we should put calories on menus.

Beth: Yeah it is a really tricky one because(#)I worked in health psychology before coming into clinical psychology and a lot of that work was around (2)like weight management for people who are(#)like(#)obese and kind of sometimes approaching bariatric surgery and(1)so like sometimes you could see how these things are well intentioned … but it is(2)like yeah it's really hard isn't it and I think it can be, if people have got weight on their minds and they feel it's something they feel really conscious about like it's so so unhelpful to hear messages like that I think

Denise: [I]

Beth: [But] then by the same token(2)the message about sort of trying to sort of like(#)be healthy is an important one as well.

Denise: I've sort of moved away, I don't know really what's happening…I guess, I'm SCARED to say it but I, I kind of agree with the idea of putting a calorie count on menus because I find *I* can make an informed decision then whereas(#)I'm kind of SCARED to go to restaurants now because I, I don't know what the calorie count, calorie count is and I'm trying my best to stay healthy right now(1)yeah(2)sorry((smiles looks apologetic))

Hilda introduces the topic to the group and provides context about when she found out this information to offer a lens for how she was approaching it *"strangely it coincided with when we had our lectures about eating disorders"* (E16). She shares that other people did not agree with this, the discursive practice of stake inoculation (Edwards & Potter, 1993; Wiggins & Potter, 2017) protects Hilda from others disagreeing with her. She pauses, before more boldly offering her position in a very clear manner; "*and I don't agree with it either, I don't think we should put calories on menus".* Beth seems less sure in her response "*yeah it is a really tricky one"* demonstrating some indecision or stuckness in where she might sit in this

discussion. She positions herself with some expertise due to previous work in health psychology and uses this to introduce the good intentions that might be behind the scheme.

With trepidation, Denise offers a different perspective, in seeing a positive impact of putting calories on menus as it supports her to make "i*nformed decisions"*. This claim of personal experience grants Denise a type of authority in the discussion but might bias her position as being subjective and vulnerable to critique from the other trainees. Beth offers Denise reassurance "*No not at all!"*.

In holding repertoires of weight being controllable, trainees' position those in fat bodies as failing, by their own choices and decisions, to be thin. They position fat people as not having control over their bodies and lives, whereas straight-sized/slim people are positioned as having self-control (Germov & Williams, 1996) and succeeding by achieving thinness. Trainees accepted, and rarely questioned the effectiveness of diets and calorie counting as effective methods of controlling (and changing) an individual's weight.

Trainees drew on repertoires of fat people not knowing how to lose weight. Aubrey (FG3) tells the group about her experience of working with a fat service user who was in a programme "*where they taught you how to eat healthy"*. This discourse constructs fat people as ignorant of dominant '*regimes of truth'* (Foucault, 1972), especially 'health truths' (Tischner & Malson, 2012). This discourse assumes fat people must not know how to eat healthy and/or exercise, as if they did, they would not be fat. It positions fat people as lazy and either uneducated or uncaring in matters of their own health and bodies.

Martha (E17) explicitly names what she sees as a narrative that weight is controllable, and people consciously choose to not lose weight. She challenges this

discourse, "*it seems completely untrue"* and connects weight controllability with weight stigma. Beliefs about the controllability of weight can mediate the effects of weight bias on anti-fat attitudes (Brochu, 2020). Thus, the social action of trainees in the current study holding these beliefs might contribute to weight stigma in the profession.

Extract 17: FG2

Martha: I've heard like the phrase(3)phrases like "big boned" umm which I guess(3)are trying to say that it's not always(3)*controllable* your weight and you know you're just built differently and umm but I think the majority of the narratives I've heard are that weight is controllable … but it feels like its(1)yeah very controllable and people are making a conscious decision almost to *not* lose weight or or be the size they are which ((chuckles)) sounds completely untrue… but yeah it feels like the narrative is then that you *can* control your weight you're(2)*not* doing something about it or you're *consciously* choosing not to control your weight and so that allows these negative associations to be drawn about you which again are so so unhelpful …

"Systemic issues that have contributed to them being overweight": weight as something to be controlled by society.

An alternative set of positions focussed on systemic factors that might impact weight and body size. Trainees were asked about their familiarity with the term '*obesity epidemic'* and whether they viewed it an important topic within their profession. In FG2, this led to trainees considering how socioeconomic factors might impact an individual's weight (E18).

Extract 18: FG2

Pam: …talking about it as a(.)as a epidemic it might not impact the individual but then as a society how are they c- kind of(#)*managing* within their community when there might be a lot

> of their community who are not(2)uhh able to leave their *home* or that the price of *food* or whatever it might be so I think it certainly needs to be discussed more...
>
> Henrietta: Yeah you brought up a really good point there Pam... the i-weigh podcast... were talking about uhh(1)how often you need to check your own privilege... including maybe growing up with a healthier diet umm rather than people in worse socioeconomic(1)uh bands who grow up with a much *poorer* diet because that's what they their family could afford and how *that* impacts your weight and your health and(1)then your relationship with not only your own body size but your relationship with food and what food represents and umm the the idea of like a food insecurity of oh well I don't know where my next meal is coming from...

Pam ("*slight"*) acknowledges barriers individuals might face in trying to '*manage'* weight. There is some systematic vagueness in the ambiguity of her statements. This discursive device allows Pam to have some flexibility in her contribution; she shares a view but minimises the possibility of getting it 'wrong'. The challenges of this vagueness are that it limits the force by which Pam introduces this alternative repertoire. The discourse, however, drew in Henrietta who was interested as it reminded her of a podcast that explored financial privilege and food access. Henrietta fleshes out Pam's statements and provides a clearer rationale using 'evidence' from a podcast.

Aubrey discusses "*systemic issues that have contributed to them being overweight"* (E19), in which blame and responsibility for people being over a specific weight is pushed to a societal level. Aubrey uses personal examples to make the topic relevant to her own experiences, demonstrating to the group insider knowledge of what these wider social factors might be. She advocates for both individual strategies and a societal intervention. It is somewhat unclear what the aim of these interventions should be or what they should be addressing. We perhaps can assume that the interventions she refers to might address weight and specifically fatness.

Extract 19: FG3

Aubrey: …I've seen these conversations that are talked about you know these people just need to move more and eat less(1)that don't take into consideration some of the(2)systemic issues that have that have contributed to them being overweight and some of the things you know like(2)if I think about like some of the systemic things that have contributed to me being overweight there's there's a LOT in there erm…my sort of parting take would be that that diet and exercise and just thinking about diet and exercise aren't aren't enough(1)I think.HH(1)there NEEDS to be more of a societal level(3)intervention(1)rather than an individual intervention

Although these positions recognise the impact of systemic inequalities on the physical and mental health of individuals, they still hold tight to the discourse that weight is controllable. The unfinished/unspoken conclusion of these discourses is perhaps observed in how it positions individuals who have financial freedom to access the 'right' food and opportunities to exercise. These people should be in straight-sized or slim bodies as they have the resources which allow them to access this body type. Trainees did not discuss the impact of genetics in determining body size.

"As long as you're within that health parameter": weight as a physical health issue.

Trainees used readily recognisable repertoires of weight being a signifier of an individual's health status (Reilly & Kelly, 2011; Saguy & Almeling, 2008). These discussions emphasized the importance of maintaining a "*healthy*" weight as a means of reducing the risk of various medical conditions. Trainees constructed weight gain and fatness as unhealthy explicitly; "*I think that rapid increase in weight could be just as unhealthy as losing lots of weight"* (Beth, FG1); "*in the past I know in*

my experiences do you know being fat has been equated with being unwell" (Aubrey, FG3).

An ideological dilemma (Billig, et al., 1988) occurs for Aubrey as she struggles to hold two opposing positions; that fatness is unhealthy, and that health is not determined by one's body size (E20). Aubrey shares a personal testimony, that she is someone who in the future (*"eventually"*) would like to lose weight before introducing some alternative repertoires (e.g., weight stigma and health at every size).

Extract 20: FG3

Aubrey: I(1)a again I think it's just something I would talk about umm quite a lot as someone who who would eventually like to lose weight and it's something... I'm on a lot of social media at the minute and there's a lot about weight stigma and you know(2)that that idea of health at every size and you you should be able to have a completely unrestricted(2)umm(1)diet and that's fine if your bodies craving doughnuts you should have a doughnut(1)d'ya know umm well it's not(1)I'm not really sure I agree with that because I suppose it's more for if you want doughnuts that's fine but just be aware you might feel shit about it afterwards(2)d'ya know if you eat fifteen(1)umm(2)but if you want to do that(3)go ahead(2)

The Body Mass Index (BMI) is brought up by Lucille (E21) as an effective tool to measure health. She describes an experience of a discussion between herself and her partner, her use of the colloquial "*you know"* assumes a shared understanding either of someone complaining about gaining weight or of what a healthy weight range is. Lucille's response of "*why would you care what you weigh"* initially seems to challenge ideas of weight gain being a negative experience, she then qualifies this statement "*as long as you're within that kind of healthy parameter*". Here Lucille constructs weight as something that should be within a specific

parameter to be considered "*healthy"*. She indicates that this is a statement she frequently makes, "*I've always said*".

Extract 21: FG3

Lucille: …the last time I discussed weight was(4)with my husband when he(#)weighed himself on(2)uh a a few days back and kind of him(3)complaining that he's now gained a little bit of weight…I said like "why would you care what you(1)what you weigh?" As long as you're within that kind of healthy(3)parameter I think that for me as well I've always said like oh well if you reach a kind of BMI of whatever it's meant to be kind of 25 then I think(.)you you do probably want to make some changes(1)to be more kind of healthy eating vegetables or whatever, exercise more…

There were examples of trainees challenging repertoires that fatness and health are inextricably connected; Ella and Pam are prompted by Henrietta to critique the BMI and consider the link between weight and health (E22).

Extract 22: FG2

Ella: Yeah and actually(3)it(#)it kind of reinforces that *weight* equals health where it doesn't you know you can be in a larger body and still be healthy(2)umm and I think BMI yeah just kind of reinforces that you(1)can't be and yeah just perpetuates that message doesn't it that you've got to be a certain weight to be healthy which(1)isn't necessarily the case.

Kate: Hmmmm

Pam: Yeah it's so true about the kind of *message* that it(3)portrays that you have to be within kind of the *strict*(2)kind of grouping of what is healthy…

Ella rejects the discourse that "*weight equals health"* and her statement "*you can be in a larger body and still be healthy*" is proceeded by a "*you know*"*,* marking it as common knowledge (Edwards & Mercer, 1989), inviting others into an implicit consensus. Pam builds alignment with Ella "*Yeah it's so true"* and constructs alternative ways of determining markers of an individual's health which might be a

more appropriate measure than weight, rejecting the BMI as a tool that is "*not helpful*".

"I've usually assumed a trauma": weight as a mental health issue

Trainees discussions of weight and body size as a mental health issue primarily drew from two recognisable (and connected) repertoires: comfort eating as a way of tolerating/regulating distress (Zivkovic, Warin, Moore, Ward, & Jones, 2015) and fatness as a result of trauma (Felitti, 1993; Mason, Flint, Field, Austin, & Rich-Edwards, 2013). Trainees also spoke about self-esteem in relation to weight of service-users (see *Trouble with talking about weight and bodies in clinical work*).

Trainees had conversations about eating to manage distress and regulate emotions. In FG1, Denise spoke to the group about an ex-colleague who began "*comfort eating"* after becoming distressed whilst working on an eating disorder unit. Beth queries the psychological understanding of why people comfort eat (E23).

Extract 23: FG1

Beth: ((nods)) Yeah I think there is like(2)very very little understand of(.)like psychologically why people would(.)eat like people say like they're comfort eating and stuff but I don't even think that that's well(1)understood it's kind of just like a phrase that people use isn't it?

The mechanism around comfort eating have been well explored (Adam & Epel, 2007; Fox & Egan, 2017; Gibson, 2006) but it was not something that the trainees spoke about (or challenged). Beth emphasises her point on the limited understanding and diminishes either the importance or credibility of the concept of comfort eating "*it's kind of just like a phrase that people use"* as a way of highlighting a supposed gap in the professions understanding of this experience. The lack of knowledge trainees brought about this topic might further contribute to uncertainty and biases.

Aubrey offers a more personal perspective in which she grapples with the acceptability of eating as a coping mechanism for her own distress, whilst acknowledging it is not something she would like to engage with long-term (E24). She seems to construct comfort eating as undesirable recognising others ("*people around me"*) may have a problem with it. Aubrey does not explicitly link comfort eating with weight gain, or being in a fat body, but might be likely due to previous contributions about others' perceptions of her own body.

Extract 24: FG3

Aubrey: …and I was discussing like my sort of journey with(1)my body and and trying to see you know maybe being overweight as neutral(1)understanding the contexts of of(#)things in MY life and things that I've been through and actually eating is something I do to cope sometimes and that's okaaay(2)and whilst I(1)maybe don't want to do that long term it's fine(.)I'm trying to sort of move towards that neutrality ermm(1)but I can find that really difficult erm(3)because although I can feel quite neutral about it at this stage of my life(.)people around me maybe don't and and there's a lot of fear:: and a lot of erm(2)difficulty with that…

Henrietta and Aubrey made a connection in their contributions between service-users' weight and a history of trauma. Henrietta (FG2) shares an experience of working with a service user who revealed a traumatic childhood event which they saw as contributing to weight gain. Aubrey discusses "*assumptions"* she holds about individuals who are "*morbidly obese"* having experienced trauma*;* she seems to acknowledge that her professional positioning is one that is not supposed to hold assumptions in their work, but she is unable to withdraw from this pervasive repertoire that if someone is fat, something very bad must have happened to 'make' them this way (E25).

Extract 25: FG3

Aubrey: …like the belief there's a belief that you can't be fat and be happy because you can't TRULY be happy with yourself because you're fat.hh ermmm and you can't like yourself(2)erm(1)I know like I'VE had beliefs and assumptions erm(1)especially about some sort of(2)super morbidly obese people that I've worked with(#)umm who've really struggled with their weight.HH(1)I've usually(3)assumed a trauma even if they haven't told me some some trauma I've assumed some some sort of developmental trauma ((exhales)) umm(3)and and waited for that to unfold and I know we're supposed to go in with no assumptions(2)but that I I I've had those assumptions umm…

By framing fatness as a response to emotional distress or trauma, trainees further contribute to the pathologizing of fat bodies. This discourse positions fat individuals as having a difficult history to 'explain' their supposed troubled relationship with food and resulting fatness and contributes to narratives of fat people as 'broken' and needing to be fixed (Gordon, 2020). This repertoire signals that there may be a hope for a fat person to become thin and 'saved' from their bodies, if they work to resolve their trauma. Framing fatness as a mental health issue over-simplifies the relationship between past trauma and weight and minimises experiences of those in straight-sized, or slim bodies, who have experienced trauma. There were no examples of trainees critiquing culturally dominant discourses of the correlation between higher weight and increased mental health difficulties, or consideration of how weight stigma may negatively impact the mental health of those in marginalised bodies (Hatzenbuehler, Keyes, & Hasin, 2009).

"There is still that stigma of fatness and incompetence": weight as a marker of worth .

Trainees in the focus groups draw on recognisable social repertoires that weight is related to people's worth.

"They're lazy and not a very good nurse": weight stigma and anti-fat bias.

Trainees were asked if they were familiar with terms related to weight stigma. Some trainees had come across these terms through social media, but the trainees in general seemed unaware around some of the broader conversations in this area. Hilda (E26) utilises systematic vagueness ("*sort of*") to share a degree of familiarity with the term in relation to employment and women. She positions herself as against weight stigma "*which is just bonkers*", clarifying that she has heard about the experience, though perhaps not encountered it herself.

Extract 26: FG1

Hilda: ((nods))I've heard of anti-fat bias(2)umm(2)not in sort of lots of(1)detail but kind of(.)ermmm that if you've got(1)I think the example I've heard umm was about interviewing … if you interview two women(.)of equal(1) umm(3)ability umm the woman who is thinner is more likely to get the job(1)is kind of the context that I've heard it in and understood it as ermm (1)which is just(3)bonkers but(2)that's what I've that's what I've heard

Henrietta constructs weight bias as something that is spoken about through alternative repertoires of body positivity, which she became familiar with through social media, specifically podcasts that discuss body positivity (E27). She describes the negative dialogues surrounding fat bodies as a "*beast*", constructing weight stigma as something strong and powerful, that needs to be fought against. Henrietta discusses some of the tools that might aid in this battle, such as "*body positivity*". Although there is importance in challenging negative relationships individuals have with their bodies, the discussion of this study will explore why focussing on individuals improving their body image is just a small part of what is needed in the battle against weight stigma.

Extract 27: FG2

Henrietta: I suppose I've heard it in contexts of uh we should be aware of those terms and those phrases and the(1)perpetuation of that kind of message but from the body positivity movement and we should you know fight against this and we should try and challenge it by being more body positive or whatever terminology we end up using … so y- yeah I suppose just in the commentary of the more body positivity movement highlighting in media and social media this whole other beast of umm more negative terminology surrounding fat bodies or larger bodies

Martha shares an experience of explicit weight bias she encountered whilst on training from her supervisor, who it is assumed is a clinical psychologist (E28). Martha positions her supervisor as someone who participates in the perpetuation of negative stereotypes about fat people (discriminatory discourse of fat people being lazy). There is no challenge to this stereotype from the group, either by Martha or the other trainees. Trainees are positioned as bystanders in experiences of weight stigma who might not agree but might not challenge it, especially when it is perpetuated by individuals in authority (e.g., supervisors).

Extract 28: FG2

Martha: I've had umm supervisors comment about the weight of other staff members so it was like in a inpatient setting umm and it was the nurse I'd not seen before and my supervisor commented about their weight in a negative way to kind of indicate that they're lazy and not a very good nurse which(2)you know((chuckles))your weight has nothing to do with how(1)good or bad you are as a nurse but umm yeah it was used to kind of(3)say "they're not a very good nurse don't really work with them".

In the third focus group, Lucille (E29) expresses some recognisable repertoires around fat people including that they want to lose weight and that they should be supported in this. Lucille considers "*obesity"* in young people and how this should be "*separate"* from weight stigma present in society. In this construction,

there is an acceptance that weight stigma is present but perhaps is more acceptable when it is directed at adults.

Extract 29: FG3

Lucille: Yeah I guess it's tricky because if you are(2)overweight or obese or(2)like you(1)I guess there is a large contingent of of people who(2)who DO want help with that and who do want support in in losing weight(1)umm(2)and so in a way I almos- I don't think we should(3)say(4)you you have to be happy with that I do think there are you know people who also need I know there(1)at the GOSH they're setting up like a new specialist(3)you know obesity service for children and and just how kind of difficult that can be(1)for you know children and their families(1)umm(3)but then that's completely separate from(3)or::: I I wish it was completely separate from from stigma and societies view and all of those things because it is(2)yeah I guess it's when you combine those(2)that that it becomes really difficult

"To me the image of the good psychologist is the THIN psychologist": thin bodies (people) as better than fat bodies (people).

Examples of weight stigma are discussed and produced in the focus groups. Aubrey (E30) simultaneously questions and reinforces these constructions; she positions trainees (potentially more broadly, clinical psychologists) as an "*enlightened bunch"* constructing individuals in the profession as being above ignorance and misinformation. There is then a statement that stigma is present, "*there is still and that's stigma of sort of fatness and incompetence"*; the conversation has qualifiers ("*sort of"*) indicating hesitancy and a lack of certainty. Aubrey acknowledges experiencing some difficulties with this as she brings in personal testimony of intentional weight loss due to her own perception of a "*good psychologist"* who is a "*THIN psychologist"*. The framing of weight loss as necessary to be viewed as a competent psychologist is constructed through this extract.

Extract 30: FG3

Aubrey: …I think there is something(1)although d'ya know I think I think we're a bit more of an enlightened bunch((chuckles)) (2)of people

> I think(1)there is still that that stigma of(1)sort of fatness and incompetence and it's something(3)I'VE struggled with so(3)before I started the course erm I lost like two stone because(1)to me the image of of the good ((smiles)) psychologist is the(1)is THIN psychologist and how could I give people advice on things? Exactly what what you were saying Julia how could I give people advice on things(2)erm when I'm not the the picture of health ((chuckles)) I've learned that that's maybe not that realistic...

"I'm phobic of ME getting fat…not phobic of someone else being fat": fatness as okay for others, but not for me.

In each focus group, trainees draw from a discourse of not minding fatness in others, but not wanting to be fat themselves. Denise (E31) in a discussion about the term "*fat-phobia"* shares she does not fear fatness in others, only in herself. The pauses and hesitation indicate Denise is struggling to share this sentiment with the group "*it feels like a::: a stra:::nge term"*. This sentiment is repeated by Martha (FG2) and how she would judge her own body more than other people's bodies and Aubrey (FG3) in not thinking that there is anything "*WRONG"* about being fat, "*but I would like to be healthy"* which links back to previous discourses about fatness and health being mutually exclusive. Drawing on repertoires of not wanting to be judged (by others) or to exist in fat bodies, continues to construct a reality in which fatness is undesirable and unacceptable.

Extract 31: FG1

Beth:	((smiles))Yes I think you mentioned that Denise ummm(1)to do with the group but I've I've never heard of a(3)*fat phobia*
Denise:	Yeah we use it, I find it an awkward term(1)because(2)as someone who's *had* a few eating disorders its sort of (3) I'm I'm phobic of ME getting fat(2)umm(4)I'm not phobic of someone else being fat so it it feels like a::: a stra:::nge(.)term?

4. Discussion

4.1 Overview

This discussion will present an overview of the research findings, consider them in relation to existing literature, and will provide clinical and research implications. The chapter will also offer a critical appraisal of the current study and a conclusion of the project.

Twelve UK trainee clinical psychologists (‘trainees’) participated in the study, across three focus groups. The groups were conducted to examine how trainees spoke about weight, bodies, and fatness and how they perpetuated, or resisted societal discourses. The study was underpinned by the researchers’ beliefs that language is a social action (Holtgraves, 2013), that people construct truth and their realities with this language. Critical discursive psychology analysis (Locke & Budds, 2020; Wetherell & Edley, 2009) was used to detect interpretative repertoires and how trainees situated themselves and others in relation to these repertoires. The analysis was concerned with identifying what trainees had to say about the topic, how they spoke about it and the social and political implications of these conversations.

4.2 Summary of findings and relevance to existing literature

The research questions were

1. How do trainee clinical psychologists construct weight and bodies in discussions with other trainees?
2. How do trainees position themselves in relation to societal ideas around weight, bodies and fatness?

These questions were informed by a review of literature into weight stigma in mental health professionals. Whilst existing research highlighted the presence of negative weight related bias in mental health professionals (see Chapter 2; Systematic Literature Review), a gap was identified in how UK based clinical psychologists may contribute to or resist these discourses. The use of trainee clinical psychologists as participants in the current study aimed to contribute to burgeoning literature examining weight stigma in mental health professionals. It aimed to consider whether trainees might need to be supported in additional ways to recognise and challenge their own, societal and professional anti-fat bias.

4.2.1 Fat-talk as a common personal topic- yet hard to talk about in trainees' professional settings.

The conversations trainees had about weight and bodies in the focus groups presented with some meaningful differences when they spoke about these topics in professional, compared to personal contexts

Trainees expressed ease and enthusiasm in discussing conversations they had had about weight and bodies in their personal lives. Examples of trainees' discussion in these spaces could be described as normative discontent (Rodin, Silberstein, & Striegel-Moore, 1984), in which dissatisfaction with one's appearance is so prevalent, expressing these views become the norm (Tantleff-Dunn, Barnes, & Larose, 2011) This social phenomenon has also been coined 'fat talk' (Nichter & Vuckovic, 1994), whereby individuals (typically women) who are peers engage in a form of mutual disparagement about the size and shape of their bodies (Salk & Engeln-Maddox, 2011). The ease and frequency with which these conversations occurred highlight that trainees appear just as susceptible to criticizing their bodies

or acting as bystanders when their friends and family critique their own bodies, as other people may be.

In contrast to conversations in their personal lives, trainees described and demonstrated difficulties and discomfort in how these topics presented in more professional settings. Trainees struggled to recall specific examples of these discussions during supervision which led them to question the lack of space for such discussions and the potential perpetuation of shame associated with these topics. Trainees pointed out the lack of discussions about body size as an aspect of diversity training. The lack of training and education for mental health professionals about weight and bodies may contribute to bias and stigmatising attitudes that impact the care service-users receive (Brochu, 2019; Flint, 2021).

Trainees expressed significant concerns regarding the power dynamics and pressures inherent in clinical supervision, which, in turn, hindered them from openly discussing their own bodies or those of their service-users. Trust might be needed for trainees to share their vulnerabilities (Bottrill, Pistrang, Barker, & Worrell, 2010), particularly when it came to their relationships with their bodies. Trainees shared they frequently encountered service-users with larger bodies, they expressed lingering concerns about how to broach the topic of weight and body size with their service-users, without imposing judgment (especially when working with service-users with larger bodies). Uncertainty about who should initiate such discussions resulted in limited opportunity in therapeutic settings for service-users, of all sizes, to discuss their relationship with their weight and bodies. Interestingly, these uncertainties echoed some of the discussion's trainees had about raising conversations about weight and bodies during clinical supervision.

Given how widespread weight stigma is, we can assume that when we encounter service-users in fat bodies, especially those in larger fat bodies, they will have been oppressed by such prejudicial discourses across all aspects of their lives. Discomfort in having conversations about bodies, or failing to express curiosity about the impact of anti-fat rhetoric, and associated negative actions on service-users, may leave fat individuals feeling unable to raise these experiences in therapy. There may be concerns that professionals will not believe their experiences, will minimise the impact of them, or in some way feel they are deserving of negative treatment because of the size of their bodies. If trainees can develop the language and tools to provide a safe space to explore these experiences and invite service-users of all body sizes (but especially those in marginalised ones) to bring these parts of themselves to therapy, it may reduce the shame and discomfort currently inherent in these discussions.

4.2.2 Weight as something that is controllable.

A common position expressed by trainees was that weight is controllable with fatness frequently constructed as a 'choice'. They expressed that fatness could and should be avoided by individuals taking responsibility for their own weight through methods like diet and exercise, or societal implemented measures, like publishing calories on menus. None of the trainees questioned the legitimacy of "*calories in-calories out"* as an effective tool to control weight. The context of this claim is based on research into the calorific equivalent of pounds lost and gained (Wishnofsky, 1958). This finding was widely repeated in medical and social literature including leading medical textbooks (e.g., Modern Nutrition in Health and Disease) as a popular weight management tool- calorie restriction. Despite over 60 years of research indicating much more complex processes contributing to weight loss and

gain including hormonal influences (Yavus et al., 2019) and genetic markers (Samblas et al., 2019; Martinez, 2000), calorie restriction is still centred in weight loss and public health (Gordon, 2023).

4.2.3 Weight as a physical health issue.

Trainees made frequent references to body weight as a significant indicator of overall health status. In these constructions, bodies are viewed as autonomous actors and health is constructed as a commodified moral choice and responsibility (Cairns & Johnston, 2015). Trainees acknowledged and primarily accepted that societal perspectives often equate fatness with being unhealthy, but some struggled with conflicting discourses that health should or may not be determined by body size. Fatness was medicalised by trainees and viewed through a health lens. This construction is suggestive of trainees holding a disease model of '*obesity'* (De Lorenzo, et al., 2019; Rosen, 2014) in which fatness is understood as a pathology and '*obesity*' is a debilitating condition (Müller & Geisler, 2017).

Overall, the trainees' constructions of weight and fatness exhibited a complex interplay of societal norms, personal experiences and medical perspectives. The discomfort and difficulty in discussing the topic highlight the deeply ingrained cultural attitudes, as well as trainees' awareness of the need for sensitive and nuanced conversations about weight and bodies (Gordon, 2023), even when they were unsure how to manage this.

4.2.4 Weight as a mental health issue.

In their discussions, trainees at times drew on constructions of weight as a consequence of psychological problems, drawing from two main themes: comfort eating as a way to cope with distress (Zivkovic, Warin, Moore, Ward, & Jones, 2015)

and fatness as a result of trauma (Felitti, 1993; Mason, Flint, Field, Austin, & Rich-Edwards, 2013). These discussions contribute to the pathologizing of fat bodies and perpetuate the belief that individuals with higher weights need to be 'fixed' by addressing their trauma to achieve a thinner body. The lack of critique towards dominant discourses about the correlation between weight and mental health, as well as neglecting the impact of weight stigma on marginalized individuals' mental health, was apparent in the discussions. Moving forward, it is crucial for mental health professionals to adopt a more comprehensive and inclusive approach that considers the complex relationship between weight, mental health, and trauma, while promoting body positivity and avoiding harmful assumptions about body size and psychological well-being.

3.2.4 Weight as a marker of worth.

Trainees constructed fatness as something that was associated with unattractiveness and shame. These negative attributions fit with literature that highlights how fat individuals are deemed as culturally undesirable and deviant (Kai-Cheong Chan & Gillick, 2009). They expressed discomfort with these initial thoughts that they shared, indicating the thoughts were associated with societal stigmatisation of fatness. Through questioning these negative association and preconceptions, they distanced themselves from the negative connotations and suggested fatness might not be inherently negative. These judgements of fat bodies as something that are disobedient (Focualt, 1979) might be viewed as a soft bigotry and an acceptable form of prejudice (Rothblum & Brown, 2019).

Some trainees expressed that while they did not mind fatness in others, they feared being fat themselves. This is a common discourse which is often framed under the guise of minimising biases towards fat bodies but fearing of or the rejection

of existing in a fat body themselves (Gordon, 2019). This sentiment may be borne from how difficult it is for us to sit with and acknowledge our own biases; trainees may want to be viewed as compassionate and just characters, who reject the negative treatment of others. To accept that we live in a society which demonises fat bodies, and that we are likely to not only hold some of these biases but have also engaged in actions which have harmed fat people in our lives, is uncomfortable. It may be easier, and less painful to offer a disclaimer to say we do not judge fatness as this does not sit with our self-perceived values, than recognise the harm we cause.

4.3 Clinical Implications & Future Research

The British Psychological Society (BPS) code of ethics states that "*all human beings, regardless of perceived or real differences"* should be treated with dignity and respect (British Psychological Soceity, 2021, p. 6). As demonstrated throughout this thesis, weight stigma is present in society and trainee clinical psychologists are not immune to this bias. The perpetuation of this discourse subjugates fat people to be unfairly treated, whilst simultaneously threatening people in all bodies to avoid fatness at all costs. The multibillion-dollar diet and wellness industry (Callaghan, Losch, Pione, & Teichner, 2021) seeks to continually benefit and profit from this fear. The system is therefore not broken, it is working exactly the way it is intended. The current study contributes to the recognition of the presence of weight stigma in clinical psychology. To disrupt the current system, the presence of stigmatising constructions needs to be addressed, and for clinical psychologists (including trainees) to recognise the power they hold in challenging discursive practices that promote anti-fat bias in their practice (Malterud & Ulriksen, 2011).

4.3.1 Trainees' relationships with their own bodies.

A potential difficulty in trainees addressing weight stigma and anti-fat bias is the relationships they have with their own bodies. Trainees are likely to have been exposed to not only broader negative beliefs about fat people, but to have been encouraged to be vigilant about their own bodies and the perceptions other may have about them. The damaging impacts of trainees not addressing this could play out in their interactions with service-users in several ways. If trainees struggle with their own relationship with their body (whether consciously or unconsciously) they may be more susceptible to projecting their unresolved body images to service-users, leading to inappropriate reactions or responses (Costin, 2008). Poor body image can negatively impact a therapist's self-esteem and self-confidence; as a result, trainees may find it difficult to empathise fully with their service-users (Park & Chan, 2014). Empathy is crucial in building a strong therapeutic alliance, and if the trainee struggles to understand and validate service-users' experiences, it can hinder the therapeutic progress. A trainee with poor body image may unintentionally project their biases and attitudes toward body image onto their service-users. This could manifest in subtle ways, such as inadvertently validating societal beauty standards or failing to address body image concerns adequately (Bombak, McPhail, & Ward, 2016).

4.3.2 Weight stigma training.

We live in an extremely biased society that actively perpetuates weight stigma; we may not consciously choose to reproduce these biases, but we must make a conscious decision to actively challenge them (Gordon, 2023). The un-doing of these biases may require ensuring that interventions to reduce weight-stigma are integrated into UK clinical training institutions. There are, however, mixed findings for

the effectiveness of weight stigma reduction. Some interventions aiming to reduce stigmatising views about weight and fat people have struggled to reduce negative bias (Gloor & Puhl, 2016; Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003) with others actually increasing negative attitudes in some participants (Kushner, Zeiss, Feinglass, & Yelen, 2014; Meadows & Higgs, 2019). A meta-analysis of 30 interventions observed a small beneficial effect of the reduction of weight-biased attitudes and beliefs in these studies (Lee, Ata, & Brannick, 2014).

One of the findings of the current study was that trainees use discourses of weight as controllable when talking about fatness. This discourse positions fat people as fat because of their own choices and decisions (Allison, Basile, & Yuker, 1991; Crandall, 1994; Thorsteinsson, Loi, & Breadsell, 2016) and further perpetuates negative attitudes towards fat people. Interventions that address weight controllability beliefs, may be more effective in reducing anti-fat bias (Brochu, 2019; Crandall, 1994; Crandall & Martinez, 1996; Hilbert, 2016). The flaw in these interventions, however, is they continue to frame fatness as something that needs to be explained and justified. They minimise the experiences of individuals who do chose to be fat and perpetuates discourses that fatness is inherently negative and that for fat people to be treated humanely and un-biasedly, others must in some way be taught that their fatness is not their fault/responsibility (Gordon, 2023). Framing anti-fat attitudes as inconsistent with values of inclusivity, which appear to at least temporarily, reduce explicit anti-fat bias (Breithaupt, Trojanowski, & Fischer, 2020), may be a more meaningful way of tackling weight stigma in a profession which promotes equality in its code of ethics (British Psychological Soceity, 2021)

The reduction of weight stigma in mental health training programmes remains a neglected issues (Brochu, 2019; Nutter, et al., 2016; Pratt, et al., 2016) but should be addressed during graduate education (Davis-Coelho, Waltz, & Davis-Coelho, 2000). Trainees in the current study acknowledged they had not been taught about weight stigma from their training institutions. Those who were familiar with weight stigma, anti-fat bias and fat activism, had learned about it from sources outside of training (primarily social media). The current study therefore advocates for the inclusion of training that highlights the biases that create anti-fat discourses and perpetuate weight stigma, before supporting trainees to recognise and challenge their own biases around this topic.

There are several ways in which raising awareness of and teaching about weight stigma could be integrated into clinical psychology training in the UK. Trainees brought forth (unprompted) that weight and body size could be included within current diversity teaching as part of the social GGRRAAACCEEESSS (Burnham, 2012; Burnham, 2018; Divac & Heaphy, 2005). Courses could also consider how fat and marginalised bodies are better represented in teaching materials across the curriculum, such as in case studies/vignettes, roleplays and in clinical practice report writing tasks and within eating disorder teaching. These changes would require small adjustments to current programs.

The current thesis has highlighted the widespread presence of weight stigma in society, in mental health professionals and the current study demonstrates trainee clinical psychologists are not immune to these biases. Perhaps minor modifications to current curriculums suggested above, are therefore not enough to tackle the

powerful biases that are held about fat people, their bodies, their rights, and their freedoms.

A mandatory one-off teaching session (typically three hours) for first year trainees could provide the opportunity to introduce this topic to trainees early in their clinical training, in an attempt to highlight and challenge the culturally dominant discourses toward weight, bodies and fatness. This session could provide the space for trainees to reflect on their relationships with their own bodies, challenge stereotypes, offer alternative repertoires about weight, bodies and fatness, introduce critical weight-science and offer practical ways that those in marginalised bodies might be better accommodated in therapeutic spaces (see Figure 4). Inclusion of fat voices would be of upmost importance in both the planning and delivery of this teaching (e.g., by fat clinical psychologists and fat service-users/experts-by-experience).

The following recommendations for clinical psychology training that might reduce anti-fat bias are based on Chappell & Reader's (2023) "*Weight stigma, fatphobia and diet culture in the therapy room"* workshop and Brochu's (2019) study in reducing weight bias in US trainee clinical psychologists.

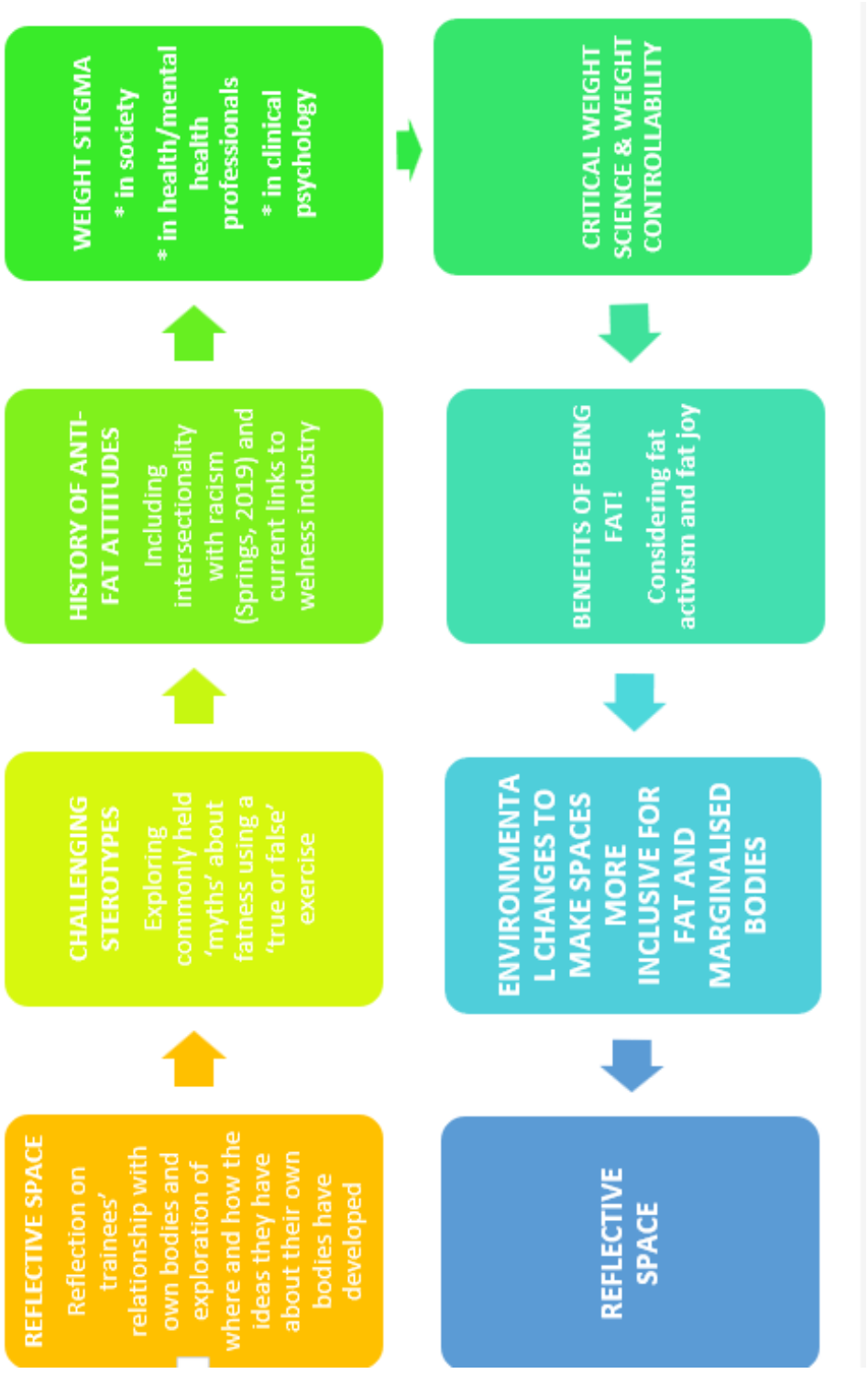


Figure 4. Suggestion of material for training on weight stigma

4.3.3 Clinical supervision.

Trainees repeated discourses of not feeling safe enough to talk about or reflect on their own bodies during clinical supervision whilst on placement. This may reinforce a sense of discomfort about how to talk about bodies and how to have these discussions with service-users in a containing and supportive way. Supervisors of trainee clinical psychologists should consider educating themselves around these issues and/or attending training to develop these skills. Currently some guidance is provided by some universities on how supervisors should explore race and diversity in clinical supervision. The inclusion of weight and body size as an area of diversity to explore in these spaces may equip supervisors to better address and explore the impact of this with trainees in their clinical work.

Supervisors may first need to educate themselves on weight stigma, having perhaps not encountered it in their own training, or later professional development. Harvard University hosts a range of implicit association tests, including one on weight, which supervisors could complete as a first step in recognising their own biases. Encouraging supervisees to explore their own connection to the social GGRRAAACCEEESSS, such as Totsuka's (2014) exercise, might be a way of recognising whether the grace of 'appearance' is raised in relation to weight/body size. If it is not, the supervisor could raise it themselves, raising awareness and modelling language for discussing this topic with their trainees. Additionally, they could encourage reflexivity during supervision sessions about trainees' responses to service-users' bodies. As with all aspects of diversity, careful consideration should be given to how this is explored with supervisees who are in fat bodies themselves, and supervisors should not make assumptions about the language those trainees may choose to use to describe their own bodies. Likewise, those supervisors who

are fat themselves may have a difficult journey in acknowledging and examining any internalised weight stigma they may hold.

4.3.4 Future research.

The current thesis has identified how limited research into weight stigma within clinical psychology is in the UK. The following section will consider how findings from the empirical study could be developed and built on to address remaining gaps. One of the primary findings from the current study was the absence of training in weight stigma trainees had received. A potential future research project could survey UK clinical psychology training institutions to see if this finding is an accurate representation of what teaching is currently being provided in this area. This could be a short survey (i.e. under five minutes), targeted at current trainees at all institutions using an online data collection tool such as Qualtrics (https://www.qualtrics.com). Questions could help provide an overview of whether trainees receive teaching on this topic, how the teaching is delivered and at what point of training it was delivered.

If a national gap in weight stigma training is identified in the UK, the next steps in future research could explore why it is absent and what steps would need to be taken to implement the training into institutions. It would be important to weigh up at what level this research should be targeted at; course or module leads might be best placed to provide consideration into its absence, but it may be more challenging to get staff to participate in this research than trainees. Interventions that have demonstrated effectiveness at reducing weight stigma in trainee clinical psychologists in the USA (see Brochu, 2019), could be administered and evaluated in the UK.

One of the prevailing sentiments from the trainees in the current study was how difficult it was to talk about weight and bodies in clinical settings, especially with their supervisors. Future research could explore this more fully and consider if this has contributed to the field not being further along in its ability to challenge weight stigma. One way of doing this might be to replicate the interview schedule, focus group structure and data analysis from the current study using qualified clinical psychologists who supervise trainee clinical psychologists. This research might highlight any overlap and differences in the ways that weight and bodies are constructed, and the discourses used and resisted in this group.

4.4 Critical appraisal of the present study

4.4.1 Quality appraisal.

The systematic literature review highlighted the importance of adhering by high quality standards throughout research. The CASP evaluation can be found in Appendix U; in summary, the current study was found to meet requirements for validity of results, findings and making a valuable contribution to the field.

4.4.2 Limitations.

When considering the findings of the current study, the limitations should be acknowledged. Two primary limitations will be considered here; the small number of universities represented by trainees in the study and the lack of diversity in the trainees that did participate.

Although all UK Clinical Psychology training institutions were contacted by the researcher with a request to circulate the study advert, we cannot determine how many adhered to this request. From the interest shown in the study, we can determine that at least 11 universities notified trainees about the study, trainees

participating in the study came from nine of these institutions. There are therefore many institutions not represented in this study in which trainees will have had different experiences of training and placements.

Of the twelve trainees who participated, all identified as female, and all but one identified as white (one trainee did not answer question in relation to this). There was also a relatively small age range of participants. Very few of the trainees identified as currently living in larger bodies. This limits the generalisability of findings outside of a white, cis-female, straight-sized perspective. Although there will of course be variations (which we saw play out) in these trainees' experiences of how they view the world and the reality that they construct, not including voices that do not fit into this frame is a limitation.

Due to face-to-face restrictions at the time of the data collection because of the Covid-19 global pandemic, it was decided that focus groups would take place on an online video platform. Conducting the focus groups online allowed for participants from a broader geographical area to be recruited and enabled greater flexibility in arranging the groups. The disadvantages of a virtual focus group include reliance on participants' access to a computer, stable internet and reduced nonverbal cues (Oringderff, 2004).

4.4.3 Researchers reflections on limitations.

My own lens(es) should be considered in the evaluation of the project. As a white, cis-gendered, middle-class female who currently resides in a small-fat body, I hold an incredible amount of privilege. Although I may experience a small fraction of negative bias in relation to my body, I am able to navigate my environment with relative ease, I can access public transport, I can book tickets to the theatre without

having to check the size of the seats, I can attend healthcare appointments without always being told my weight is the cause of all my ailments. I have however noticed how frequently I am the largest bodied individual in spaces within clinical psychology. I say this not as a critique of my own body, or something that upsets me, more as a reflection of the absence of diversity of bodies I have so far observed. It makes me wonder how trainees, qualified clinical psychologists and service users in larger bodies navigate these spaces and the importance of centring these voices in future research.

4.4.4 Strengths.

To date, no research has looked at the way in which UK trainee clinical psychologists construct weight and bodies in conversations, so a notable strength of the current study is in offering a novel contribution to research. The use of Critical Discursive Psychology analysis offered the opportunity to explore the ways in which trainees spoke about weight, bodies and fatness, the discourses they privileged and resisted and the social and political implications of this talk. It is hoped that the main strength in the current study is its ability to hold a mirror up to the profession of clinical psychology. In doing so it acknowledges that without actively challenging weight stigma and the treatment of marginalised bodies in training, the profession risks perpetuating negative discourses and is limited in its ability to offer alternative repertoires in which people of all weight and body size can access mental health support.

4.5 Conclusion

This study explored 12 trainee clinical psychologists' discussion about weight and body size across three focus groups. It aimed to explore how trainees constructed weight and bodies, in particular fat bodies, and which societal

discourses they accepted and challenged in these constructions. What became apparent was how frequently conversations were had in the trainees' personal lives, and their role in fostering connection with others. This was in stark contrast to the limited discussions reported in trainees' clinical experiences, with opportunities for learning about this being limited on training, and space not being provided in supervision to explore it.

Trainees are in a powerful position to challenge weight bias, but to challenge it, they must first be made aware of it and the detrimental impact it can have on all people, especially those in marginalised bodies. As the future of the profession of clinical psychology, they must be encouraged to critically consider concepts which are widely accepted as 'common sense'. They should be supported to explore the relationships they have with their own bodies to be able to better advocate for the melioration of fat justice and reduce stigmatising views held by themselves, their profession and their wider networks.

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Appendices

Appendix A: Reflexive Bracketing Interview Extract (from Ahern, 1999)

Preparation- *Interview with JG*

1. Identify some of the interests that, as a researcher, you might take for granted in undertaking this research. This might include issues such as gaining access or obtaining
a degree. Write down your personal issues in undertaking this research, the taken-for-granted assumptions associated with your gender, race, socioeconomic status, and the political milieu of your research. Finally, consider where the power is held in relation to your research project and where you belong in the power hierarchy.

I have taken for granted my level of education in situating myself within this research, though I recognised I am a white female who is a small fat I perhaps haven't thought about what that means in the fat community, I am aware there is backlash in the body positivity movement around small fat white females being bp … my position feels different to this. I have not thought enough about my socioeconomic status in relation to this research (fat activist movement seems to be driven by middle class women). This is a political topic at its core as I consider weight stigma a political and capitalist issue. I have an incredible amount of power in this research due to my position as a trainee, my whiteness, my social class, and my size.

2.Clarify your personal value systems and acknowledge areas in which you know you
are subjective. These are issues to which you need to keep referring back when analyzing your data. This is an important strategy in developing a critical perspective through continuous self-evaluation (Hanson, 1994).

My personal values are of compassions, kindness, social justice, equality, fairness. I am an intersectional feminist and identify as liberal, I am vocal about injustices and try to take more relational risks than previously. Sometimes I become too fired up by my passion and it is difficult to take a step back and consider where the other individual is coming from and how their experiences have led them to perceive an issue in a different way, but I fundamentally do not believe that racism, sexism homophobia and transphobia are an 'opinion', I feel there is a reality to these

experiences and can be angered by those who don't acknowledge this. I recognise I need to lean in and adjust my position at times.

Appendix B: Reflective Diary: Articles/material read during thesis period

During the MRP, I tracked and monitored articles and material that I consumed. I aimed to do this for everything I read during this process, but it became somewhat unmanageable with podcasts and audiobooks. Here are some examples from responses/ reactions I had to material. Some of these I recorded as notes on articles/responses which I have transferred to tables. Other articles I provide a broader summary of reflections…

Reference: Yalom, I. D. (2012). The fat lady in *Love's executioner: & other tales of psychotherapy*. Basic Books. (1989) pp94-95

Date Read: 22/07/2020

Quote	Responses
I have always been repelled by fat women. I find them disgusting:their absurd sidewise waddle, their absence of body contour-breasts, laps, buttocks, shoulders, jawlines, cheekbones, everything, everything I like to see in a woman, obscured in an avalanche of flesh"	I was immediately shocked by this reaction to a fat person and was curious about where this disdain came from and the acceptability of describing it in a published book, the de-sexualisation of the feminine figure made me feel physically uncomfortable, as if he 'eyes up' all his clients in this way. It made me instantly change my positioning of what I would gain from the article and I became ready to critique and bring this monster down. Typing this I recognise the strong reaction this has caused in me, is it to do with fear of myself being observed and judged in this way or feeling bereft that someone accessing support when they are distressed would be treated like this?
The origins of these sorry feelings? I had never thought to inquire. So deep do they run that I never considered them prejudice.	Made me think about how infrequently weight stigma might have come up in training historically, wonder if that's changed at all
But were an explanation demanded of me, I suppose I could point to the family	Ahhhh…I feel instantly more understanding, the fat woman

of fat, controlling women, including-featuring-my mother, who peopled my early life. Obesity, endemic in my family, was a part of what I had to leave behind when I, a driven, ambitious, first-generation American- born, decided to shake forever from my feet the dust of the Russian shtet!.	represented fat women through his life. Still cross but the reflexivity softens it
Betty represented the ultimate counter-transference challenge-and, for that very reason, I offered then and there to be her therapist	Felt frustrated reading this, as if he is taking on some valiant challenge, not thinking if he might be the best therapist for Betty given his revulsion, it's seems to be what he can learn/change about his own bias as oppose to what might be best for Betty.
But what, I wondered uneasily, about the rights of the pa- tient?... It is one thing to improve one's backhand service return but quite another to sharpen one's skills at the expense of some fragile, troubled person.	He seems to notice point 4 but is quite dismissive of it
I had secretly huped that her appearance would be offset in some way by her interpersonal characteristics-that is, by the sheer vivacity or mental agility I have found in a few fat women-but that, alas, was not to be. The better I knew her, the more boring and superficial she seemed.	Made me think of the fat but funny or fat but clever archetype, they are fat **but** they have something so much more to offer, as if their character could brush off his deep disdain
Since she was phobic about seeing doctors (because of her shame about her body, she rarely permitted a physical exam and had never had a pelvic exam), it was hard to reassure her about her health.	Her shame as opposed to the blatant marginalization of fat bodies not getting access to appropriate health care due to stigma
He details are weightloss attempt	Thoughts of him thinking she has finally become a 'good fatty' that doesn't want to be fat anymore and is making herself more acceptable, he heaps praise on her for the changes she makes to lose weight, not recognising that these changes would improve her life sans weight-loss!
Suddenly she was off! She went on a liquid Optifast diet	Horrified that therapist is supportive of this! If this was a non-fat patient there would be questions about health (physical and mental) of liquid diets but with this individual no concern seems evident

I was delighted for her and commended her strongly each week on her efforts.	As point 8 and 9….
Those were ghastly months. She hated everything. Her life was a torment-the disgusting liquid food, the stationary bicycle, the hunger pangs, the diabolic	Common things that happen when the body and brain is deprived of nutrients!
Every day was a bad day. Nothing in her life gave her pleasure	In a non-fat client there would be concerns about severe depression! At what cost is the weight loss coming, why is it not addressed in the therapy room?! ARGHHHHH
My respect for her grew	The more she shrinks the more he respects her…this doesn't sound as if he is working on his fat-phobia at all!
It happened that, during this period, I passed the upper weight limit I allow myself, and went on a three-week diet.	No reflexivity on the weight-stigma around this? How was that limit decided?
She had always craved sex and was angry that society's attitude toward the obese sentenced her to sexual frustration.	These seeped into this appraisal of her, I felt in the early reading of it that he couldn't imagine having sex with her so he couldn't respect her

Reference: Smith, C. A. (2019). Intersectionality and sizeism: Implications for mental health practitioners. *Women & Therapy*, *42*(1-2), 59-78.

Date Read: 18/08/2020

Reflections: *Was interested by the idea of weight as a diversity issue that* ***'can'*** *be controlled (or at least that is the mainstream belief, not mine or seemingly the authors).*
One of the first papers I've read that discusses the worth of a fat person separate to their appearance and chastises the approach of 'be nice to fat people so they do not gain more weight, and perhaps they will lose some'. Which 'Calogero, Tylka and Mensinger (2016) noted, this advice does not come from a feminist perspective and is "saturated with anti-fat bias and stigmatizing discourse"(p9)' Increasingly find myself wanting the author to situate themselves when reading these articles, are they fat? Black? Working class? I'm not sure if I experience this when reading other research articles so there is something inherently personal about discussing other bodies and I'm curious about my desire to want to know about the body of the person who is writing about other bodies.

This article is a review of literature but doesn't appear to specify how they searched for the literature, it's unclear whether they had the framework of areas they were interested in and specifically found articles related to this or vice versa? What was found, what was reported, what was left out? What wasn't found?
Was helpful to read a paper from a feminist lense, the section on empowerment I found particularly compelling…

Reference: Akoury, L. M., Schafer, K. J., & Warren, C. S. (2019). Fat women's experiences in therapy:"You can't see beyond… unless I share it with you". *Women & Therapy*, *42*(1-2), 93-115.
Date Read: 17/08/2022
Reflections: *Recognition that this is the first article I am reading about a research study of the client's perspective, other than the chapter from 'the fat lady sings' which was an individual perspective. I identified I was primarily focussing on therapists and thought it would be important to see the impact of weight-bias and discrimination on service users.*

I'm perplexed…most participants did not observe weight-stigma in the study, some denied micro-aggressions but then reported them, but if they are not reporting being distressed by them should we focus on them? Where's the power if we are pointing at things and saying 'that was offensive, they were stereotyping you, you should be offended!' or is weight bias so internalized that they take the therapists 'side'? Many even think they're therapist ***should*** *mention weight gain for their own benefits/improve health…wow this really struck me! I found myself not wanting to highlight or quote these bits because it doesn't fit into my perception of it so I am becoming aware of my own bias in the material*

Reference: Rothblum, E. D., & Gartrell, N. K. (2019). Sizeism in mental health training and supervision. *Women & Therapy*, *42*(1-2), 147-155.

Date read: 09/01/2021

Reflections: *Before I start to read I notice that I am thinking back to instances of fat-phobia in supervision, both clinical and research and curious about how it will be reported on in this paper. I feel excited! I was interested in the Burmeister et al (2013) study about US psychology graduate applicants, with obese women being less likely to receive an offer of acceptance when attending in-person interview. I wondered this sometimes about clinical training in the UK…I'm not sure I have ever met a larger bodied clinical psychologist and have not seen any trainees. Wonder if it would be worth reaching out on facebook group? It gives me anxiety to think about bringing about sizeism in supervision, perhaps because I am in a larger body, I am aware of how supervisor feels about their body (speaks about not eating sugar etc). … How could I navigate this?"*

Reference: Fahs, B., & Swank, E. (2017, March). Exploring stigma of “extreme” weight gain: The terror of fat possible selves in women's responses to hypothetically gaining one hundred pounds. In *Women's Studies International Forum* (Vol. 61, pp. 1-8). Pergamon.
Date: 10/02/2021
Reflections: “I wonder if I could include a hypothetical question within the focus group around weight gain…It’s really upsetting to read people’s reactions and interesting to note that some people are at smaller starting weights which would bring them to others weights and how different they imagine their lives to be. How sad that this is how much they feel they would hate to live in a fat body, it really hurts my heart that these views are embedded with them about fat bodies, they may feel unable to share them about others fat bodies but they are there because imagining gaining 100 lbs seems like a fate worse than death…. I am wondering what I would feel like in this study/ gaining 100 lbs, it doesn’t feel that something too removed from me, I think about what I would lose (perhaps some friendships) access to spaces but also what I would gain (friendships in fat acceptance community). I think I would be more concerned about how society would treat me than my body itself…a sign of how fat phobic our society is, I wonder if it would impact on my work? I want to say I wouldn’t hate myself, I would be gentle, but I don’t know….

Appendix C: Reflective Research Diary

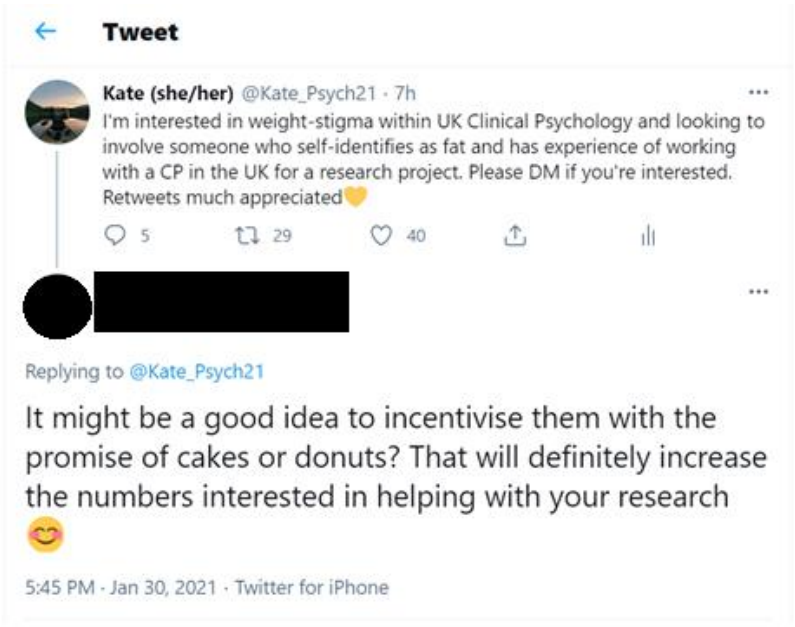
I kept a notebook in which I hand-wrote thoughts, feelings, reflections, and ideas in during the MRP process. Some of these notes were just a few scribbled words, quotes I had heard, things that sparked ideas about the project. Other pages were a bit more coherent and tracked some of my thinking about directions of research. Here I have typed up some examples of some of the extracts.

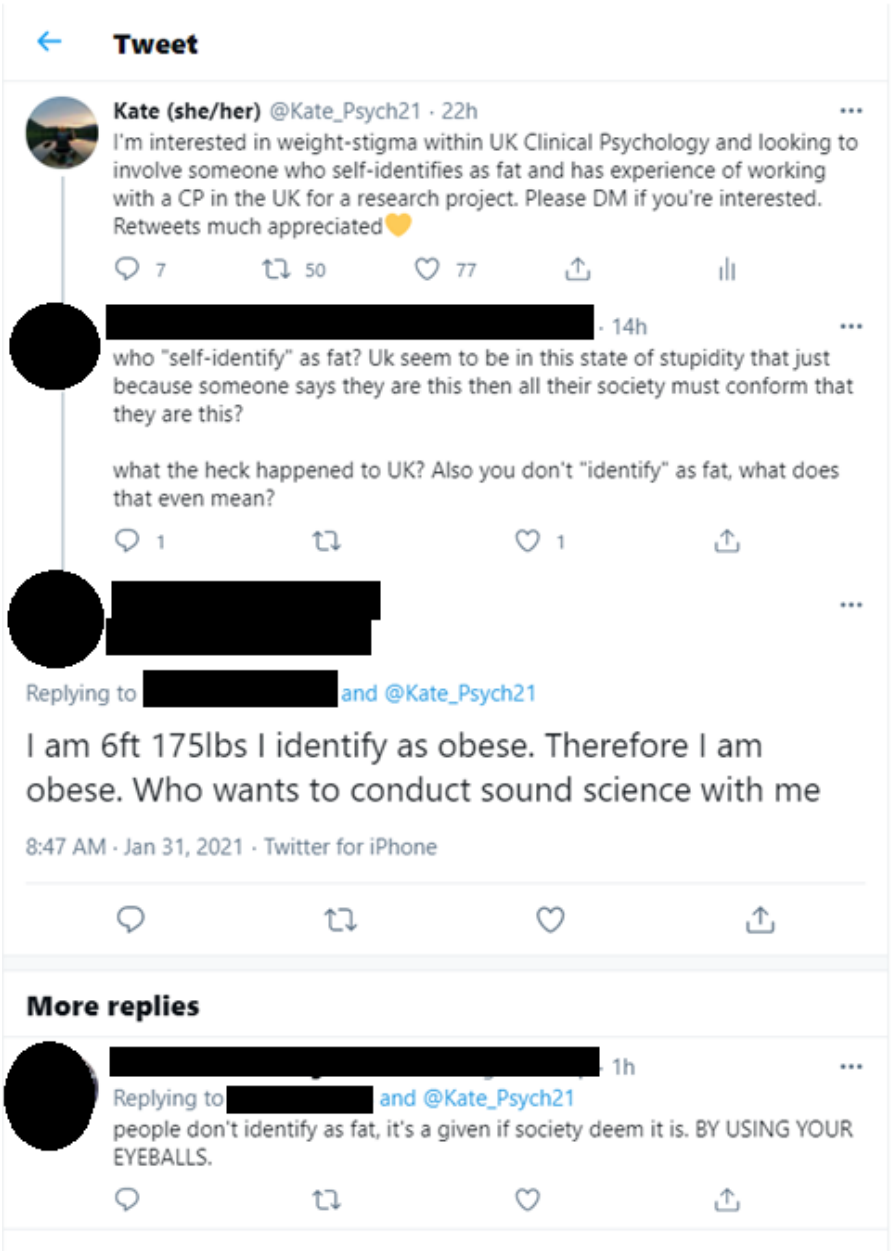
14/10/20

I'm feeling a bit stuck knowing where to go with MRP, I think I want to explore how weight stigma/sizeism gets talked about on UK training courses, is it discussed? What are people's thoughts about it? Why is it not being explored as part of diversity and respecting all bodies in a therapy room. How do you go about finding out what universities teach on their courses. Could I start off with a questionnaire exploring whether UK universities explicitly include it within their curriculum? Or smaller than this, thinking about personal relationship with our own and fat bodies in clinical psychology. Feel a bit overwhelmed, not sure how to connect with others over this….

30/01/2021- An attempt to find an Expert-By-Experience on twitter.

I joined Twitter in part to try and connect with other researchers. Another trainee suggested it as a method for recruiting an EBE consultant. I posted a tweet and the responses were jarring (to put it lightly) and received a few DMS about negative experiences individuals had with clinical psychologist in relation to weight stigma. I suppose the number (and speed) of responses highlight the importance in this research and how needed it might be BUT it made me feel incredibly vulnerable and made me doubt whether this would be a manageable project for me to do…..




Tweet
Kate (she/her) @Kate_Psych21 · 22h
I'm interested in weight-stigma within UK Clinical Psychology and looking to involve someone who self-identifies as fat and has experience of working with a CP in the UK for a research project. Please DM if you're interested. Retweets much appreciated
7
50
77
[redacted] · 14h
who "self-identify" as fat? Uk seem to be in this state of stupidity that just because someone says they are this then all their society must conform that they are this?
what the heck happened to UK? Also you don't "identify" as fat, what does that even mean?
1
1
[redacted]
Replying to [redacted] and @Kate_Psych21
I am 6ft 175lbs I identify as obese. Therefore I am obese. Who wants to conduct sound science with me
8:47 AM · Jan 31, 2021 · Twitter for iPhone
More replies
[redacted] · 1h
Replying to [redacted] and @Kate_Psych21
people don't identify as fat, it's a given if society deem it is. BY USING YOUR EYEBALLS.

13/01/2023

Reflections whilst coding Focus Group 1

This is the first time I've read through the transcripts since maternity leave. Feels like a different lifetime ago, I can still hear the voices and accents of the trainees which makes me feel connected to the groups.

Focus Group 1

I really appreciate the immediate honesty and transparency the trainees share when I ask them to think about the word fat, I then wonder if this is a product of people feeling very comfortable expressing anti-fat bias. The ideas of health and weight that come up are so dominant… Notice a sense of frustration that the trainees talk about people caring more about weight loss than weight gain in the context of how rewarded weight loss is!

Interesting to think of the film that come to mind when reading and coding these transcripts and how weight and bodies are constructed and judged in those.

It reminded me of a scene in Bridget Jones where Bridget doesn't want to get dressed in front of Mark Darcy as she doesn't want him to see 'her wobbly bits' (after have sex and being naked in bed with him). Mark tells Bridget that he has a high regard for her wobbly bits and she proudly throws off the blanket and comes back to bed. Something about the male gaze in this and wobbly bits being acceptable if men say they are/ the man we are with?

Also has made me think about Bridget Jones in general and how problematic it was for a generation of women to see a 'average weight' conventionally attractive woman being portrayed as a very fat person who it was just unimaginable that these two men would want to date and be with. Seeing Bridget step on the scales and weigh ten stone and wanting to lose weight when I was probably at least 20-30lbs heavier than this….

12/02/2023

Focus Group 2

Something is happening in first and second group where trainees keep re-iterating that they don't mind other people being fat but they don't want to be fat, no one

seems to be exploring this more or digging it to it. This isn't a 'surprising' thing to notice really but it's interesting how it is justified in quite similar ways across the groups. Why don't trainees want to be fat?...

04/04/2023: Attending a weight stigma in the therapy room workshop

*One of the other attendees shared a quote (not sure the source) '**"You can only take your client as far as you take yourself"…**this has stuck with me and I think about what I have felt comfortable exploring in both therapy and supervision and how this connects to 'where' I could take people I work with on this journey. Thinking a lot about some of the young people I am currently working with and how to support them with their relationships with their bodies. Also connected to focus groups where trainees express hesitation about using supervision to be vulnerable or to talk about their bodies.*

Appendix D: SLR- Key papers reviewed to contribute to search terms

Papers checked

Akoury, L. M., Schafer, K. J., & Warren, C. S. (2019). Fat women's experiences in therapy:"You can't see beyond… unless I share it with you". *Women & Therapy*, *42*(1-2), 93-115.

Bacon, L., & Aphramor, L. (2011). Weight science: evaluating the evidence for a paradigm shift. *Nutrition journal*, *10*(1), 1-13.

Bergen, M., & Mollen, D. (2019). Teaching sizeism: Integrating size into multicultural education and clinical training. *Women & Therapy*, *42*(1-2), 164-180.

Bogaardt, A. (2019, August 13). *Obesity stigma and the misdirection of responsibility*. British Psychological Soceity. https://www.bps.org.uk/psychologist/obesity-stigma-and-misdirection-responsibility

Brochu, P. M. (2019). Teaching clinical psychology trainees about weight bias. *Women & Therapy*, *42*(1-2), 191-199.

Brochu, P. M. (2023). Testing the effectiveness of a weight bias educational intervention among clinical psychology trainees. *Journal of Applied Social Psychology*, *53*(3), 231-241.

Chrisler, J. C. (2019). Should feminist therapists do weight loss counseling?. In *Overcoming fear of fat* (pp. 31-38). Routledge.

Daníelsdóttir, S., O'Brien, K. S., & Ciao, A. (2010). Anti-fat prejudice reduction: a review of published studies. *Obesity facts*, *3*(1), 47-58.

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

Emmer, C., Bosnjak, M., & Mata, J. (2020). The association between weight stigma and mental health: A meta-analysis. *Obesity Reviews*, *21*(1), e12935.

Erdman, C. K. (1999). Fat as a therapeutic issue: Raising awareness in ourselves and our clients. *The Rerifrew Perspective*, *3*, 9-11.

Fahs, B. (2019). Fat and furious: Interrogating fat phobia and nurturing resistance in medical framings of fat bodies. *Women's Reproductive Health*, *6*(4), 245-251.

George, T. P., DeCristofaro, C., & Murphy, P. F. (2019, September). Unconscious weight bias among nursing students: a descriptive study. In *Healthcare* (Vol. 7, No. 3, p. 106). MDPI.

Kinavey, H., & Cool, C. (2019). The broken lens: How anti-fat bias in psychotherapy is harming our clients and what to do about it. *Women & Therapy*, *42*(1-2), 116-130.

Matacin, M. L., & Simone, M. (2019). Advocating for fat activism in a therapeutic context. *Women & therapy*, *42*(1-2), 200-215.

McHugh, M. C., & Kasardo, A. E. (2012). Anti-fat prejudice: The role of psychology in explication, education and eradication. *Sex Roles*, *66*, 617-627.

McHugh, M. C., & Chrisler, J. C. (2019). Making space for every body: Ending sizeism in psychotherapy and training. *Women & Therapy*, *42*(1-2), 7-21.

Meulman, M. A. (2019). Sizeism in therapy: Fat shaming in supervision. *Women & Therapy*, *42*(1-2), 156-163.

Pascal, B., & Kurpius, S. E. R. (2012). Perceptions of clients: Influences of client weight and job status. *Professional Psychology: Research and Practice*, *43*(4), 349.

Pausé, C. (2019). Hung up: Queering fat therapy. *Women & Therapy*, *42*(1-2), 79-92.

Rothblum, E. D., & Gartrell, N. K. (2019). Sizeism in mental health training and supervision. *Women & Therapy*, *42*(1-2), 147-155.

Smith, C. A. (2019). Intersectionality and sizeism: Implications for mental health practitioners. *Women & Therapy*, *42*(1-2), 59-78.

Search keywords

Anti-fat
Bias
Body liberation
Body weight in therapy
Clinical Psychology
Counselling
Fat
Fat-affirmative psychotherapy
Fat activism
Fat Pedagogy
Fat phobia
Fat stigma
Fat shaming
Fat Studies
Fat talk
Health at every size
Mental health training
Obesity
Overweight
Prejudice
Prejudice reduction
Psychotherapy
Size acceptance
Sizeism
Stereotype
Social Justice
Stigma
Training
Therapeutic bias
Weight and dieting
Weight Bias
Weight discrimination
Weight stigma

Appendix E: Search terms/concepts used for SLR

Concept 1: Terms relating to participant group ("mental health professionals")	AND	Concept 2: Terms relating to outcome (weight stigma)
"Psychologist*" OR "Clinical Psychologist*" OR "Clinical Psychology" OR "Counselling Psychologist*" OR "Counselling Psychology" OR "Counseling psychologist*" OR "Counseling psychology" OR "Mental Health Professional*" OR "Mental Health Worker*" OR "Psychotherapist*" OR "Psychotherapy" OR "Family Therapist*" OR "Family Therapy" OR "Systemic Therapist*" OR "Systemic Therapy		Weight stigma OR Anti-fat bias OR Fat phobia OR Body shaming OR Fat shaming OR Weight bias OR Weight Prejudice OR Obesity Stigma OR Size Stigma OR Size Bias

Appendix F: Appraisal tool for Cross-Sectional Studies (AXIS)

Quantitative Cross-Sectional Studies Critical Appraisal Table

Abbreviations: N/A – not applicable; N/S – not stated

#	1	2	5	6	7	8	10	11
Author/Authors & Year	**Agell et al. (1991)**	**Bleich et al. (2015)**	**Davis-Coelho et al. (2000)**	**Forristal et al. (2021)**	**Hassel et al. (2001)**	**Pascal et al (2012)**	**Pratt et al., (2016)**	**Stapleton et al., (2015)**
1. Were the aims/objectives of the study clear?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
2. Was the study design appropriate for the stated aims?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Was the sample size justified?	No	Yes	No	Yes	No	No	No	No
4. Was the target/reference population clearly defined?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	Yes	Yes	Yes	N/S	Yes	Yes	Yes	Yes
6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	Yes	Yes	Yes	N/S	Unsure-participants obtained through meetings and conventions	Yes	Yes	Yes
7. Were measures undertaken to address and categorise non-responders?	No	No	No	N/S	No	No	No	No
8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled,	Yes	No	No	Yes	Yes	Yes	Yes	Yes

piloted or published previously?								
10. Is it clear what was used to determine statistical significance and/or precision estimates (e.g. p-values, confidence intervals)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12. Were the basic data adequately described?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13. Does the response rate raise concerns about non-response bias?	N/S	N/S	N/S	N/S	N/S	N/S	N/A	N/S
14. If appropriate, was information about non-responders described?	No	No	No	No	No	No	N/A	N/A
15. Were the results internally consistent?	N/S	N/A	N/A	Yes	N/S	Yes	N/S	Yes
16. Were the results presented for all the analyses described in the methods?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. Were the authors' discussions and conclusions justified by the results?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18. Were the limitations of the study discussed?	Yes	Yes	No	Yes	No	Yes	Yes	Yes
19. Were there any funding sources of conflicts of interest that may affect the authors' interpretation of the results?	N/S	No	N/S	No	N/S	N/S	N/S	N/S
20. Was ethical approval or consent of participants attained?	N/S	Yes	N/S	Yes	N/S	Yes	Yes	Yes

Appendix G: Quality Appraisal: EHPP for intervention study

Quality Appraisal Tool: Effective Public Health Practice Tool		
Paper: Brochu (2019) Testing the effectiveness of a weight bias educational intervention among clinical psychology trainees		
Section	**Question**	**Response**
Section A: SELECTION BIAS	Q1. Are the individuals selected to participate in the study likely to be representative of the target population?	1: Very likely
	Q2. What percentage of selected individuals agreed to participate?	5 : Can't tell
	RATE THIS SECTION	**Moderate**
Section B: STUDY DESIGN	Indicate the study design	5: Cohort (one group pre+post (before and after))
	Was the study described as randomized? If NO, go to Component C	N/A
	If Yes, was the method of randomization described? (See dictionary)	N/A
	If Yes, was the method appropriate? (See dictionary)	N/A
	RATE THIS SECTION	**Moderate**
Section C: CONFOUNDERS	Q1. Were there important differences between groups prior to the intervention?	N/A- Cohort design pre+post intervention
	Q2. If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?	N/A
	RATE THIS SECTION	**N/A**
Section D: BLINDING	Q1. Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?	3: Can't tell
	Q2. Were the study participants aware of the research question?	3: Can't tell
	RATE THIS SECTION	**Moderate**
Section E:	Q1. Were data collection tools shown to be valid?	1: Yes

DATA COLLECTION METHODS	Q2. Were data collection tools shown to be reliable?	1: Yes
	RATE THIS SECTION	**Strong**
Section F: WITHDRAWALS AND DROP-OUTS	Q1. Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?	No: drop-out numbers provided, reasons are not
	Q2. Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).	1: 80-100%
	RATE THIS SECTION	**Strong**
Section G: INTERVENTION INTEGRITY	Q1. What percentage of participants received the allocated intervention or exposure of interest?	1: 80-100%
	Q2. Was the consistency of the intervention measured?	1: Yes
	Q3. Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?	5. No
Section H: ANALYSES	Q1. Indicate the unit of allocation (circle one)	individual
	Q2. Indicate the unit of analysis (circle one)	individual
	Q3. Are the statistical methods appropriate for the study design?	1: Yes
	Q4. Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?	1: Yes
	GLOBAL RATING FOR THIS PAPER	**Strong**

Appendix H: Quality Appraisal: MMAT for mixed-method study

Quality Appraisal Tool: Mixed Methods Appraisal Tool (MMAT) (Hong, et al., 2018)					
Paper: Pratt et al. (2014) Marriage and Family Therapists' Perspectives on Treating Overweight Clients and Their Weight-Related Behaviours (WRB)					
Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't Tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1 Is the qualitative approach appropriate to answer the research question?	X			
	1.2 Are the qualitative data collection methods adequate to address the research question?	X			
	1.3 Are the findings adequately derived from the data?	X			
	1.4 Is the interpretation of results substantiated by data?	X			
	1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?			X	The process of analysis is described (p369) but a specific analytic method was not used/described to it is unclear why this approach was

					chosen and how it fits with research question,
2. Quantitative randomised controlled trials	2.1 Is randomisation appropriately performed?				N/A
	2.2 Are the groups comparable at baseline?				N/A
	2.3 Are there complete outcome data?				N/A
	2.4 Are outcomes assessors blinded to the intervention provided?				N/A
	2.5 Did the participants adhere to the assigned intervention?				N/A
3. Quantitative non-randomised	3.1 Are the participants representative of the target population?				N/A
	3.2 Are measurements appropriate regarding both the outcome and intervention (or exposure)?				N/A
	3.3 Are there complete outcome data?				N/A
	3.4 Are the confounders accounted for in the design and analysis?				N/A
	3.5 During the study period, is the intervention administered (or exposure occurred) as intended?				N/A
4. Quantitative descriptive	4.1 Is the sampling strategy relevant to address the research question?	X			
	4.2 Is the sample representative of the target population?	X			
	4.3 Are the measurements appropriate?			X	Not all measurement tools used were validated
	4.4 Is the risk of nonresponse bias low?	X			
	4.5 Is the statistical analysis appropriate to answer the research question?	X			
5. Mixed methods	5.1 Is there an adequate rationale for using a mixed methods design to address the research question?			X	
	5.2 Are the different components of the study effectively integrated to answer the research question?		X		

	5.3 Are the outputs of the integration of qualitative and quantitative results adequately addressed?		X		
	5.4 Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				N/A
	5.5 Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	X			

Appendix I: Quality Appraisal: CASP for qualitative study

Cravens, Pratt & Palm (2016)

Section A: Are the results of the study valid?

1. *Was there a clear statement of the aims of the research?*
   Yes- Study outlines purpose of the research based upon the literature review. The study aimed to better understand marriage and family therapy (MFT) students reactions to weight bias training and explore their previous experience with the topic and any ideas they had for integration of this into their future training.

2. *Is a qualitative methodology appropriate*

   Yes- the study wanted to explore students responses and reactions in a way that quantitative tools might not have been able to capture in such a meaningful and rich way

3. *Was the research design appropriate to address the aims of the research?*
   Yes
4. *Was the recruitment strategy appropriate to the aims of the research?*

   Yes – Participants recruited from MFT programs

5. Was the data collected in a way that addressed the research issue?
   Yes- students/ participants participated in weight bias training before attending focus group to explore the aforementioned aims. Clear links to the purpose of the study
6. *Has the relationship between researcher and participants been adequately considered?*

   No- Briefly mentioned in limitation of the study that researchers who developed the training collected feedback from the students but limited consideration about this or any further noting of this relationship.

Section B: What are the results?

7. *Have ethical issues been taken into consideration?*

   Yes

8. Was the data analysis sufficiently rigorous?

   Yes-

9. Is there a clear statement of findings?

   Yes-

Section C: Will the results help locally?

10. How valuable is the research?

Valuable -Researcher discusses contribution of the study to existing knowledge and understanding by considering how the findings might inform future training of MFT students to address and reduce weight stigma in trainees and the profession. Future research has been identified.

Appendix J: Quality Appraisal: CASP for current SLR

Current Systematic Literature Review

Section A: Are the results of the study valid?

11. Did the review address a clearly focused question?

Yes- Clear question outlined focussed specifically on a 'population' (mental health professional) and an 'outcome' (weight stigma)

12. Did the authors look for the right type of papers?

Yes – the author identified relevant studies which addresses the review's question and included appropriate study design. However, no RCTs were available in the research area.

Is it worth continuing?

13. Do you think all the important relevant studies were included?

Yes- appropriate bibliographic databases were selected, reference lists were examined with some personal contact with expert in the area. However, unpublished research (e.g. masters or doctoral theses were not included which might add a valuable contribution to the review. Only studies available in English were included due to limited resources and time pressures of completing the SLR

14. Did the review's authors do enough to assess quality of the included studies?

Yes- the authors considered the rigour of selected studies using a range of critical appraisal tools and took the limitations and quality of the studies into consideration as part of the review.

15. If the results of the review have been combined, was it reasonable to do so?

Yes- study results were similar, where there were differences, quality of the different studies was considered. Results of included studies were summarised, though more detail could have been provided. Variations and differences are discussed.

SECTION B

16. What are the overall results of the review?

The review was able to consider the results of the separate studies to answer the research question about what current research literature has to say about weight stigma in mental health professionals.

17. How precise are the results?

Due to a range of studies it was not appropriate to combine statistical results

Section C: Will the results help locally?

18. Can the results be applied to the local population?

Yes- a range of mental health professionals were identified, including trainee clinical psychologists which will form the participants of the empirical study for this thesis.

19. Were all important outcomes considered?

Yes- Author outlined process of reviewing articles for outcomes relevant to the research question

20. Are the benefits worth the harms and costs?

Yes

Appendix K: University of Hertfordshire Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Kate Arnold

CC Wendy Soloman

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair

DATE 06/07/2021

Protocol number: **LMS/PGR/UH/04606**

Title of study: Weight Stigma in Clinical Psychology

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 06/07/2021

To: 01/06/2022

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstances may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix L: Participant consent

UNIVERSITY OF HERTFORDSHIRE ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE') FORM EC3 - CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

Consent Form

Please read the following statements before you agree to take part in this study.

1) **I confirm that I have read and understood the participant information sheet and I understand what my participation in this study involves.**

   ☐ Yes ☐ No

2) **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I withdraw from the study, the data that I have submitted will also be withdrawn at my request. I understand that following the transcription of the data it will be difficult to remove my data without it impacting on the group discussions however if I withdraw at this time none of my quotes of additional information will be included as part of the study.**

   ☐ Yes ☐ No

3) **I understand that the information that I will submit will be confidential and anonymous, used only for the purpose of this study. I understand that relevant sections of the data collected by the research will be looked at by authorised persons from the University of Hertfordshire. Anonymised transcripts may be shared with research supervisors for data analysis. Anonymised sections of the data collected may also be looked at by representatives from academic and professional assessment bodies to assess the quality of this doctoral research project. All will have a duty of confidentiality to you as a research participant.**

   ☐ Yes ☐ No

4) **I agree that research data gathered for the study may be published and if this occurs precautions will be taken to protect my anonymity.**

   ☐ Yes ☐ No

5) **Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.**

   ☐ Yes ☐ No

6) **I agree to take part in the above study and for the focus group to be recorded.**

☐ Yes ☐ No

Participant Name:

Participant Signature:

Date:

Appendix M: Participant recruitment email

Hello, I hope this email finds you well. I was wondering if you would be able to distribute the email below to your Trainee Clinical Psychologists. Many thanks

*****

Hello! My name is Kate Arnold, and I am a second year DClinPsy trainee at the University of Hertfordshire and I am beginning to recruit participants for my Major Research Project (MRP) and would like to invite you to participate.

I am interested in Trainee Clinical Psychologists' thoughts about weight and body size. For this MRP I would like to recruit participants to take part in a focus group exploring these topics. I hope to run three focus groups with four to six participants in each group.

To participate you must currently be a Trainee Clinical Psychologist within the UK.

If you choose to participate, I will invite you to join an on-line focus group in which I would use a semi-structured interview to explore some of your experiences of conversations you might have had in your personal and professional lives about weight and body size. I might also ask you to think about your experiences working as a Trainee Clinical Psychologist, but you can choose how little or how much you might want to contribute to these discussions. The focus-group will be recorded to allow me to transcribe the material. Confidentiality will be strictly observed throughout the MRP which would include keeping your name and identifying information securely and separately from the recordings of the focus group.

If you are interested in the study, please contact me on my email address (ka19abt@herts.ac.uk) and I will send you a participant information sheet with more details about the project and participation, including information around consent and your rights to withdraw from the study at any point without having to provide justification.

I really appreciate you taking the time to read this information. Please feel free to contact me if you have any questions or are interested in participation.

Warmest wishes

Kate Arnold
Trainee Clinical Psychologist
University of Hertfordshire
Ka19abt@herts.ac.uk

Supervisor: Dr Wendy Solomons
Clinical Psychologist
University of Hertfordshire
w.solomons@herts.ac.uk

Appendix N: Participant information sheet

Title of study

Trainee Clinical Psychologists' thoughts about weight and body-size.

Introduction

Thank you for getting in touch with relation to participating in this research study. This sheet is designed to provide you with more information about the study to allow you to decide whether you would like to participate. The area of research that I am interested in is thoughts about weight and body size within the profession of clinical psychology. I hope to recruit three groups of between four to six participants who are currently Trainee Clinical Psychologists within the UK.

I am more than happy to discuss the material below if you are unsure of anything or would like me to elaborate on any of the information.

What is the aim of the study?

The research aims to explore the experiences Trainee Clinical Psychologists have of discussions around weight and body size, both in their personal and professional lives. I will introduce and moderate the focus groups, facilitating a semi-structured interview within the group.

Do I have to take part?

No! It is completely up to you whether you choose to participate in this study. If you choose to participate you may withdraw from the study at any point without providing justification for this.

What will happen if I choose to take part?

Participation would involve being invited to an online focus group interview which would last between 1 ½-2 hours. I will moderate the focus group interview and will ask your thoughts about weight and service users and you can choose to contribute to these discussions as much or as little as you like. The meeting will be recorded.

After the interview I will ask you whether you would like to be contacted to comment on the research findings but there is no obligation to be part of this section of the study.

Are there any disadvantages from taking part?

As a current Trainee Clinical Psychologist myself, I can appreciate how busy you might be. I recognise that asking for 1 ½ - 2 hours of your time will add to that pile of things to be done. I am happy to be very flexible about finding a date and time to meet that fits in with your schedule and commitments.

The topic area might cause some distress as we often do not talk about bodies and weights as psychologists, but you would only be required to contribute what you feel comfortable. A full debrief will be provided after the focus group, with sign posting to further support if you feel like you need it.

Are there any benefits from taking part?

I am unable to guarantee that participating in this study will help you. It might however allow you time and space to reflect on your thoughts about weight and body size in your personal and professional lives, which you may not have the opportunity to do as part of your training. It is hoped that this study will inform future research in the area, and possibly training, that will benefit both psychologists and service users.

If I choose to participate, will my participation be kept confidential?

There are several ways that I will keep your participation in this study confidential. I will take the minimum amount of personal information about, only asking for information to be able to contact you to arrange the focus group and demographic information that you should not be identifiable from. All the information collected will be kept strictly confidential. Any identifiable information, including your name, will be kept securely and separately from the recording of the focus-group. I will be the only person with access to raw research data.

As the research uses a focus group design there may be between 3-5 other participants in the same group as yourself. At the beginning of the group, we will discuss confidentiality around the discussions we will be having, and group members will be asked not to use identifiable details to discuss other group members or their contributions to the discussions.

It is possible that I may be required to use an approved transcription service to transcribe your interview if there is not time for me to transcribe it myself. Recordings

will be labelled to protect your identity and the service will be required to sign a non-disclosure confidentiality agreement.

As part of the research process, some data, including anonymised transcripts, may be looked at by authorised individuals from the University of Hertfordshire. to support the quality of analysis and its impact (e.g., links to training or future research). To ensure the quality of the research, anonymised sections of the data might also be viewed by academic and professional assessment bodies. Any individuals who have access to this anonymised data will have a duty of confidentiality to yourself as a research participant.

Identifiable data and recordings will be stored securely for five years after the completion of my degree. The purpose for this is so the data is available if there are any appeal procedures or examinations queries. All the data and recordings will be destroyed after this time.

Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

The UH protocol number is LMS/PGR/UK/04606

What will happen to the results of this study?

The data collected during the study will be used as a part of a Doctoral Clinical Psychology project at the University of Hertfordshire. Research findings will be submitted as part of doctoral thesis. In addition, I will write up an article for publication in a journal, again no participant will be identifiable. The research may be presented at conferences and written up for mainstream media. Results may be shared with Clinical Psychology Training courses and specific NHS service. The data may be used for future related studies. Ethical approval for this study has been obtained from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority and the UH ethics protocol number is [to amend this once awarded].

Taking part in this study

If you wish to take part in this study, please contact me on ka19@herts.ac.uk

Further information

If you would like further information about the study, please contact me by email (ka19@herts.ac.uk).

The UH protocol number is [to be added once awarded]

Further support

This study will be reviewed by The Health, Science, Engineering and Technology ECDA at the University of Hertfordshire.

If participation in this research has caused you any distress, discomfort or upsetting feeling, you may wish to contact immediate sources of support such as your family, friends, GP or a therapist.

If you would like further support, please find below the details of some organisations that may be useful. These sources of support will be able to help you regarding any concerns or worries you have regarding your emotional and psychological wellbeing.

Your GP

Please consider contacting your GP if you are feeling low or anxious.

Psychological therapies

If you think that you may benefit from engaging in a talking therapy (such as cognitive behavioural therapy), then you may wish to consider self-referring to your local psychological therapies service or asking your GP to refer you.

To find your nearest service, you can search on the NHS choices webpage: https://www.nhs.uk/Service-Search/Psychological-therapies-(IAPT)/LocationSearch/10008

NHS Choices

If you're worried about an urgent medical concern, call 111 and speak to a fully trained adviser. Website: https://www.nhs.uk/pages/home.aspx Helpline: 0113 825 0000

Samaritans

This is a 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress. Freephone: 08457 90 90 90 Website: www.samaritans.org

Beat Eating Disorders

Beat is the UK's eating disorder charity that aims to raise awareness and minimise the distress caused by eating disorders. Talking about bodies (our own or others) can be a difficult topic for many people and you may wish to seek support from the charity if reading this participant information sheet has prompted any thoughts around historic or current difficulties with eating disorders. Freephone: 0808 801 0677 Website: www.beateatingdisorders.org.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please contact my supervisor (Dr Wendy Solomons at w.solomons@herts.ac.uk) and/or write to the University's Secretary and Registrar at the following address: Secretary and Registrar University of Hertfordshire College Lane, Hatfield. Herts AL10 9AB

Thank you very much for reading this information and considering taking part in this study.

Appendix O: Recruitment Poster

Appendix P: Participant Demographic information

Participant screening form

All participants will be asked the following questions to screen for inclusion and exclusion criteria of the study.

Was verbal consent obtained from the potential participant before asking the questions below?

☐ Yes ☐ No

1. Is the participant a Trainee Clinical Psychologist at a UK university?

☐ Yes ☐ No

Demographic questions: (*these questions are not intended as a screening for inclusion/exclusion from the study, and no answer need be given if the participant does not wish to)*

1. What University are you (the participant) currently completing your doctorate in Clinical Psychology at?

2. Current year of training:

3. Age:

4. Gender:

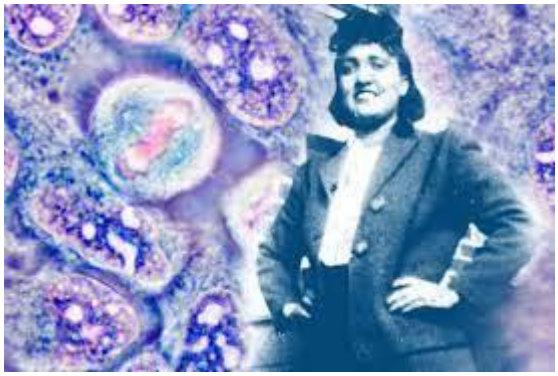
5. Ethnicity:

6. Nationality:

7. How would you describe your body size?:

Appendix Q: Fat women from history: Participant pseudonyms

Beth Ditto: Singer from The Gossip 	**Hilda Campos Soares da Silva aka** **Leny Eversong**: Brazilian singer 
Denise Borino-Quinn: Actress 	**Mama Cass**: Singer 
Pam Ferris: Actress	**Ella Fitzgerald**: Singer

	
Henrietta Lacks -cells used to cure polio and create human papillomavirus 	**Martha Walsh**: Singer 
Stephanie Yeboah: Author/Activist	**Julia Child**: Chef

Lucielle Ball: Actress

Aubrey Gordon: Author/Activist

Appendix R: Semi-structured interview schedule

Intro

- Thank you all so much for agreeing to participate, really grateful.
- Just wanted to run through some ground rules and check in about consent around recording
    - Thank you for all consenting to participating in the study, just wanted to confirm that you're all happy for me to record out session today. It is likely that I'll be transcribing the audio myself but if I do use a transcription service they will be required to sign a confidentiality agreement
    - Would be grateful if people can keep their cameras and mics on as sometimes easier to facilitate conversations when people can see and hear each other (understand if something comes up and this isn't always possible)
    - In terms of confidentiality please respect the confidentiality of those in the group and don't discuss other people's contributions outside this space, it's possible that some of you might know each other and to just be mindful of this in different spaces
    - Really want this to be a curious and non-judgmental space, honesty and transparency is really valued and would like to welcome it as a brave space and for people to feel comfortable to raise different views as might share similar and different views but aware in a group it can be difficult and uncomfortable to share dissenting views
    - Please don't feel like you have to share anything that you are not comfortable sharing or that you have to answer every question. I might do a general invite, asking if there are people who haven't shared that would like to add something but please don't feel under pressure, it's just to create a space that people might feel easier to step in to.

Opening stage of interview

Fatness in general- facilitate broad discussion.

1) Brainstorm- If I say the word 'fat' what does it make you think about?

Thank you all, that's a really helpful place to start. Just in terms of terminology, I'll be using the word fat as a neutral descriptor of a body, but it's fine if that's not what comes to your mind I might also use larger body interchangeably. Please don't feel like you need to modify your language or terminology around that though

Stage 1: Personal constructions of weight and fatness

- “Can you tell me about the last time you had a conversation with friends or family about weight or body size?”

Prompts:

- “Was this about your own weight?”
- If it doesn’t naturally occur, consider asking about this in the context of the Covid-19 pandemic and other factors that might be in the news currently.

Stage 2: Professional constructions of weight and fatness

- **“**Can you tell me about a time you have had conversations at work (e.g., on training placements) about weight or body size.”
    - **“**Can you tell me about a time you have worked with someone in a larger/fatter/bigger body”. “Did any issues relating to their weight come up at any point” (either in conversation with the individual or with other professionals)
    - “Why do you think this was?”
- **“**Can you tell me about a time a conversation about weight or body size has come up during supervision (either in relation to a service user or reflecting on your own)
    - Did you reflect on the impact that had on the relationship with your own body
    - If not shared, was it that it didn’t come to mind or not comfortable talking about it with supervisor?

Stage 3: Conversations relating to weight and body size whilst on Clinical Psychology Training

- “Can you tell me about a time when conversations about weight or body size have come up with your cohort whilst you have been training?”
    - Was this in the context of one of your own bodies?
    - Was it in the context of teaching/case study/vignette/research?
    - Was it in the context of a service-user body?

Stage 4: Societal constructions around weight and body size

- “Can you tell me about a time the Body Mass Index (BMI) came up in conversation either at work or in your personal life”.
  Prompts
    - What’s your understanding of the BMI?

  - Was anyone you discussed BMI with critical about the use of it?
  - Do you think this is relevant to clinical psychology?

- "Could you tell me about a situation you have been in in which the phrase 'obesity epidemic' has come up."
  Prompts

  - What does that phrase mean to you either in a personal or professional setting?
  - Do you think this is relevant to clinical psychology?

- "Have you been in situations where the terms weight-stigma or fat-stigma or anti-fat bias have been used?"
- "Have you been in situations where the term 'critical weight science' has been used?"

Prompts

- If so in what contexts
- How did people respond to this discussion?

Stage 5 – Concluding the interview and debrief.

- If there is anything that participants would like to add that they've not been asked about
- Any questions for moderator
- Confidentiality
- ***Debrief about research, what the research is exploring.***
- Any questions
- Next steps

<u>Questions from a journalist position:</u>

- "So do you think…?"
- "So do you mean…?"
- "Are you saying that…?

<u>Moderator/facilitator's position:</u>

- Empathic listening prompts (mmmm…)

- Encouraging the conversation probes (can you say a bit more about that)
- Bringing people into the conversation
    - Does everyone else agree/disagree?
    - What other conversations have people had about that?
    - What do other people think?
    - I'm conscious we've heard from some people but not others, would anyone else like to comment on this?
- Moving discussions on to cover all material (I'm really pleased we're able to have such a rich conversation about this, but I am aware of how generous you all have been to give up your time for this group and there are a few other points I'd like us to consider)
- Recognising silence (Are these hard conversations to have? Is it hard knowing what to say or how?)

Appendix S: Participant Debrief sheet

Debrief Sheet

Thank you for giving your time to take part in this research project. I hope this research will help improve understanding of weight stigma in clinical psychology. Weight stigma (also referred to as weight-bias) is a negative attitude towards and beliefs about others because of their weight. There is a current gap in the literature around weight stigma within the profession and this study aims to begin considering whether we as trainees have bias against fat bodies.

As we live in a society where weight stigma is highly prevalent, it is likely we incorporate some of the beliefs that are dominant within our society. Without raising awareness, increased training and beginning to challenge these perspectives, we risk perpetuating oppressive structures that can damage the mental and physical health of ourselves, our colleagues and our service users.

The research aimed to explore how Trainee Clinical Psychologists construct weight and fatness in discussions about fat bodies and how you position yourselves in relation to societal ideas around weight and fatness and if you were aware of debates around critical weight science, weight stigma and fat justice. I did not advertise the specifics of this study and kept it broad to ensure a broad range of participants and views could be collected.

As a profession we do not often tend to talk explicitly about our own or service-users' bodies, this may have been the first time you have been involved in a discussion of this nature, or you may be passionate about the topic. It is likely that different participants might have different positions which they may or may not have felt comfortable expressing. I wanted to take this opportunity to offer further information about weight stigma and resources for support if any of the information that was discussed left you feeling distressed in anyway.

The information that you have provided will be kept confidential. All data will be safely destroyed after the completion of the research.

If participation in this research has caused you any distress, discomfort or feelings that feel difficult to process, you may wish to contact immediate sources of support such as your family, friends, GP or a therapist.

If you would like further support, please find below the details of some organisations that may be useful. These sources of support will be able to help you regarding any concerns or worries you have regarding your emotional and psychological wellbeing.

Your GP

Please consider contacting your GP if you are feeling low or anxious.

Psychological therapies

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NHS Choices

If you're worried about an urgent medical concern, call 111 and speak to a fully trained adviser. Website: https://www.nhs.uk/pages/home.aspx Helpline: 0113 825 0000

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Beat Eating Disorders

Beat is the UK's eating disorder charity that aims to raise awareness and minimise the distress caused by eating disorders. Talking about bodies (our own or others) can be a difficult topic for many people and you may wish to seek support from the charity if participating in this project has prompted any thoughts around historic or current difficulties with eating disorders. Freephone: 0808 801 0677 Website:

www.beateatingdisorders.org.uk

If you have any further questions, or would be interested in being informed in the outcome of this study, then please contact the researcher, Kate Arnold by email on

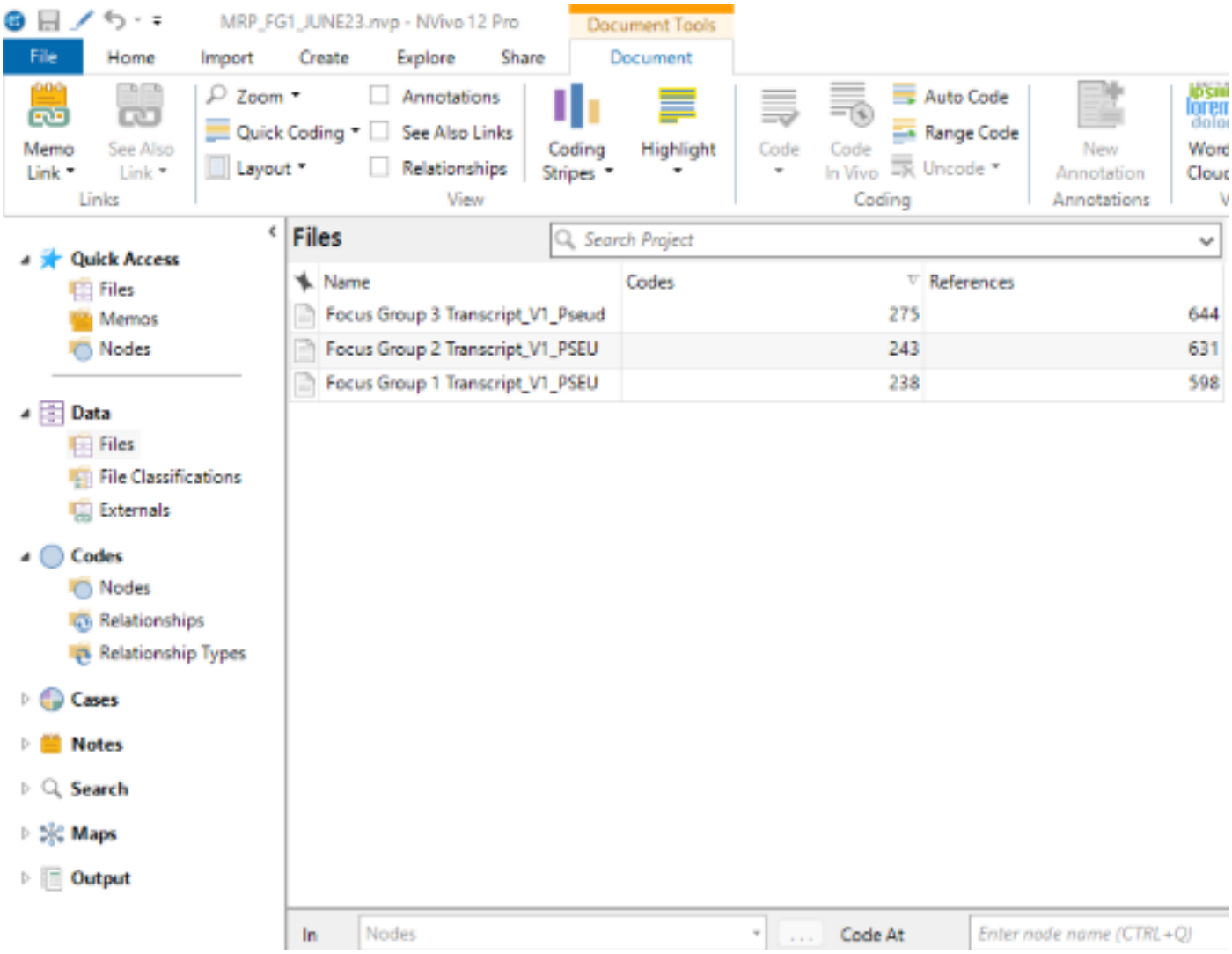
ka19abt@herts.ac.uk

If you have any complaints about the study, please contact Dr Wendy Solomons by email (**w.solomons@herts.ac.uk**).

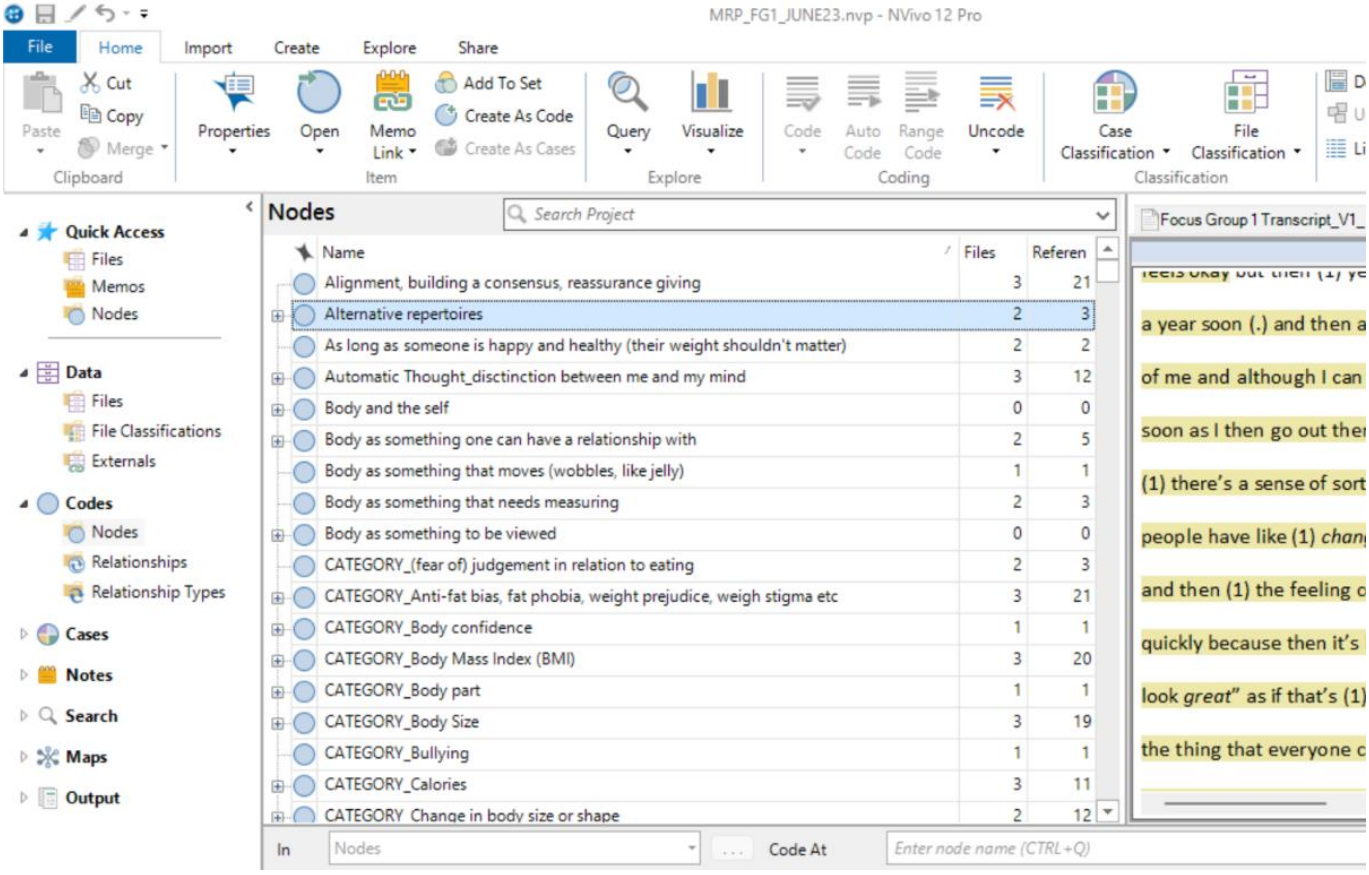
Thank you again for your participation and support.

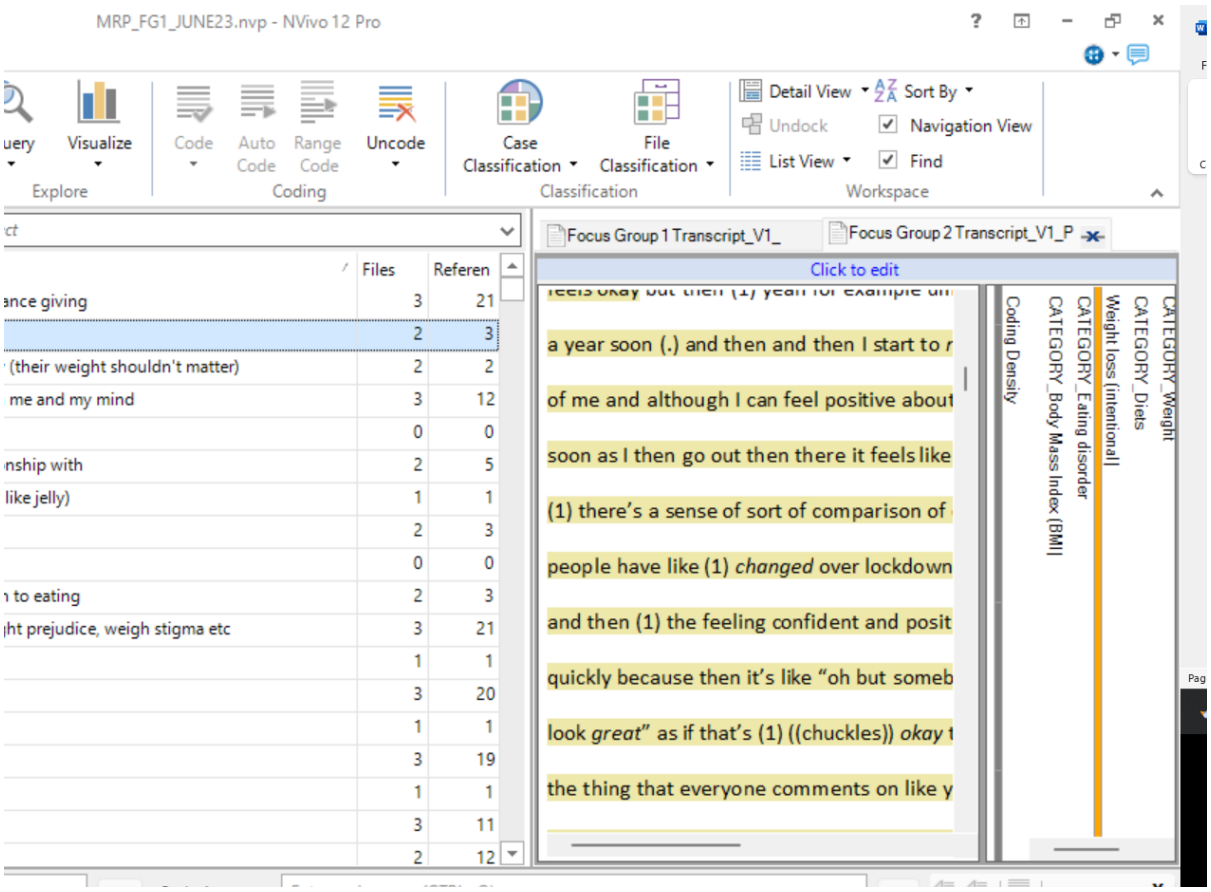
Appendix T: Transcript Extract

NVivo 12 Pro- Transcripts were imported into NVivo and coded

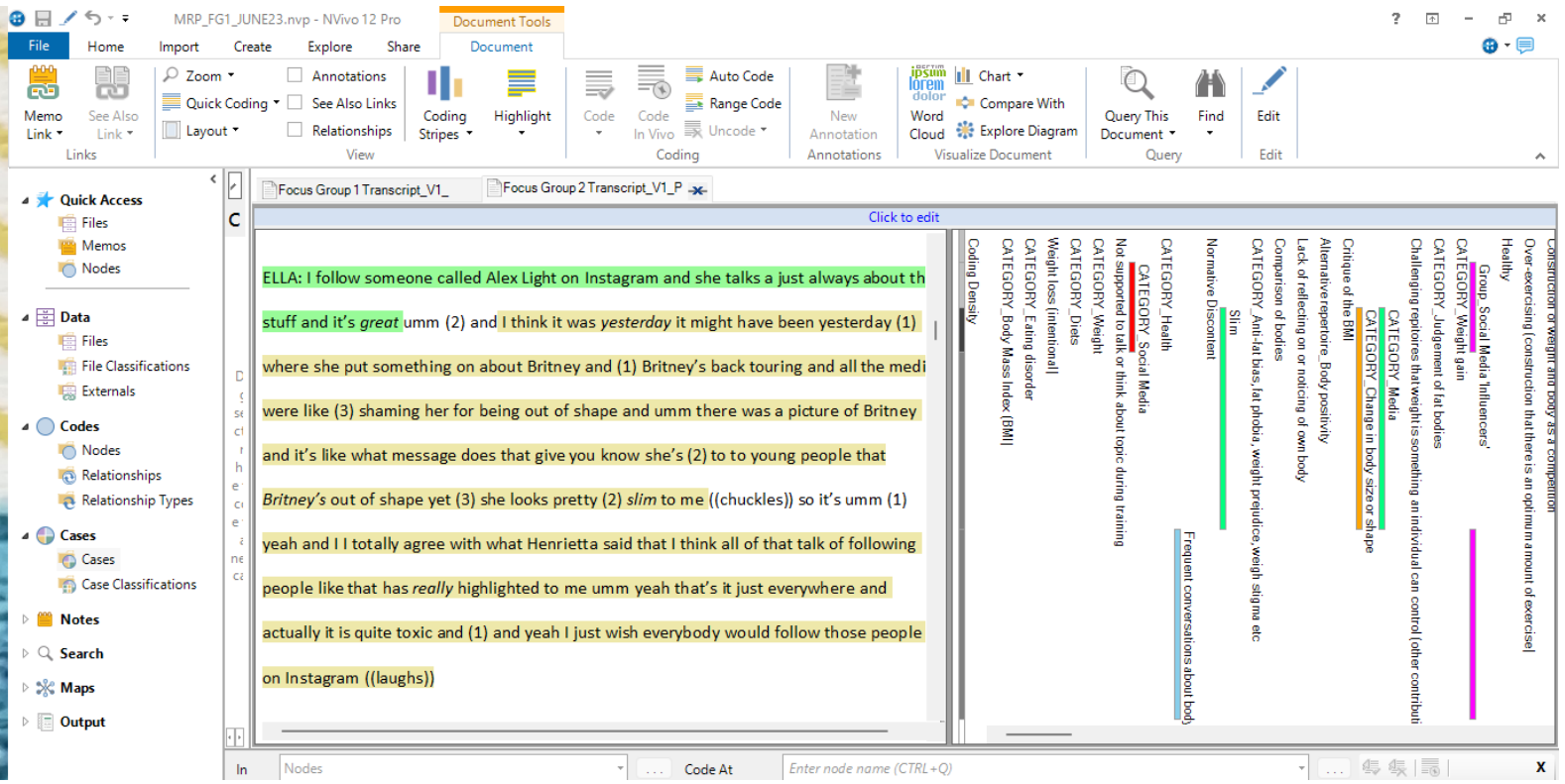


Examples of codes and representation in the different focus groups (Files) and frequency of codes (reference)





Appendix U: CASP Quality Appraisal of empirical study



Section A: Are the results of the study valid?

1. *Was there a clear statement of the aims of the research?*

Yes – there was a clear goal of the research, to explore how weight, bodies and fatness was constructed by trainee clinical psychologists and how they positioned themselves in relation to societal ideas around weight and bodies.

2. *Is a qualitative methodology appropriate*

Yes- the aims of the study could not have been addressed using quantitative methodology. The specific qualitative methodology was chosen to allow the researcher to explore how trainees were the products and producers of discourse about weight and bodies. Critical Discursive Psychology analysis provided opportunities to examine what trainees had to say about weight and bodies, the discursive tools they used to express this, the interpretative repertoires that available to them, and the subject positions they held in relation to these repertoires. Importantly, it allowed the researcher to consider the practices which were upheld by trainees and how these practices might be challenged, aiming to reduce weight stigma in the profession.

3. *Was the research design appropriate to address the aims of the research?*

Yes – the use of a focus group provided opportunities to explore trainees' constructions through their discussions and interactions with one another. There was some consideration about using 1:1 individual interviews due to the

potentially sensitive nature of the topic. However, as one of the aims of the study was to explore how trainees constructed weight and fatness, it was hoped that the open discussions generated in a focus group might allow for the presentation, exploration and challenging of different viewpoints. In addition to this, trainees frequently participate in group discussions (e.g., multi-disciplinary teams), it was therefore considered a format that would create opportunities for more naturalistic discussions about the subject area

4. *Was the recruitment strategy appropriate to the aims of the research?*

Yes – Researcher contacted all the UK clinical psychology training institutes to request trainees be provided with information about the study.

5. Was the data collected in a way that addressed the research issue?

Yes- The setting for the data collection was justified (e.g., use of online focus groups due to wider geographic access to trainees and COVID-19 restrictions). Clear details were provided around how the data was collected, using a semi-structured interview schedule in a focus group setting. The semi-structured interview schedule has been provided an overview of the focus groups was provided.

6. *Has the relationship between researcher and participants been adequately considered?*

Yes- The researcher critically examined their own role, considering their role as an insider researcher (being a trainee and identifying as a ‘small fat’ researcher),

the potential bias and influence they had in the focus group, analysis of data and interpretation of the findings.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes – Ethical consideration was outlined for the study, with ethical approval being sought by the researcher's institution. Details of how participants were informed about the study and debrief were provided.

8. Was the data analysis sufficiently rigorous?

Yes- An in-depth description of the analytic process has been provided. The researcher demonstrated rigour through inclusion of coded transcripts. Researcher explained how data presented was selected from the original sample to demonstrate the analysis process. The researcher's own role, potential bias and influence during analysis was considered through interactions with consultants, supervisors and sharing data with another trainee.

9. Is there a clear statement of findings?

Yes- Findings explicitly laid out with consideration of how the findings are situated within existing literature and discussed in relation to the original research question.

Section C: Will the results help locally?

10. How valuable is the research?

Researcher discusses contribution of the study to existing knowledge and understanding by considering how the findings might inform future training of clinical psychologists to address and reduce weight stigma in trainees and the profession. Future research has been identified.

Appendix V: Social GRRRAAACCCEEESSS

Used with permission from Juliet Young (@creative.clinical.psychologist)