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Young people's perceptions of fat counsellors: "How can THAT help me?"

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Abstract

Being fat is widely recognised as a stigmatised identity which disproportionately impacts women - personally and professionally. Women are numerically dominant as therapy practitioners, and we use this group to explore the ways a 'fat counsellor' is imagined in the context of counselling. A qualitative story completion task, about a woman starting therapy, was presented to 203 British young people aged 15-24. Participants were 75% female, 88% white, 93% heterosexual, and 98% able-bodied. The story stem did not specify the sex of the counsellor, who was identified as fat; the vast majority of stories assumed the counsellor was female. Overall, fatness was perceived as negatively impacting therapy, and the counsellor's professional credibility, because fatness was equated with a lack of psychological health, which rendered fat counsellors professionally 'unfit.' This finding

extends the literature on 'weight bias' in professional settings and has implications for counsellors of all body sizes.

Key words: Weight bias, obesity, perceptions, qualitative, story completion, thematic analysis

In western industrialised nations, the fat individual attracts a broad array of negative stereotypes (Puhl et al., 2015). Fat people are commonly seen as lazy, undisciplined, lacking will-power, unmotivated, sloppy, and untidy, as well as thinking more slowly, having poorer work habits and attendance and generally being less competent in the workplace (Pascal & Kurpius, 2012; Puhl & Heuer, 2009; Puhl & Brownell, 2001). Negative attitudes towards fat people are a form of *weight bias*, which research suggests is on the rise globally (Andreyeva, Puhl & Brownell, 2008; Brewis et al., 2011). Critically, increases in weight bias are co-occurring with increases in average body weight in places like the UK and US (Health and Social Care Information Centre, 2017; Ogden et al., 2014), which means increasing numbers of fat individuals are subject to negative stereotypes.

For women, the negative associations of fat are compounded (Bordo, 1993; Farrell, 2011; Tischner, 2013; Weitz, 2003) – men, for example, generally receive substantially less harsh judgements for weight gain or being fat than women (Chrisler, 2011; Rothblum, 1992; Smith, 2012). Fikkan and Rothblum (2012) reviewed evidence of weight bias towards fat women in employment settings, education, romantic relationships and health care and concluded that in all these domains, fat women are more stigmatised than fat men. In this

paper we use the term fat, in line with other feminist and fat acceptance literature, rather than the terms 'overweight' and 'obese', which reinforce the pathologisation of the fat (female) body (Tischner, 2013).

Aligned with the stereotypical view of fat individuals as lacking self-control/discipline, fat individuals are often seen as to blame for their weight/size (Puhl et al., 2015). This stereotype arises from the persistent belief – particularly in countries where neoliberal and healthist ideologies predominate – that body weight is within individual control (Dejong, 1993; Puhl and Heuer, 2010). This idea, often also promoted by health providers (Puhl & Heuer, 2009), persists despite increasing evidence that body weight is impacted by a range of individual, environmental and social factors *outside* individual control, including a person's genetics and the availability of affordable and healthy food (The Foresight Report, 2007).

In a context in which fatness has a range of negative impacts on how fat individuals are perceived by others, it is significant that fat is often understood as a proxy for ill health. This conflation is evidenced in the term 'obesity epidemic,' which frames global rises in body weights in terms of disease outbreak (Mitchell & McTigue, 2007, p. 391), and the extensive research which associates body weights above the medically designated 'healthy' weight range with adverse physical (e.g. Wang et al., 2011) and mental health outcomes (Simon et al., 2006; Ul-Haq et al., 2014). While there is debate about the links between obesity and physical and psychological health (e.g. Flegal et al., 2013; Gard, 2011; Markowitz, Friedman & Arent, 2008), socioculturally it seems to be taken for granted 'truth' that increased weight and negative health correlate. Because of this, weight is widely assumed to be a proxy indicator of health status (Tischner & Malson, 2011) – for both 'fat' and 'thin'

individuals. This idea, that to be seen as both physically and psychologically healthy a person must appear to be of an 'appropriate' weight, that a slender *appearance* of health is more important socially than *actual* health, has been discussed by various feminist researchers (e.g. Markula, Burns & Riley, 2013; Saguy, 2013; Tischner, 2013).

Yet this is not just a lay issue: research on attitudes of medical staff to fat patients suggests that they, too, often interpret fatness as an indicator of poor health (e.g. Hebl & Xu, 2001; Puhl, Warton & Heuer, 2009; Wright; 1998). For example, a British study with 255 medical professionals (doctors and psychologists) found that 'overweight' patients were seen as less healthy than their 'normal' weight counterparts (Ferrante et al., 2009). Overall, the evidence suggests that a range of physical- as well as mental-health professionals exhibit weight bias towards their fat patients and clients (Agell & Rothblum, 1991; Davis-Coelho, Waltz & Davis-Coelho, 2000; Mold & Forbes, 2013; Pascal & Kurpius, 2012; Puhl & Heuer, 2009; Puhl et al., 2014; Swift et al., 2013; Young & Powell, 1985).

Fat stigma and fat counsellors

Although research has investigated the impact of weight bias on fat patients/clients, to date there is almost no research on how weight stigma might impact fat mental health professionals. This is relevant because limited research on counsellors (Puhl et al., 2014) and medical doctors (Hash et al., 2003) suggests that it is safe to assume that an increasing proportion of medical professionals, including counsellors and psychotherapists, are also heavier than the BMI-defined 'healthy weight,' and would thus be medically designated as 'overweight' or 'obese'. Hutson (2013), who conducted a qualitative study with 26 personal trainers and 25 fitness clients, the majority of whom were female, drew on Bourdieu's

concept of “bodily capital” (Bourdieu, 1984) to conclude that because it is assumed that health status can be read from the body, “corporeal credibility has become increasingly tied to health authority” (p70) and perceived professional competence. The question of how negative stereotypes associated with fatness impact health and medical professionals, including therapy practitioners, is therefore an important one.

Almost no research has examined how fat therapy practitioners are perceived, but limited research on physicians has examined this question. The general conclusion of this literature is that patients generally trust doctors they perceive as ‘overweight’ less than those they perceive as having a healthy weight, and that they would be less likely to follow the advice of a fat physician (Hash et al., 2003; Puhl et al., 2013; Royal Society for Public Health, 2014). Monaghan (2010a, 2010b) examined how medical doctors themselves perceive ‘overweight’ and ‘obese’ doctors, concluding that such clinicians are also at risk from their colleagues of “being discredited by obesity discourse” (Monaghan, 2010a, p. 2). Regarding counsellors, two quantitative US-based studies reported mixed results. McKee and Smouse (1983) asked students presenting for counselling to judge the expertness, attractiveness and trustworthiness of ‘normal’ and ‘overweight’ counsellors from a photograph and description; and did not find clear evidence for an impact of counsellor weight. In contrast, Wiggins (1980) had found fat male *and* female counsellors *were* rated as less able in all areas tested, including in terms of global counselling effectiveness. These studies were, however, conducted over 35 years ago, well before the intensification of attention of fatness related to the ‘global obesity epidemic’.

The lack of recent research on how fat therapy practitioners are perceived sits alongside evidence of the prevalence of fat stigma and of the potential negative impact of being fat on

the authority and credibility of fitness and medical professionals. In this context, we were interested in understanding the intersections between fatness and professional competence, as well as gender, through exploring how a (hypothetical) fat counsellor is responded to, by a (hypothetical) new client.

METHODOLOGY

We used story completion to explore the topic. This method asks participants to write a response to a scenario. They are not expected to describe their *own* views or perceptions, but how they imagine the scenario would play out (see Clarke et al., 2018). Story completion offers the opportunity to tap into dominant social understandings available to, and used by, young people – in relation to fat generally, and in the context of counselling more specifically. Our approach to the data is critical realist (Ussher, 1999), meaning we treat the stories as arising from shared social meanings, which can influence individual behaviours in the real world. We do not treat the stories, however, as giving us access to the ‘actual’ thoughts, values, or beliefs of the individuals themselves, and we do not assume that the responses of the young people to the story completion convey anything about how they would themselves behave or respond in a counselling session with a fat counsellor.

Following recommendations for developing strong story stems (Braun & Clarke, 2013; Clarke et al., 2016), a story stem featuring a distressed client seeking therapy was written and piloted with a group of graduate students; feedback led to the original stem being simplified to avoid potential narrowing of the responses. The final story stem was:

Kate has been finding it really difficult to cope with life so she has decided to go for counselling. As she walks into the counselling room for the first time, her first thought is: "Oh, my counsellor is fat!"

We decided to make the client (Kate) female, because body weight typically has more salience for women than men (Fikkan & Rothblum, 2012). In other aspects, however, the story stem was deliberately under-elaborated: the reader does not know why Kate was having trouble coping; the sex of the counsellor was not specified; and Kate's first thought was given no emotional description, allowing the participant to read the thought as surprise, pleasure or horror (or something else). This minimal context allowed participants to potentially tell a wide range of stories in response to the story stem. It also allowed us to explore participants' predominant associations for the sex of a fat counsellor.

Instructions before the stem invited participants to read the opening lines of the story and write what happens next. Following Braun and Clarke (2013: p143), participants were advised that "there is no right or wrong way to complete the story, and you can be as creative as you like in completing the story! We are interested in the range of different stories that people tell". They were also told that they could choose the timescale of their story, and that they should aim to spend at least 10 minutes writing it. The SC task was administered to the participants online (university students) or in hard-copy (secondary school students). Data from the paper-and-pencil SC task were typed up into a Word document, and data from the online task was downloaded into the Word document. Spelling and minor punctuation and grammar errors (e.g. lack of capitalisation) were

corrected in this process to improve the readability of the data but the data were not altered otherwise; slang, abbreviations and other colloquialisms/text speak were retained.

The participants consisted of 203 young people aged 15-24 (mean age 18.5 years). A young sample was chosen for the study because this is a group that is known to be particularly vulnerable to weight anxiety (All Party Parliamentary Group on Body Image, 2012). The participants were either psychology undergraduates at a South West England university (N = 93, mean age 20, age range 18-24) who completed the study in exchange for a very small amount of course credit, or 6th form college students (N = 110, mean age 17, age range 15-22) who completed the study while on a 'taster' day visit to the same university. By their self-report, participants were 75% female, 88% white, 93% heterosexual, and 98% able-bodied, and fairly evenly spread class: 'middle class' (52.5%) and 'working class' (47.5%). Apart from age, with the university students a little older, the demographic profile of the two groups was similar.

The dataset consisted of 203 stories. Stories ranged from 14-1524 words long, with the average word length at 209 words. The data was analysed using thematic analysis (TA; Braun & Clarke, 2006), a theoretically flexible qualitative method, which has been the primary analytic method in qualitative SC research (Clarke et al., 2018). The TA process followed the six analysis steps proposed by Braun and Clarke (2006), including an initial period of reading the stories and making preliminary notes, followed by systematic coding across the dataset, and then collecting the codes into potential themes. The initial themes were reviewed and reworked until the authors were happy that the final analysis provided a coherent story of key patterns strongly rooted in the data and clearly evidenced.

Because TA is independent of theory, Braun and Clarke (2006) argued that researchers should specify the theoretical assumptions that inform their use of TA. Our work is theoretically critical-realist, as noted earlier, and we read the data as giving us access to participant assumptions and social understanding of fatness and counselling/the role of counsellors. Beyond this, “owning one’s perspective” (Elliott, Fischer & Rennie, 1999) is a key criterion for the quality of a piece of qualitative research. Both authors have past (author 2) or current (author 1) experiences as fat women. Together, we bring to the research a range of standpoints and perspectives – as fat and no longer fat, as therapy practitioners and clients, as feminist scholars critical of the stigmatisation of fat bodies and fat female bodies in particular, and as critical scholars sceptical of the value of the rhetoric of an ‘obesity epidemic’. These perspectives have enriched our engagement with the data by facilitating a strong desire to unpack the potential impact of current social understandings of fatness for young people in therapy with a fat counsellor.

The study was conducted in accordance with the ethical framework of the British Psychological Society (BPS, 2009, 2014); approval to conduct the study was granted by the Faculty ethics committee in the university where the research was conducted. All participants were provided with information about the study, including that participation was entirely voluntary, and all provided their consent.

RESULTS

Despite the fact the sex of the counsellor was not specified in the story stem, almost three quarters (147) specified or evoked a sex, and in 79% of these stories, the counsellor was depicted as female. Men do increasingly appear to be a minority in the psychological

therapy professions (e.g. Isacco, Hammer & Shen-Miller, 2016), yet it was still the case that in the stories, fatness tended to be associated with women's bodies. Despite the strong cue in the story stem, which ended with Kate's noticing of the counsellor's fat body, the majority of the stories did *not* provide any description of the counsellor's body, maintaining instead a narrative silence on the topic. Where there was comment, it was typically both vivid and negative, focussed on bellies that cause buttons to strain, huge thighs, flabby arms, "chunky fingers" (#30) and the existence of multiple chins (e.g. #162). (Participant quotations throughout are identified in terms of participant number (e.g. #1).) While there were a few positive counsellor descriptions across the dataset, these did not describe the counsellor's body, focussing instead on their personality (e.g. "caring" #182), "soothing" voice (#139) or "friendly" smile (#44).

The absence of *any* clear positive description of the counsellor's body in the stories is telling. It was also not only the counsellor's fat body that was sharply criticised; other aspects of their appearance, such as their glasses, shoes, make-up, ill-fitting and unfashionable clothes and poor personal hygiene, were also negatively depicted:

[The counsellor] was wearing a long black skirt, a plain green jumper and ugly heels, her hair was scraped back into a pony tail, with 1 thin piece of hair still left in front of her face. She had a bit of mascara on, with bright blue eyeliner, but other than that was not wearing any makeup. Kate may be going through a tough time, but even she made the effort with her appearance, and couldn't understand how someone could let themselves go that much. (#34)

The descriptions seemed to imply that fatness indicated a lack of personal discipline and low investment in multiple aspects of the counsellor's personal appearance, not just body weight.

In a number of stories, a fat appearance was, with the same apparent logic, linked to poor health behaviours. Generally the stories depicted the counsellor eating badly, both in terms of what they ate (junk/fast food) and how they ate (greedily and messily):

*How much does she eat? McDonalds for breakfast, KFC for lunch and BK for dinner.
(#145)*

As Kate focused on her counsellor in disbelief, she noticed what looked like the remains of a McDonalds meal spilt down her blouse. (#77)

Some stories also linked the counsellor's fatness to a lack of physical fitness ("She would be tired after walking down the road." #145) and depicted the counsellors as lazy or uninterested in exercise: "Kate got a very lazy vibe from the counsellor who remained seated in her extra support chair when Kate entered the room" (#2). Overall, the depiction in the stories of fatness as associated with a lack of nutritional and physical health accords with "the neoliberal health discourse [in which] the fat body is constructed as an unhealthy, failed body" (van Amsterdam, 2013, p.157).

In the remainder of the paper, in an effort to better understand the potential ways in which social understandings of fatness may interact with social understandings of counselling, we focus analytic attention on the ways fatness was described in relation to the counselling and the counsellor. We identified three themes: the first described the negative ways the counsellor's fatness was depicted to impact the therapeutic relationship; the second

described how fat counsellors were seen as being unable to help their clients; the third explained why fatness was understood in the stories to professionally discredit a counsellor.

Theme 1: Fat is distracting and distancing in the therapeutic relationship

Across the dataset, the depiction of fat was overwhelmingly negative. Fatness was also portrayed as distracting to clients in therapy:

The counsellor attempts to give Kate advice but she is very distracted by the size of her Counsellor. Kate is no longer paying attention. (#49)

Kate seems fixated on Esther's body and the way her stomach folds over itself several times. (#25)

In these data extracts, the counsellor's fat was impossible for Kate not to focus on, so salient that it prevented Kate from fully engaging with the counselling or with the counsellor. While fat was made salient by the task story stem, the construction of fat as a key *negative* social cue in the stories is in line with evidence of the increasing strength and pervasiveness of weight stigma (Brewis et al., 2011) and also its disproportionate impact on women (Fikkan & Rothblum, 2012).

Fat was also depicted as creating distance between Kate and the counsellor. In some stories, Kate's strong negative reaction to the counsellor's fat body caused her to actively put physical distance between her and the counsellor, sitting as far away as possible (#11) or avoiding eye contact (#16). In other stories, Kate was depicted as putting emotional distance between herself and the counsellor because of her feelings about the counsellor's weight/body:

She holds back some of her feelings and emotions she has at first. She does not say anything to the counsellor regarding her weight, but remains distant and conscious about the way she acts towards her. (#88)

Some stories stated that the counsellor's fatness makes Kate conclude that she cannot "relate" (#3, #38, #40, #88, #104) or "open up" (#4, #37, #82) to the counsellor. As one story put it, because Kate perceived the counsellor to be fat, "They may not be able to form a relationship" (#84).

Counsellor fatness was depicted in the stories as a barrier, which created distance in a therapeutic relationship, preventing clients from opening up to the counsellor and engaging in the counselling process. Weight bias has been shown to impact ratings of the attractiveness of fat individuals as both sexual partners and potential friends (Puhl & Heuer, 2009), with studies suggesting that children as young as four do not want a fat friend (Harrison, Rowlinson & Hill, 2016). What the stories in this study suggest is that this relational impact of weight bias has particular potential implications for forming a therapeutic relationship, widely regarded as a key ingredient for successful therapy (Norcross, 2011).

Theme 2: Fat counsellors cannot help

The idea that the client Kate found it difficult to 'relate' to the counsellor because she is fat was linked to a set of assumptions evident in the stories about the implications of the counsellor's fatness. The first was simply that a fat counsellor could not help Kate by virtue of their fatness. This was especially evident in the stories where Kate, as a client, was depicted as having issues with her own body, weight, or eating:

The counsellor's "fat" body shape distresses her – Kate doesn't want advice or help off somebody who presumably doesn't understand her desire to be slim. (#91)

This data extract suggests that fat counsellors were seen as unable to help, because they could not possibly understand clients' concerns about their shape, weight or eating issues. It was as if their fatness signified that they did not understand the social meaning of fat or the pressure to be thin, and would have no empathy with clients who struggle with these issues. The logic here seems to be that no fat person could *want* to be thin(ner), because if they did, they would already be thin. But anti-fat bias and stigma, and the sociocultural valuing of thinness, are not limited to thin individuals. Research on weight bias in people across the weight range has found anti-fat stigma in even the fattest participants, such that they too prefer thin to fat people (Schwartz et al., 2006). Such research suggests that fat individuals (and fat counsellors) will certainly understand the weight-related concerns of others. Yet the logic here positions the fat person/counsellor as effectively outside of culture, and also outside of full humanity.

A very few stories (10 in total) suggested that having a fat counsellor might be positive for a fat client, on the grounds that a fat counsellor would be less likely to 'judge' a fat client. This depiction of positive therapeutic impact of being a fat counsellor was, however, contrasted by the suggestion in many narratives that being fat meant being unable to help any client, irrespective of their body size. Often this 'truth' was stated plainly and in dehumanising terms:

Kate eyed the woman as if this couldn't be happening - how could someone who literally fills a sofa help anyone with their problems? (#22)

“Well this isn’t going to help me. How am I supposed to gain any help from those sessions when my counsellor looks like that.” (#157)

‘This was a mistake,’ she thought. ‘How is THAT meant to help?’ (#160)

The data conveyed an understanding of the role of counsellors as being to ‘help’ people with ‘their problems’ through ‘sessions’, as well as the idea that counselling is a ‘treatment’: “How can she treat me for counselling, when she’s fat?” (#108). In order to understand why fatness was understood to mean that a counsellor could not engage in this professional role, the next step of the analysis involved a careful examination of stories in which this type of statement appeared, to see what other understandings of fatness were present. This process resulted in the identification of four inter-linked understandings of what fatness implies about a person, which were used in the stories to explain why a fat counsellor cannot help. These understandings are explored in Theme 3.

Theme 3: Fatness as a signifier of psychological ill-health

As discussed already, fatness in some stories was linked to poor physical health. However, fatness was also understood in some stories using quasi-diagnostic language as indicating the counsellor’s poor *psychological* health, in particular their psychologically disordered eating (e.g. “binge-eating” #55) which the counsellor was *unable* to “control” (#51) or “sort out” (#61). This understanding echoes that in some obesity research, where similar links have been made between obesity and disordered eating (e.g. Marcus & Wildes, 2009). For example, Darby et al. (2009) have even called for “an integrated approach to ED [eating disorder] and obesity prevention efforts” (p. 107). Some stories also included the suggestion

that fatness indicated not only disordered eating but also underlying/broader psychological ill-health:

Thoughts flow through her head that surely someone who allows themselves to get fat must already have issues or at least a bad relationship with food, so how can she feel comfortable talking about her own issues when she feels her own counsellor may still be harbouring some? (#40)

Surely healthy minds relate to a healthy body and [the counsellor] does not look healthy. (#134).

Some obesity researchers have similarly argued for a connection between obesity and broader psychopathology (e.g. Carpenter et al., 2000; Kasen et al., 2008; Onyike et al., 2003). The ‘fat is bad’ norm means that in much obesity research, the idea that obesity is a causative factor in psychological ill-health is not questioned, yet a growing number of researchers are arguing that it is weight bias (rather than body weight per se) which has a causal relationship with both disordered eating (Vartanian & Porter, 2016) and negative psychological and physical health (Hunger et al., 2015). In the stories, however, fat was commonly understood as indicating current and unresolved disordered eating, and thus underlying behavioural and psychological problems in the counsellor. Further, as in the above extract, the consequence of the counsellor’s fatness evoking the understanding that she, too, had ‘issues’ was used to justify why the client Kate did not trust the counsellor’s professional capacity to help.

As well as being seen to signify disordered eating, fatness was in many stories seen to imply eating as a (failed) emotional control strategy, indicative of so-called “comfort eating”

(#123): “Kate asks herself if the counsellor must have issues too as she may eat her feelings - - excessively” (#143). This quotation implies that *some* degree of comfort eating is acceptable, something that is also expressed in a story in which Kate’s mother tells her off for being so judgemental about the counsellor, suggesting that the counsellor “may have been through a very traumatic experience which has caused her to comfort eat” (#67). However, implicit here was the notion that being (too) fat was a sign that a person has been comfort eating too much, which in turn implied that they were not coping with their emotions, or not managing their problems in a correct way. There is a line of obesity research which suggests biological models to explain why ‘comfort eating’ might be a common human mechanism to manage chronic stress (Adam & Epel, 2007; Dallman et al., 2003). More recently, however, a cyclical biological model has been proposed which suggests it is the stress caused by experience of weight bias that increases eating and leads to weight gain (Tomiya, 2014). The idea that negative attitudes towards fat may cause both stress and ‘comfort eating’ was, however, absent from the stories. Instead the counsellor’s fatness was understood as a failure to cope or manage their own issues, which was then presented as evidence that a fat counsellor was not professionally capable:

"How the hell is she going to be able to sort my problems out, she doesn't look like she's doing a good job with her own!" Kate thought to herself. (#47)

[Kate] doesn't believe that a fat person can guide others on their problems if they themselves cannot control their own. (#72)

Fatness was depicted in the stories as evidencing not only an ongoing inability to cope, but also as implying an unhappy history of ill-treatment by others (#199) and creating ongoing personal unhappiness. Although some obesity researchers have argued that there is a

strong association between obesity and depression (e.g. Luppino et al., 2010), those working in the weight bias tradition have suggested that weight bias likely plays a key mediating role in explaining depressive symptoms and that the perception of the self as fat (e.g. internalised weight bias) is what is key rather than being (as defined by the researchers) actually fat (Sienko, Saules & Carr, 2016). This more complex understanding of potential relationships between mood and body weight was not evident in the stories, where the association between being fat and being unhappy was often depicted as if it were self-evident – as if a fat person is ‘naturally’ not psychologically well-adjusted. Moreover, this association was rhetorically used to consequently justify claims that the fat counsellor was unable to help their client:

As the counsellor is fat he/she may be unhappy with their lives and therefore be of little or no help to her. (#181)

Kate decides to give [the counsellor] a chance but is very sceptical because fat people are unhappy so she doesn't see how she could help her if she has problems of her own. (#188)

If fatness is understood as a proxy for personal unhappiness, then it makes sense that some stories presented fatness as a reason the fat counsellor should seek counselling themselves (#177; #189). However, needing professional help in the stories was understood as further disqualifying the fat counsellor:

How can she treat me for counselling, when she's fat? Does she not need counselling for her weight? (#108)

[Kate] doesn't really want to ask someone for help who she feels needs to get some help themselves. (#3)

She felt that the counsellor needed counselling or something to help her before she could help anyone else. (#188)

Another assumption in the stories was that fatness indicated a culpable lack of personal discipline and responsibility. As discussed, this assumption was read into accounts of the counsellor's sloppy dress and personal hygiene, and poor eating and exercise behaviours. For the counsellor, however, this *personal* failing was read as having implications for *professional* credibility, rendering the counsellor untrustworthy, or a joke:

Kate does not feel that she can trust counsellor because if she cannot control her own weight, how will she be able to help her sort her life out? #45

Kate is thinking, 'How can I take life advice from someone who can't even control their own eating habits? This is a joke.' #51

Importantly, the credibility-destroying assumption that fatness equates to failure of personal discipline is itself predicated on another belief – that fatness is something individuals have complete control over. This latter belief was apparent in the few stories in which the counsellor had a “medical condition” (#67), “gastro problem” (#74), or thyroid condition, which meant that the counsellor “can't help being the size she is” (#113). The notion of a medical cause that not only explained but also legitimised the counsellor's body weight, demonstrates that there is an understanding that fatness might not *always* signify a lack of personal discipline. However, as with the discussed de-humanising understandings of fatness, it was clear that the assumption was that it typically does. This fits with neoliberal

responsibilisation and healthism (Tischner, 2013), but sits in contrast to research which suggests a range of factors not in personal control are related to body weight including the local level of social and economic deprivation (Slack et al., 2014) and a person's genetics (Locke et al., 2015). The meanings that appeared in participants' stories, then, do not appear to map well with biopsychosocial understandings around bodies and weight that are emerging from the weight bias research field.

The inter-linked assumptions outlined – that fatness indicates that a counsellor engages in disordered eating behaviours, is not coping emotionally, is unhappy, and lacks personal discipline and responsibility – together illustrate why a fat counsellor was seen in many stories as a counsellor who is not psychologically healthy. This association between fatness and psychological ill-health was then used in the stories as grounds to argue that a fat counsellor was unable to help psychologically distressed, unwell, clients. Thus the key finding of this research is that the participants' stories depicted a fat counsellor as being not psychologically healthy enough to do their job.

How [is] this counsellor is going to be able to help Kate cope with her own life when she clearly cannot maintain a healthy, stable lifestyle herself? #41

DISCUSSION

This study suggests a potential mechanism through which weight bias may lead to a perception of fat counsellors as not professionally competent: the collision of a social understanding that to be credible, counsellors should embody psychological health, with negative social understandings of fatness, in particular as indicative of psychological ill-health. We have drawn on theory and research on weight bias to outline the host of

negative beliefs about fat individuals, including the idea that fatness is an indicator of both physical and psychological ill-health. The idea of 'bodily capital' suggests that professional competence may be read from the body with negative consequences for those who are not 'embodied elites,' but instead possess bodies that are subject to discrimination (Hutson, 2016). Research suggests the impact of weight bias in the employment field is extensive (e.g. Giel et al., 2010; Nowrouzi et al, 2015) and includes the perception that fat individuals are less competent and less conscientious, as well as less healthy (Roehling, 1999).

The idea of fatness as a proxy for psychological ill-health was repeatedly used in the stories to justify claims that a fat counsellor cannot help the protagonist Kate. This idea that a psychologically unhealthy counsellor is not able to help their clients is itself based on a binary understanding about the requirement for psychotherapy professionals to be psychologically 'healthy'. Professional body codes such as those of the American Psychological Association (Connor, 2015) and the UK Health and Care Professions Council (HCPC), the regulatory body for practicing psychologists, which rules on concerns raised about psychologists' "fitness to practice" (HCPC, 2016), all require that psychotherapy professionals are 'well-enough,' psychologically, to practice. Within the counselling and psychotherapy literature, both theory and research on the 'wounded healer' suggests that many therapy practitioners may carry histories of psychological 'ill-health' – difficulties that explain their motive to practice and potentially increase their professional capacities, but which may also render them vulnerable to relapse (Barnett, 2007; Zerubavel & Hilsenroth, 2012). Research on eating disorder therapists with a history of eating disorders themselves suggests that this history similarly may explain career pathway and carry potential *advantage* as well as potential risk. That research additionally underlines that it is not

straightforward, theoretically or clinically, to understand what 'recovered' or 'psychologically healthy' means for such practitioners (Rance, Moller & Douglas, 2010, Williams & Haverkamp, 2015). The clear implication is that psychological fitness for counsellors is not a binary thing (well/not well), but likely much more complex and potentially variable. The stories, however, tended to invoke a binary understanding.

While a binary understanding of counsellor psychological health may be simplistic, and a social understanding that a fat counsellor is psychologically unhealthy may be a negative stereotype, this study suggests both the prevalence of, and potential adverse interactions between, these social understandings. The finding that fatness professionally discredits a fat counsellor extends prior research that found social understandings of body weight negatively impact evaluations of individuals in a work setting (Fikkan & Rothblum, 2005; Rudolph et al., 2009), and that for professionals in a medical or health context it impacts on their professional credibility (Brown & Thompson, 2007; Hutson, 2013; Monaghan, 2010a, b; Puhl et al, 2013). A tradition of social influence research in counselling has also examined how therapy practitioners establish themselves as "expert, attractive and trustworthy – that is a credible source of advice and help" (Hoyt, 1996, p.430). A meta-analysis that included a range of counsellor variables (but not gender) found that appearance-related cues impacted on both perception of counsellors and their capacity to influence clients to change (Hoyt, 1996). However, this research tradition has, with two exceptions (McKee & Smouse, 1983; Wiggins, 1980), not examined the impact of counsellor weight. Our study therefore makes an important contribution to the literature, through suggesting that a fat counsellor may face potential negative perceptions of their professional competence.

There are limits that contextualise how widely this analysis might be extrapolated. Our participant group was young and majority white and female. A more diverse (in terms of age and gender, as well as other diversity variables) sample might potentially have access to and/or draw on different social understandings of both fat and the role of a counsellor in their responses to the story stem. Yet the stories told resonate strongly with wider societal messages about fatness. The nature of the story completion task means that it is not possible to know how fat stigma operates in practice for fat counsellors. Future research could usefully examine this by exploring the perceptions, understandings and behaviours of both counselling clients and counselling professionals. Nonetheless, the value of qualitative story completion for a stigmatised topic like fatness was that it allowed a range of social understandings of fat to be drawn on, including 'rude' or discriminatory ones, precisely because participants were writing stories, not reporting their own views or judgements. And in this way it does provide access to the wider social-meaning contexts in which (fat, female, British) counsellors will be operating.

The key finding of this study – that fat counsellors may be read as professionally incompetent on account of their fatness – contributes to the growing literature on the negative impacts of weight bias, and suggests the importance of attending to negative stereotypes around fat in the counselling room for counsellors of all body sizes.

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