WHAT ARE THE EXPERIENCES OF OBESE, LATINA THERAPISTS; A QUALITATIVE STUDY

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTORATE OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

DEPARTMENT OF PHILOSOPHY AND PSYCHOLOGY

COLLEGE OF ARTS AND SCIENCES

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DECEMBER 2015

TEXAS WOMAN'S UNIVERSITY
DENTON, TX

November 9, 2015

To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Sonia M. Carrizales entitled "What Are the Experiences of Obese, Latina Therapists: A Qualitative Study." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Counseling Psychology.

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ACKNOWLEDGEMENTS

I would like to express the sincerest gratitude to my family, friends, mentors, faculty, and other supporters who have all helped me along the way in completing this dissertation. I would like to thank my co-chairs, Dr. Sally Stabb and Dr. Shannon Scott, for their unwavering support, encouragement, and guidance as I have progressed through this last step before completing my doctoral degree. I also want to thank my other committee members, Dr. Debra Mollen and Dr. Carmen Cruz, for their contributions and feedback in making my work stronger. To Elizabeth Aranda, thank you for helping me complete this project by offering to help in the coding process.

I also want to thank my parents for their unconditional love and support. Thank you, Mom! You have helped me more than you know! I never would have gotten through all of this without you. Dad, I miss you every day and wish you were here to see me complete this major accomplishment. You were always proud of me and wanted me to be happy. Thank you both for everything! Also, I want to thank my sister, Rocky, for her endless movie quotes and silliness. Lastly, thank you to all of my extended family, especially my aunts. I treasure you all more than you know.

Thank you to my many friends who have encouraged me and have kept my spirits up with endless laughter. I cannot possibly name you all but knowing this list would be really long shows me how fortunate I am to have such a strong support system.

ABSTRACT
SONIA CARRIZALES
WHAT ARE THE EXPERIENCES OF OBESE LATINA THERAPISTS?
A QUALITATIVE STUDY
DECEMBER 2015

The purpose of this study was to address the experiences of obese Latina therapists. Research has not been previously conducted on this population and this particular study adds to the growing need of addressing the experiences of an underrepresented population. Individuals who belong to marginalized populations will likely experience stigma, oppression, and discrimination and this researcher wanted to address three marginalized identities: ethnicity, gender, and body size. As more individuals seek mental health professionals for psychological care, it is also important to address how mental health professionals are experiencing their roles as therapists. Understanding these experiences in relation to their own intersecting identities will help to obtain information so that therapists can provide the best possible therapeutic services to their clients. This study included 11 participants who all identified as obese Latina therapists. The researcher utilized the six phases of heuristic inquiry: engagement, immersion, incubation, illumination, explication, and creative synthesis (Moustakas, 1990). Depictions were created and themes were found. A blog titled *Dances with Fat* (Chastain, 2013) was used for triangulation as a way to find similar and different themes from a different data source. Common themes that emerged were pride in identifying as Latinas, pride in identifying as women, shame with obesity, body size affecting clinical

work and self-perception, discussion of identity in therapy, and negative experiences with microaggressions. Implications and limitations are discussed.

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CHAPTER I

INTRODUCTION

"Throw it at that fat bitch!" Those are the words I heard before looking up and seeing three male students on a second floor balcony of my university's student union. One of those three men was a classmate. He tried to get his friends to stop but as I walked away, I saw something fly past my head that almost hit me. I never saw what it was. I never looked back. I never said anything to defend myself. I only felt the shame, humiliation, fear, and shock of being publically degraded for being an obese woman. I remember there were several people standing around in this public area but it was silent. No one said anything. My classmate never spoke to me or acknowledged what happened during the rest of the semester. It took me years to talk to others about what I experienced.

Having such an unfortunate and hurtful experience was a significant moment in my life when I knew that being a fat woman was not acceptable and that it was permissible for others to criticize me, harass me, and treat me in such a cruel way. Consequently, this was a defining moment in my life. When I find myself in public places or encountering people whom I do not know, I have my guard and defenses up not knowing if I will have a similarly negative experience. Even though it has been over 10 years since the event, I still have the expectation that something degrading will happen to me. I had my guard up when I entered graduate school even though I wanted to share my

experiences of living as an obese Latina. I wanted to talk about my fears and struggles of living with these integrated parts of my identity. I carried these same fears into my work with clients, assuming they would take one look at me and decide I could not help them without even giving me a chance to work with them in therapy. I was pleasantly surprised to see how my clients reacted to me. This was the reason why I chose to focus on this specific group, to see how other obese Latinas experienced their roles as therapists with their clients.

An Overview of the Problem

Obesity affects 35.7% of individuals in the United States (U.S. Department of Health and Human Services, 2012a). Latino(a)s make up 17% of the U.S. population (U.S. Census Bureau, 2013b). There are approximately 158.3 million women in the U.S., making up just over half of this country's population (U.S. Census Bureau, 2013b). Researchers have conducted multiple studies on these groups; however, they have not focused on these three identities as an intersection for therapists' consideration. While the focus of this paper has been on obesity regarding body size, it is important to note that size issues are not necessarily always related to larger weight. Both men and women can experience height discrimination as well (Puhl, Andreyeva, & Brownell, 2008). Women can experience stigma based on being tall and men can experience stigma for being short.

Researchers have acknowledged that identity has become more complicated and that the majority of individuals do not identify with one single part of their identity (Burke & Stets, 2009). Instead, individuals are more likely to address issues related to an

integration of their different identities. For individuals who face oppression in at least one of their identities, they tend to acknowledge these oppressed identities as the most salient parts of their identities. Individuals differ, however, in how they view saliency, with some focusing on the more negative experiences they have, while others may find strength in their oppressed identities. Individuals will also differ in how they react in certain environments. In any particular environment or situation, individuals may activate only specific parts of their identities depending on who they are with, where they are, and what expectations are for them in that particular setting.

A large part of this study has been about stigma and how individuals from these oppressed groups have struggled as a result of being stigmatized (Puhl & Heuer, 2009). Stigma towards women, Latino(a)s, and obese individuals has been represented in research. Obese individuals have faced stigma in a multitude of settings including work (Puhl et al., 2008), academic (Neumark-Sztainer, Story, & Harris, 1999), and medical (Merrill & Grassley, 2008). Latino(a)s have encountered stigma in work environments (Major, Kaiser, O'Brien, & McCoy, 2007) and medical settings (Rastogi, Massey-Hastings, & Wieling, 2012) as well. Women have dealt with their own struggle with stigma in medical settings (Churchman & Doherty, 2010) and in the way they are viewed if they do not take on traditional roles that tend to be expected of them because of their gender (Koeing, Zimmerman, Haddock, & Banning, 2010). These studies do not cover all of the ways in which these groups are stigmatized; however, these examples of stigma in each group are a good indication of serious issues in each group. Looking at the

intersection of stigma in women, Latinas, and obese individuals in a therapeutic setting has been addressed in this study by exploring the experiences of obese Latina therapists.

Rationale for this Study

Researchers have focused on the importance of mental health as it relates to individuals and their cultural identities (Yoon, Langrehr, & Ong, 2011). As more and more individuals seek services for their mental health issues, it is also important to address how mental health professionals experience their roles as therapists so that they can provide the best service possible to their clients. It is important to know what therapists coming from multiple stigmatized identities actually experience in therapy with their clients, and this study has helped to provide that information. The results of this study have contributed not only to our understanding of intersecting identities in general, but have specific implications for psychotherapy practice and training. Since research has not been conducted on this group, utilizing qualitative methods as the approach for this study provided deep and meaningful data upon which future researchers can build (Patton, 2002).

Brief Preview of Methodology

My qualifications and biases as a researcher are both discussed. This is common in qualitative methods because it adds to the credibility of doing this kind of research (Patton, 2002). I also discussed some of my personal experiences as they pertain to being an obese Latina therapist.

Obese Latina therapists were sought for this qualitative study by sending an announcement through the National Latina/o Psychological Association (NLPA) listserv and also through the use of snowball sampling. All participants self-reported their weight and height. I determined if they were obese by calculating their body mass index (BMI). Those who participated signed an informed consent, were interviewed for approximately 25-50 minutes depending on how much each participant had to share, and were given gift cards from major retailers depending on each participant's interest for their participation in the study.

Heuristic inquiry is the qualitative method that was utilized to conduct this study (Moustakas, 1990). Heuristic inquiry is a type of qualitative method that allows researchers to address their own biases and experiences while also taking in the experiences of others to create a bigger picture of what it is like to experience a certain phenomenon. There are significant parts of heuristic inquiry including self-dialogue, tacit knowing, and indwelling. These concepts have been explained in further detail in the method chapter of this paper, but in basic terms they involve researchers exploring their own experiences, accepting that knowing all experiences cannot always be explained verbally, and becoming fully immersed in the data that are collected, respectively.

There are six steps to heuristic inquiry which are initial engagement, immersion, incubation, illumination, explication, and creative synthesis (Moustakas, 1990). I have gone through each of these steps by identifying a research question, becoming engrossed

in the material, and taking a break from the material for a certain amount of time with the expectation of returning to it with fresh eyes and new perspective. I looked for different meanings within the data and created a way to present the themes that I found in the data.

Triangulation is another part of the qualitative process that allows researchers to strengthen their study by using data from a different source (Patton, 2002). For this study, I analyzed a blog by Ragen Chastain where she describes her experiences of living as an obese woman (Chastain, 2013).

Once all the data were collected, analysis was completed with the help of a peer who also was trained in qualitative analysis (Miles, Huberman, & Saldaña, 2014). All interviews were transcribed verbatim, code lists were developed, and transcripts were coded iteratively throughout the data analysis. Individual depictions were created so that the results could be explained and presented.

Definition of Terms

The following are definitions of terms that have been used or referred to throughout this document. There may be other definitions to some of these terms but for the purpose of this paper, the following definitions have been adopted.

Culture: Culture is "defined as the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes and organizations" (APA, 2003, p. 380). Individuals are all "cultural beings" (APA, 2003, p. 380). Culture has universal aspects as well as parts that are specific to the cultural group.

Ethnicity: Ethnicity is referred to as "the acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging" (APA, 2003, p.380). For this paper, individuals were able to identify as Hispanic, Latina, or Chicana. All of these are exemplars of ethnicity.

Identity: Identity refers to the set of meanings that describe who a person is based on their role in society, their membership to a particular group, or their special characteristics that make that person unique (Burke & Stets, 2009). Individuals may have one identity but most individuals will identify multiple parts of themselves. Individuals may have different identities based on several cultural factors that include, but are not limited to, gender, age, ethnicity, body size, and sexual orientation.

Intersectionality: Intersectionality is the combination of more than one group membership where individuals will experience both significant meaning and consequential effects imposed on them by societal and cultural expectations (Cole, 2009).

Latina: Latina refers to an individual who identifies as both a woman and of Latino(a) heritage. Latino(a)s may be of any Latin descent which includes South American, Central American, Puerto Rican, Cuban, and Dominican Republic descent (U.S. Census Bureau, 2013a).

Obese: Obese is defined by the Center for Disease Control and Prevention (CDC) as having a Body Mass Index (BMI) of 30 or higher (U.S. Department of Health and Human Services, 2012a). BMI can be calculated by taking an individual's weight in

pounds and dividing it by the squared amount of her or his height in inches. That amount is then multiplied by 703 to obtain the body mass index of the individual.

Race: Race is defined as "the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result (APA, 2003, p. 380)."

Stigma: Stigma is defined as the negative attitudes and stereotypes that can lead to prejudice and discrimination to oppressed groups in a multitude of settings that include work settings, academic settings, health settings, and personal relationships (Puhl & Heuer, 2010). Stigma imposes suffering, both overt and covert, on oppressed groups.

Therapist: A therapist is an individual who has mental health and counseling training to work with people in a therapeutic environment (Ladany, Hill, Thompson, & O'Brien, 2004). A therapist may be a counselor, psychotherapist, or psychologist. A therapist may utilize a variety of theories while working with clients and may also see clients in different formats including individual, couples, group, and family therapy.

Therapeutic alliance: Therapeutic alliance is defined as the collaborative relationship developed between a therapist and client as a result of working together in therapy (Martin, Garske, & Davis, 2000). This bond between the therapist and client is built based on their respect for each other and how well they are able to agree on treatment and goals for therapy.

CHAPTER II

LITERATURE REVIEW

Perception of My Own Efficacy

I am an obese Latina therapist. When people see me, there is no doubt that they can see my gender, ethnicity, and body size. As a therapist, the part of my identity I have been the most concerned about is my obese body size. There is no way to hide it, there is no way to trick someone else into thinking that I am any other body size other than obese, and there is no way to keep my own experiences as an obese woman outside of the room when I am in a therapy session with a client. Through my negative experiences in other parts of my life aside from being a therapist, I assume that individuals walking into my office during a session will have negative judgments and biases towards me before a single word is said. In the early part of my development as a therapist, I was terrified to see clients because I assumed none of them would be comfortable with me. Over time, these feelings have decreased greatly and for myself, I believe this is due to one of two reasons, or possibly a combination of them both. First, I feel more competent in my ability to work with clients compared to how I felt during my first semester of training. I have learned a tremendous amount through coursework, practicum/internship, supervision, and reading. I believe that I have something valuable to offer my clients through therapy and I have had great success in being able to guide my clients through their struggles. Second, I have learned not to internalize my clients' potential views on

obesity. I have grown more comfortable with who I am and have learned through training and my own personal journey that I am more than an obese Latina.

Regarding my gender and ethnicity, these parts of my identity have become more salient in my role as a therapist as I have more male clients and am also having more conversations with my clients about ethnicity. I am currently in a personal process of exploring these other parts of my identity; however, over the last 10-15 years, my body size has been the most salient.

My Purpose in Conducting This Study

My initial fears for working with clients involved their perceptions of me and how those perceptions would negatively impact therapy. I assumed that I would not be able to work with clients who dealt with any kind of eating dysfunction or body image issue because they would look at me and assume that I had those same problems. I learned quickly that many of my clients reacted positively towards me and in some cases, my extra weight was perceived as helpful to clients because they felt I could relate to their struggles. I also know that my experiences are simply my own and my purpose for doing this study was to find out what the experiences are for other obese Latina therapists.

Research Questions

The following were the main questions that were addressed through the progression of this study:

1. What are the experiences of obese Latina therapists?

2. How have their therapeutic relationships with their clients been impacted by their own body size?

Definitions and Statistics

Body Size: Obese

Obesity rates are at high levels. The CDC reported the obesity rate in the U.S. to be 35.7% during 2009-2010 (U.S. Department of Health and Human Services, 2012b). This does not include those who are considered to be overweight, which would increase that percentage to 69.2 for both obesity and overweight combined (U.S. Department of Health and Human Services, 2012c). Currently, obesity is defined as those who have a (BMI) of 30 or over (U.S. Department of Health and Human Services, 2012a). Overweight individuals have a BMI between 25.0 and 29.9. Not only do individuals face unfortunate physical health consequences when dealing with obesity, but they also can experience unnecessary psychological consequences (Puhl & Heuer, 2009). Researchers have focused on individuals who face weight stigma and discrimination in school settings (Wardle, Waller, & Jarvis, 2002), work environments (Puhl & Brownell, 2006), romantic relationships (Boyes & Latner, 2009), and medical settings (Merrill & Grassley, 2008). Currently, there is very little research investigating experiences related to obesity in therapy and mental health settings. Furthermore, no previous research was found on the experiences of obese Latina therapists in therapeutic settings.

Ethnicity: Latino/a

There are different terms used to describe ethnic populations. For the purpose of this paper, the term Latino/a was used to include individuals of a Latin ethnic background. Some may use the term Hispanic while others may acknowledge the diversity within the Latino(a) community by identifying individuals according to region, country, or skin color (Quiros & Dawson, 2013). For example, there is a large amount of Latino/a empirical research on the Mexican American population. Even within this group, there is diversity and it is important to clarify that all individuals within this group will not necessarily have the same types of experiences.

Currently there are 53 million Latino(a)s in the United States making up 17% of the population in the United States. As of 2011, 65% of Latino(a)s in the United States had a Mexican background (U.S. Census Bureau, 2013a). However, the Latino(a) population also includes individuals from Puerto Rican, Cuban, Dominican Republic, South American, and Central American backgrounds. By 2050, the Latino(a) population is expected to rise to a point when one out of every three Americans will be identified as Latino(a) (Lopez, 2013). Researchers have mainly focused on many issues in the Latino(a) community related to immigration (Raffaelli, Tran, Wiley, Galarza-Heras, & Lazarevic, 2012), education (Ceballo, Maurizi, Suarez, & Aretakis, 2013), illness (Hwang & Myers, 2013), parenthood (Lakes, Vargas, Riggs, Schmidt, & Baird, 2011), criminal activity (Harris-McCoy, & Cui, 2013), and intimate partner violence (Mankowski, Galvez, Perrin, Hanson, & Glass, 2013). In addition, there is also research

on the Latino(a) community regarding body image (Menon & Hartner, 2012), body dissatisfaction (Ferguson, Muñoz, Contreras, & Velasquez, 2011), and obesity levels (Franko, Jenkins, & Rodgers, 2012). However, again there is a dearth in the empirical research on Latina therapist experiences in a mental health setting.

Gender: Women

The definition of gender has become somewhat fluid as individuals are becoming more comfortable with their gender expression (Petchesky, 2009). APA defines gender as "the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex" (APA, 2012a, p. 11). The focus of this paper regarding gender has been on women. In 2011, there were 158.3 million women in the U.S. compared to 153.3 million men (U.S. Census Bureau, 2013b). Women have been the focus of many researchers on a multitude of topics. For example, recent investigations of women's issues have included motherhood (Barkin & Wisner, 2013), employment (Featherstone, 2013), objectification (Allen, Gervais, & Smith, 2013), reproductive rights (Lindsey, Sigillo, & Miller, 2013), relationships (Scholz et al., 2013), education (Taylor, 2013), trauma (Lutwak & Dill, 2013), mental health (Liu, Setse, Grogan, Powe, & Nicholson, 2013), physical health (Mulherin, Miller, Barlow, Diedrichs, & Thompson, 2013), sexuality (Jozkowski & Peterson, 2013), and many other areas of research.

Population of Interest: Obese Latinas

There is a small amount of research on this population when all three of these identities are considered. These will be discussed in more detail later in the paper.

However, obese Latinas are still not well represented in the literature, especially when all of the statistics indicate that they comprise a large part of the population in the U.S. Since no research was found on the experiences of obese Latina therapists, the purpose of this paper was to outline some of the foundational research regarding identity, stigma, influential factors, client expectations, and client/therapist matching regarding this underrepresented group.

Identity

Identity is a set of meanings that determine when individuals belong to a certain societal group, when they play a particular role in society, or when individuals claim specific traits to define themselves as unique or special (Burke & Stets, 2009). Individuals may define themselves in different ways based on gender, race, age, sexual orientation, employment status, hobbies, political views, religion, familial status, able-bodiedness, and many other factors. Individuals may also be defined by the kind of people they are and the morals that they have. For example, an individual can be kind, thoughtful, or fair towards other individuals. Individuals have multiple identities and share many characteristics with other individuals in society.

Mascalo (2004) stated that individuals cannot separate themselves from their culture and therefore, people react based on the behaviors of others. For the vast majority of people in Western civilization, there is a progression of exposure to different worlds or different groups (Miller, 2011). Children first learn about their identities through their families and then through the education system as they get older. As adults, people

continue to develop their identities through their employment and the families they form if they choose to do so. Families may include biological families, friends, and/or families of choice. While this progression is occurring, individuals are constantly influenced by their surrounding culture which is also impacted by communities (Jost & Li, 2013), the media (Burgess & Burpo, 2012), tourism (Miller, 2011), the internet (Schnurr, Mahatmya, & Basche, III, 2013), large corporations (Miller, 2011), and the larger social context (Parigi, State, Dakhlallah, Corten, & Cook, 2013). Identity theories are helpful in that they are used to explain how individuals identify, how people behave based on their identities, how they think and feel, and how they fit into other parts of society. It is also important to acknowledge how the larger social context impacts individuals and identity development (Miller, 2011).

Since individuals have more than one identity, a single identity is not normally isolated on its own (Burke & Stets, 2009). Identities tend to interact with one another depending on the environment and the situation. For example, an individual who identifies as an obese, married, Latina mother with a professional job will tend to act differently at work than at home. This does not mean that her identity changes but her environment changes and therefore, certain identities will be more salient than others depending on where she is. This is the case for many who have more than one role in their lives and who interact in different environments. It is also possible for one identity to be continuously salient regardless of the situation (Reynolds & Pope, 1991). In this same example, being Latina may be salient for this particular individual at all times.

It has been suggested that the more unrelated identities individuals have, the more those individuals will be able to create a protective buffer against situational stressors (Burke & Stets, 2009). When these identities are not overlapping with other identities, the stressors felt by one identity do not cross over to the other identities. If more than one identity is activated at the same time, it can be expected that the more prominent identity will have more impact on how individuals behave versus an identity of lesser prominence. Identities can also take on different levels of commitment, which means that others depend on a particular identity more than other parts of their identity. Using the previous example, when the same individual is at home, her identity as a mother may become salient due to her children depending on her to take care of their needs. Her role as a professional most likely will not be as important. So both prominence and commitment will influence the saliency of an identity and will therefore impact how individuals behave.

Identity Theories

Several identity models have been explored for this paper including the Identity Status Model, Multicultural Identity Development, and the Multidimensional Identity Model. For the purpose of this paper, the focus has been on the progression of identity theory development and how individuals manage multiple identities instead of looking at each identity separately.

Identity status model. Marcia (1966) built on previous theories by Erik Erikson which resulted in the development of the identity status model. Marcia stated that identity could be categorized into four variations, derived from a 2x2 model, where the axes were exploration (high to low) and commitment (high to low). Exploration involves looking at different identities to get an idea of which one may fit better compared to others. Commitment involves being assigned a particular identity and staying with it. Identity diffusion is one of the four categories and it occurs when there is less exploration and less commitment by individuals. An example would be a young individual trying to figure out which political party to belong to and after not knowing anything about the different parties, the individual does not commit to any specific one. Identity foreclosure is the second of the categories and it occurs when individuals have less exploration and a high level of commitment. In this situation, individuals may have chosen an identity too quickly, due to the fact that additional identities were not thoroughly explored. Relating to the previous example about political parties, an individual would commit to being a Democrat, for example, without fully knowing what the party represents. Identity moratorium is the third category and this occurs when individuals have a large amount of exploration and are not committed to any particular role or identity. For example, an individual would explore all the political parties but not make a decision to belong to a particular party. Identity achievement is the last of the four categories and it occurs when both exploration and commitment are at high levels. Using the same example, an individual would learn about the Democratic party and would commit to

being a Democrat. According to Marcia (1966), individuals who are in the identity achievement category tend to have more fulfilled, satisfying, and healthier lives compared to those who are in the other categories.

Multicultural identity development. Taking identity development one step further is important because individuals have more than one identity across different cultural factors (Miller, 2011). The cultural context of individuals will shape their identities. When individuals have a strong sense of who they are, they are less likely to suffer from identity crises. However, individuals can still experience an imbalance in their identities as they continue to age and are exposed to different cultural contexts. Within the Western culture, and particularly in the U.S., individuals are more accepted when they fit in the privileged status of being White, male, wealthy, Christian, heterosexual, young, and unimpaired in their mental, physical, and emotional health (Reynolds & Pope, 1991). However, most individuals do not fit into this mold and therefore will experience different levels of oppression and privilege based on the different aspects of their multicultural identity (Miller, 2011).

Multidimensional identity model. The Multidimensional Identity Model (MIM) has four categories to demonstrate different levels of identity development when individuals are dealing with more than one oppressed identity (Reynolds & Pope, 1991). The first two categories include areas in which individuals will identify with only one aspect of themselves. This can be identifying in a more passive way when identity is based on societal roles and expectations or it can be more active where individuals make

a more conscious effort to identify with one aspect. The difficulty with either of these two categories is that individuals may be suppressing other aspects of their identities in order to feel more accepted by the group to which they wish to belong. The third category involves individuals who accept their different identities but keep them separated based on their environments. For example, a Latina, feminist therapist may identify more with her traditional Latin culture at home with her family while embracing other ethnicities and diverse cultural backgrounds when at work. The issue with this level is that individuals may have a difficult time keeping their identities separate. The last category involves individuals who intersect their multiple identities which may in turn lead to the development of a new group. Using the previous example of the Latina, feminist therapist, in this category she would either find or create a new group where all of her identities would be accepted. This way she would not have to keep any part of herself separate. People tend to identify with particular groups who help them feel a certain level of pride and self-esteem (Tajfel & Turner, 1979). If individuals do not reach this level, then there may be a question as to whether individuals are satisfied with their identities (Reynolds & Pope, 1991). It is important to acknowledge that while the last category may seem ideal, there can be both positive and negative aspects to any of these four categories in identity development and resolution (Reynolds & Pope, 1991). Researchers have shown that ethnicity (Alcoff, 2005), gender (Hillock, 2012) and body size (Puhl & Heuer, 2009) may all be areas of potential oppression; however, individuals may not always see these diversity factors as automatically oppressive due to their own

individual experiences and beliefs. This will be important to keep in mind as the identities of the obese Latina therapists are assessed. They may not necessarily see certain parts of their identities in a negative way, as researchers suggest (Dawson & Quiros, 2014).

Additional Identity Models. Major contributions have been made in the development of ethnic identity models, feminist identity development, and identity development of sexual minority persons. Models were previously developed for Black racial identity (Cross, 1995), ethnic minority identity (Sue, 1994), and feminist identity (Downing & Roush, 1985). Likewise, the processes by which gay, lesbian and bisexual persons negotiate identity have been developed (Levy, 2009). These models are similar in that they all have a common theme in which individuals go through certain phases. They accept the dominant culture while rejecting certain parts of their identities that are oppressed. They then discover and deeply engage with their minority identity, often with a consequent rejection of dominant culture. Lastly, they find a way to embrace both so that a harmonious relationship is established between the two or more identities. This relationship may also be possible if there was a body size identity model but no such model was found during the research for this project.

The Intersection of Identities

Researchers have studied different aspects of identity including race, ethnicity, gender, sexuality, spiritual beliefs, political viewpoints, and socioeconomic status (Cole, 2009). It is important to consider the intersection of different identities and how this

intersection impacts individuals. It is even more important to consider the intersection of oppressed identities such as those included in this paper: obese, Latina. Cole (2009) discussed three essential questions when regarding identity intersection. First, it is necessary to consider who is included in a particular category or identity, and in particular, who is included in an oppressed category. Second, it is important to take into consideration not just that certain categories are different but also that certain categories have been historically and politically stigmatized. Third, addressing similarities across groups is just as significant as addressing their differences. Looking at similarities allows for individuals to see the representation of others through a cultural lens instead of simply placing characteristics on individuals based on the groups in which they belong.

Conclusion for Identity Models

Individuals are most likely to focus on the parts of their identities that are not only oppressed but also the most salient (Reynolds & Pope, 1991). For many individuals, the most salient part(s) of their identities are the one(s) in which they face oppression (Sue, 2001). It is important to acknowledge that these individuals may not see these parts of their identities as negative but they are very likely aware of the societal oppression they face due to their identities (Carpenter, Zarate, & Garza, 2007). While there is no guarantee that individuals of larger body size will address their body size as their most salient part of their identity, researchers have shown that weight discrimination may be the last acceptable form of oppression (Puhl & Heuer, 2009). There is still oppression regarding race and gender; however, when these examples of oppression take place,

individuals are more likely to speak up to defend the oppressed groups (McHugh & Kasardo, 2012).

Research Overview

Overview of Research on Obesity

Researchers of obesity tended to focus on health-related issues. The coverage on higher risks of diabetes, heart disease, and cancer is abundant in the obesity research (O'Brien, Hunter, & Banks, 2007). Researchers have also found difficulties with mental illness in relation to obesity. Obese individuals have been found to suffer from depression, anxiety, low self-esteem, and social isolation (Puhl & Brownell, 2006; Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). Stigmatization (Puhl & Heuer, 2009) and discrimination (Sutin & Terracciano, 2013) play a key part in the research currently being conducted. There is also a plethora of research on obesity prevention; however, most of this research is on children (Chin & Ludwig, 2013; Masse et al., 2013). The research on weight stigma has increased over the last decade (Johnson, 2005) and this has been addressed in more detail later as it is a significant part of this paper.

Overview of Research on Latino(a)s

Current research on Latino(a)s tends to have a focus on immigration (Akresh, 2008; Sussner et al., 2008), parenthood (Baker et al., 2009; Raffaelli, et al., 2012), and low socioeconomic status (Tang et al., 2012). Roughly 10% of the U.S. population is made up of immigrants and about half of the immigrants are of Latin descent (Raffaeli, et al., 2012). Many Latino(a) immigrants take great risk to come to the U.S. and are found

to be quite resilient when faced with the struggles of adapting to a new environment. These trends in research may be contributing to the common stereotypes of Latino(a)s due to the fact that many individuals tend to view Latino(a)s as immigrants of low socioeconomic status (Winders, 2011).

Researchers have studied parenthood in the Latino(a) community related to childhood obesity (Baker et al., 2009). Immigrant Latina mothers who worked and had lower incomes were more likely to have children with a higher BMI compared to mothers who worked and had a higher income. In addition, immigrant Latina mothers who worked, regardless of their income, also were more likely to have children with a lower BMI compared to Latina mothers who did not work. It was suggested that this finding was linked to the immigrant mothers being exposed to the thin ideal of U.S. bodies while they were at work and that this spilled over into their homes after work.

Researchers have also discussed a relationship between socioeconomic status and weight (Yeh, Viladrich, Bruning, & Roye, 2009). While some Latino(a)s may have a genetic predisposition to gaining weight, there are also social factors that can have an impact on body size. Access to adequate health care, time to spend on physical activity, and access to healthier food options can be problematic for individuals wanting to engage in weight loss behaviors when there are SES barriers making these opportunities less available.

While this research is important, it is also essential to consider that these experiences are not universal for all Latino(a)s. More research is needed on Latino(a)s in

higher level and more powerful jobs, including the health field. A small amount of research was found on Latino(a) therapists with some emphasis being placed on Spanish-speaking therapists (Santa Ana et al., 2009). However, there was no discussion of weight or body-related issues in this research. Other research was found that was based on the importance of being ethnically matched with clients (Erdur, Rude, & Baron, 2003). This topic will be discussed in more depth later in this paper. However, the trends in the research are important to consider here as they are also part of the cultural context that contributes to how individuals perceive Latino(a)s.

Overview of Research on Women

The research on women has grown tremendously in many areas including health (Mulherin et al., 2013), trauma (Lutwak & Dill, 2013), employment (Featherstone, 2013), and other women's issues (Scholz et al., 2013; Straiton, Hjelmeland, Grimholt, & Dieserud, 2013). Without getting into great detail, some of the most meaningful research on women in relation to this paper has been on stereotypes (Burkley, Andrade, Stermer, & Bell, 2013), stigma (Thompson, Nitzarim, Her, & Dahling, 2013), objectification (Davidson, Gervais, Canivez, & Cole, 2013), and societal expectations (Thwaites, 2012). Many women are taught to be submissive, compassionate, empathic, and care-giving. While some of these traits are admirable, they can also be problematic such that women are often taught to put others' needs before their own. Women face societal pressures to accomplish motherhood, a successful career, the ideal body, and a successful relationship. There is pressure to get married, have children, be physically fit, have a

healthy sex life, earn an education, and have a full-time career. Researchers have shown that this idea of being a Superwoman has put tremendous strain on women and in turn, women have reported low levels of happiness and life satisfaction overall (Zhou, 2013). Additional research has been conducted in the field of psychology showing that the number of female psychologists has grown. There is a larger number of women compared to men in the applied professions such as counseling, clinical, and school psychology (Pion et al., 1996). Men tend to dominate more in other areas such as experimental, cognitive, and social psychology. Developmental psychology has closer to even amounts of both men and women, but women still just barely dominate this field. There may be more men in powerful positions as stated by King and Cubic (2005); however, the number of female psychologists is on the rise (Norcross, Karpiak, & Santoro, 2005). Addressing the pressures women face is significant in that it can impact the expectations clients have of their female therapists. This, in turn, can affect the experiences of female therapists and more specifically, obese Latina therapists.

Overview of Research of Obese Latinas

Currently, researchers are focusing on more health-related issues when studying obese Latinas. Obese Latinas deal with major health problems, such as liver disease (Flores, Lang, Salmeron, & Bastani, 2012). Additional researchers have conducted studies on the physical activities of obese Latina girls and their hormone levels (Gyllenhammer et al., 2013). There is also a great deal of research on the physical activity levels of young Latina girls and physical activity (Torres, Meetze, & Smithwick-

Leone, 2013). Leaders in the community (Leviton & Lavizzo-Mourey, 2013), schools (Cook & Hayden, 2012) and church (He et al., 2013) are making efforts to combat childhood obesity in the Latino(a) population.

Some researchers have focused on the psychological effects of young Latina adolescents who are overweight and obese (Lanza, Echols, & Graham, 2013). These young Latinas were found to report higher levels of peer victimization, depression, anxiety, and lower self-esteem as they gained weight. The more weight they gained, the more they reported these psychological and psychosocial consequences.

Another study was conducted on development of weight gain in Latino(a) families (Sussner et al., 2008). In this qualitative study looking at the impact of immigration and acculturation on becoming overweight, Latina mothers reported that their families experienced an unhealthy change in their dietary habits and the development of a more sedentary lifestyle. They also reported a change in their cultural beliefs surrounding food, the way they feed their children, and decreases in their social support systems. Latina mothers reported having easy access to fresh fruit and vegetables in their native countries and then not having that access when they moved to the U.S. They also reported a decline in their breastfeeding habits due to the negative nature of how mothers are treated in the U.S. when they breastfeed. The mothers believed that these changes in lifestyle led to weight gain in their families to the point where their family members were considered overweight. They did not specify the amount of weight or the gender of the family members in the study; however, the participants in the study

were all Latina mothers and each participant had at least one child who was 2 years old or younger in their homes. While these studies are relevant to the individual populations being addressed in this study, more research is needed on the experiences of the integration of these identities. In particular, research is needed on obese, Latinas in professional mental health settings.

Overview Conclusions

Researchers have provided significant studies on women, Latino(a)s, and obese individuals. Combining the identities of gender, ethnicity, and body size to study one population has contributed to an area of research that is strongly needed. The focus of this paper has been on these three identities with more focus being placed on what is considered to be the most oppressive of these three identities: obesity (Puhl & Heuer, 2009).

General Attitudes Towards Obese Individuals

Weight Stigma

Weight stigma is the negative experience that individuals of size face due to the constant stereotypes and discrimination that tend to be associated with being overweight and obese (Brownell, 2005). Some of the more common stereotypes associated with being overweight and obese are being considered ugly, stupid, lazy, and not having a lot of friends (Crandall, 1994). Individuals can also suffer from psychological problems such as depression and anxiety due to experiencing weight stigma (Brownell, 2005). Research has continued to grow in this field, but the overwhelming epidemic of obesity

indicates that there are many areas of growth to help in this fight so that overweight and obese individuals can live happier and healthier lives. Current trends have focused more on the physical aspects of weight but the psychological components are just as important. It has also been said that since the negative attitudes towards individuals of size are so acceptable, weight stigma may be the last tolerable and acceptable kind of discrimination (Puhl & Brownell, 2001).

Work Settings

Previous researchers have focused on weight stigma in multiple settings (Puhl & Heuer, 2009). One of those areas has been in the work environment, where individuals have faced isolation, less pay, fewer opportunities for advancement, and even the inability to find employment. When individuals of size are in a work environment, some have reported being victims of tasteless jokes related to their size as well as inappropriate and hurtful comments made in private and in front of other coworkers (Puhl & Brownell, 2006). This type of behavior can lead to isolation in the work setting which can have an impact on an individual's psychological well-being. When an individual faces negative and cruel comments as well as feelings of being alone, then that can potentially lead to depression and other harmful disorders (Stunkard, Faith, & Allison, 2003).

Researchers have also shown the difficulty some individuals of size can have in gaining and maintaining their employment (Puhl et al., 2008). If individuals have a difficult time with employment, this could potentially lead to added financial stressors. Without the proper finances, one will have less access to both medical and psychological

care, further contributing to what can appear to be a never-ending cycle of lower life satisfaction levels (Cawley, 2004). Cawley (2004) also discussed the lower wages that individuals of size can receive by a differences of 9% when compared to average-sized individuals.

Medical Settings

Individuals who are overweight or obese are also likely to have medical problems such as cardiovascular disease, higher cancer rates, gastrointestinal problems, and diabetes (O'Brien, Hunter, & Banks, 2007). When dealing with these medical issues, people need to find reliable medical professionals they can trust. Merrill and Grassley (2008) conducted a qualitative study on the experiences of overweight women in medical settings. Some of the women discussed the poor treatment they received from their doctors and nurses which included being embarrassed for not being able to fit into the medical equipment and clothing. Items such as blood pressure cuffs and hospital gowns were found to be too small and the medical professionals made comments that shamed participants. Individuals who have such negative experiences are unlikely to return for treatment and may not even seek treatment if new medical difficulties arise, which is a very serious consequence of weight stigma. Thus, many overweight individuals do not have the proper medical settings where they feel comfortable, so they may avoid treatment completely (Fabricatore, Wadden, & Foster, 2005). If society can start to look at the negative cycle this kind of behavior perpetuates, then it is very possible that this

unfortunate epidemic can begin to decrease, and overweight and obese individuals can begin to live more satisfying lives with fewer medical issues.

Physicians reported having difficulty providing care to obese patients due to lack of time, insufficient preparation and training in weight loss counseling, and failure to address the comorbidity that often comes with obesity (Forman-Hoffman, Little, & Wahls, 2006). Many have focused on the weight loss aspect of treating obesity but failed to recognize the importance of the underlying issues that can include depression, trauma, anxiety, and loss (Puhl & Heuer, 2009). Physicians have reported that their medical school and residency training programs did not provide the necessary training for treating obese patients (Forman-Hoffman et al., 2006). While some physicians feel obesity is a disease and were found to use more positive methods of treatment with their patients, other physicians viewed obesity as something that can be controlled.

It is also important to address the issue that individuals may have a difficult time seeking health advice from individuals who are perceived not to take good physical care of themselves (Hash, Munna, Vogel, & Bason, 2003). When individuals are overweight, they tend to be stigmatized as being unhealthy (Puhl & Heuer, 2009). Accordingly, there may be reluctance for people to seek the advice that could potentially help them. This seems like another way in which people may be denying themselves access to proper care due to their own perceptions of others. It is concerning that these stereotypes of overweight and obese individuals, combined with the gender role expectations and stereotypes of men and women, make it difficult for overweight and obese women to

have a fair chance of obtaining proper care in medical settings. There may be similar experiences in the mental health settings when clients have perceptions about their obese therapists.

Interpersonal and Romantic Relationships

Weight stigma has also been found in interpersonal and romantic relationships (Puhl & Heuer, 2009). Individuals can experience stigma from the people in their lives who are supposed to be supportive such as family members, partners, and friends. Unfortunately, this phenomenon occurs frequently for obese women. The thin ideal is common in Western society and this mostly applies to women (Ferguson, 2013) so it is not surprising that women would experience more weight stigma compared to men. Women tend to experience stigma more when they are trying to date (Puhl & Heuer, 2009). Smith, Scmoll, Konik, and Oberlander (2007) found that women who were overweight or obese were perceived to be less likely to be attractive or less likely to date because of their body size. This issue indicated that heterosexual men may be less likely to respond to dating advertisements in which a woman describes herself as overweight or shows a picture of herself as overweight or obese. Other researchers have found that obese women are less likely to date compared to women who are thin or are of average size (Sheets & Ajmere, 2005). Another concern is with obese women who are already in relationships. These women tend to report less satisfaction and overall quality in their relationships compared to women who are thinner (Boyes & Latner, 2009).

Obese and overweight individuals can also experience weight stigmatization from their families, especially when the individual is the only overweight or obese individual in the family (Sobal, 2005). This again tends to be true for women and sometimes this stigma may lead to eating dysfunction, therefore contributing to this unhealthy lifestyle and more stigma. When individuals do not get the support they need from family members, it can be problematic in that the individual may become even more isolated from their family members.

Individuals can also experience stigma from their close friends (Sobal, 2005). Previous researchers have found that weight stigma can begin at a very young age (Puhl & Latner, 2007). Overweight and obese individuals are perceived in negative ways and they are seen as having few friends and are not as popular compared to thin and average-sized peers. Since these views can begin at an early age, it can be very destructive for individuals as they get older and try to develop healthy friendships. There are some reports that obese adults do have fewer friends and tend to spend less time with their friends (Sobal, 2005). While women tend to have closer and more intimate friendships compared to men, it has been found that obese women tend to have fewer close friends. There is also some research that indicates individuals tend to associate more with other individuals who are similar to them in age, body size, and level of attractiveness (Beer & Watson, 2008).

Academic Settings

Some researchers have begun to focus on weight stigma in academic settings (Puhl & Heuer, 2009). Even though most other researchers studying weight stigma have focused on work environments and medical settings, it is important to acknowledge the range of areas in which stigma has been an unfortunate occurrence. Wardle et al., (2002) indicated that individuals dealing with obesity are often associated with less education compared to average-sized individuals. This is concerning because some researchers have shown it is important to be educated on how to eat healthfully and how to determine whether or not someone is participating in a healthy amount of physical activity (Chambliss & Blair, 2005). However, individuals can have common misperceptions about what contributes to obesity and will often leave out systemic factors such as inadequate access to proper nutrition and physical activity (Yeh et al., 2009). Obese individuals also experience marginalization due to large body size due to skewed belief systems that higher weight can always be controlled by the larger body-sized individual (Crandall, 1994). In addition, obese students were perceived in a more negative way, being perceived as less orderly, having more emotional difficulties, being less likely to succeed in their schoolwork, and having more problems at home with their families (Neumark-Sztainer et al., 1999). When these perceptions and biases are present among educators, it could negatively impact the development of students and their achievements.

Therapeutic Settings

Since psychological well-being and obtaining proper mental health care can still be taboo topics for so many individuals (Kim & Stout, 2010), it is not surprising that overweight and obese individuals may stay away from seeking treatment in therapeutic settings where they feel they are treated poorly. This is not to say that all therapists are going to be biased towards individuals of size but researchers have shown that individuals have biases across a multitude of multicultural issues (Henretty, Currier, Berman, & Levitt, 2014). It is important to understand what overweight and obese individuals experience across different settings in order to get a firmer grasp on the problem. This would make it easier and more effective for researchers and program planners to come up with prevention and intervention treatments not only to help individuals of size, but also to help professionals become aware of their biases and to learn how to keep them from impacting their work with clients.

Sizeism

Sizeism can be described as prejudice or discrimination towards individuals based on the size of their bodies (O'Brien, Latner, Ebneter, & Hunter, 2013). Individuals may have biases and may experience the stigmatization of others based on misperceptions or stereotypes (Sechrist & Stangor, 2005). Sizeism goes one step further in that discriminating behaviors take place in a way that is very harmful towards the oppressed group of obese individuals (Oliver, 2006). Sometimes the discrimination can be towards individuals who are just overweight and do not fit in the obese category that was

previously described (U.S. Department of Health and Human Services, 2012c). It is also possible for individuals not even to be aware of the discrimination in which they are participating (O'Brien et al., 2013). There is significant research to demonstrate that discrimination occurs (Oliver, 2006; Solovay, 2005); however, little research has been implemented to understand the reasons why individuals are discriminatory towards obese individuals. Some have suggested that the reasons involve the belief that obesity can be controlled and therefore, individuals who are obese lack the control of their eating habits (Puhl & Heuer, 2009). Other researchers have focused on individuals who look at obese individuals as disgusting and in turn are repulsed when they see people dealing with obesity (O'Brien, Hunter, Halberstadt, & Anderson, 2007).

Researchers in feminist and evolutionary psychology have often been at odds; however, there are some researchers working on integrating these two disciplines regarding views on body size (Smith & Konik, 2011). Feminist psychologists have discussed the ways in which society and the media have put pressure on women to have a thin body size, as has already been discussed in this paper (Pankratow, Berry, & McHugh, 2013). From an evolutionary psychology perspective, researchers have suggested beauty is a dependable measure for indicating whether or not a woman is healthy and fertile (Singh & Singh, 2011). Researchers have shown that the risk for different diseases, such as cardiovascular disease; adult-onset diabetes; gallbladder disease; and ovarian, breast, and endometrial cancers depends more on the ratio of waist-to-hip body fat than overall body fat. Women have gone to drastic measures to attain a

supermodel-type figure (Newsom, 2013); however, they may be putting themselves at extreme risk for developing diseases due to the decrease in their body fat around their hips, waist, and buttocks (Singh & Singh, 2011). This view contradicts the belief that women have to be thin in order to be healthy and is significant in developing healthier attitudes towards individuals with larger bodies.

Everyone has biases and there is no expectation that all persons will be able to fully eliminate the biases they have (Henretty et al., 2014). However, problems occur when individuals have such strong biases and beliefs that they act on these in a discriminatory way, causing physical or psychological harm (Solovay, 2005). In the medical field, researchers have found that health care professional have demonstrated biases towards patients with a large body size (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). The individuals in the Schwartz et al. (2003) study were health professionals who treated obese individuals. They were found to display an implicit weigh bias towards obese individuals and viewed these individuals with some of the stereotypical characteristics such as being "lazy, stupid and worthless" (p. 1033). Schwartz et al. (2003) also found that being overweight, knowing individuals who were obese, and understanding what it felt like to deal with obesity issues were all predictors of lower implicit weight bias among the health care professionals. It is important to address these biases within the health field since the participants in this study were all attending an obesity conference and they were in different professions in the health care field including physicians, researchers, pharmacologists, and psychologists.

Merrill and Grassley (2008) completed a particularly relevant study on overweight women's experiences in medical settings. They interviewed eight participants in person utilizing a phenomenological approach. The researchers started the interviews by saying to each of the women, "Tell me a story, one you will never forget about going to your health care provider and your experience of being overweight" (p. 140). This seemed like a creative way to get the individual speaking about a particular experience and also left it open so that individuals did not feel they had to answer in a particular way. Merrill and Grassley (2008) looked for themes in the transcripts by reading them repeatedly again. They started by looking at the stories as a whole piece, then started to break down the stories and finally chose to look at the stories in more detail by looking at individual sentences or sentence structures. Four themes were found: "struggling to fit in, feeling not quite human, being dismissed, and refusing to give up" (p. 141). Along with not fitting in hospital gowns and blood pressure cuffs, participants also reported offensive and hurtful comments from medical professionals. One reported being compared to a whale and she expressed how hurtful that comment was as she was giving birth to her son. Other responses from the participants included not wanting to give up on living a healthier life and feeling that being overweight was taking control of their lives. One woman expressed being consumed by her weight and felt that it was present with her every day, almost as if she could not escape it. The last responses discussed by the researchers involved the participants expressing how they felt medical professionals did not listen to them. It seemed as though the focus was always on the

weight and not other medical conditions. It was suggested that health professionals may have this bias towards overweight patients with the belief that if these individuals would simply lose weight, then their medical issues would be solved, regardless of whether or not those issues had anything to do with the participant's weight.

Merrill and Grassley (2008) demonstrated how the negative stigma that medical personnel attaches to overweight individuals may be impacting the health care treatment provided to these patients. Some of the behaviors were humiliating to the patients and were discriminatory in nature. This qualitative study on weight stigma is a powerful example of how to address experiences of overweight and obese individuals in the health care system. It is possible that obese Latina therapists may experience humiliating situations with their clients where the professional becomes the target of stigmatization, and that obese and overweight clients are stereotyped by their therapists.

Positive Attitudes About Size

There are countless blogs and websites on the internet addressing fat acceptance such as *The Rotund: Still here, Still Fat* (Kirby, 2013), and *Dances with Fat* (Chastain, 2013). The National Association to Advance Fat Acceptance (NAAFA) was organized to help end discrimination against those with a large body size (NAAFA, 2013). Books such as *Fat! So?* (Wann, 1998) and *Health at Every Size* (Bacon, 2008) are resources for individuals looking for information on fat acceptance. The research, however, on the genuine acceptance of obese individuals is scarce. Some of the fat acceptance research comes from participants and their own self-acceptance of their bodies (Satinsky, Dennis,

Reece, Sanders, & Bardzell, 2013). It was found that the women who were more accepting of their bodies also had sexually healthier lives. Fat acceptance has also been found within a community of men who are attracted to overweight and obese women (Swami & Furnham, 2009). However, this is problematic in that some believe that these men have developed a fetish for larger women and are objectifying them. There has also been some evidence of body size acceptance within the lesbian community (Courtney, 2008). It is believed that this occurs because lesbian couples are made up of two individuals who belong to a group comprised of individuals who are objectified and judged on their bodies. As women, lesbians may have more body acceptance for their partners compared to heterosexual couples. However, it is important to note that lesbian women were found to weigh significantly more than heterosexual women (McElroy & Jordan, 2014).

While these studies and resources are important, there does not seem to be any research that supports the true acceptance of obese individuals by the mass public in Western society. This lack of acceptance may impact the experiences of obese therapists and the possible concern that they will not be accepted by their clients due to their large body size. However, it is also possible that obese therapists may have some positive experiences with clients dealing with body size issues and may be seen as more understanding and relatable compared to thin-sized therapists.

General Attitudes Towards Latino(a)s

Stigma for Latino(a)s

Stigmatization of Latino(a)s in Western cultures varies. Stigmatization has been found in education (Guyll, Madon, Prieto, & Scherr, 2010), work environments (Morales, 2009), primary care (Manoleas, 2008), mental health (Watson, Kaltman, Townsend, Goode, & Campoli, 2013), community groups (Ramirez-Valles, Kuhns, Campbell, & Diaz, 2010), and interpersonal/familial relationships (Mizock & Russinova, 2013). There are negative impacts to consider when stigma becomes so prevalent that it leads to mistreatment, misjudgment, and discrimination (Major et al., 2007). These issues can be experienced in more intimate relationships as well as in the larger social context. This in turn can impact how individuals are treated in places such as a therapeutic setting.

Academic Settings

Latino(a)s may experience stigma in academics where the differential treatment by teachers and instructors due to students' ethnic minority status may lead to negative experiences in the academic world (Benner & Graham, 2012). While this problem starts with Latino(a) youth, it has also been documented in Latino(a)s who pursue higher education (Pinel, Warner, & Chua, 2005). Students' grades may be lower compared to their peers due to the incorrect perceptions that Latino(a)s lack intelligence compared to their White counterparts. One of the solutions to help combat the lack of diversity in some higher education programs is affirmative action (Grodsky & Kalogrides, 2008). Unfortunately, ethnic minority students given academic opportunities due to affirmative

action have also experienced unfair judgment because some individuals see these programs as making admission decisions based on ethnicity and not academic merit (Pratkanis & Turner, 1996). Students then may face a different kind of stigma not solely based on their ethnicity but on the assumption that they were given special privileges due to their ethnicity. Additionally, school books are written in a way that describe Latino(a)s as struggling against the majority culture and they are often portrayed stereotypically as non-English speaking immigrants who are working class (Rojas, 2013).

Work Settings and Immigration

Latino(a)s also experience stigma in the workplace (Major et al., 2007). Stereotypes such as being hot-tempered, uneducated, and overly sexualized can lead to some of this stigma (Lopez, 2013). Other stereotypes include having children out of wedlock at a young age and living with traditional machismo values where the women are seen as submissive and the men are dominant in heterosexual relationships. These stereotypes are problematic because they lead to others forming unrealistic perceptions of individuals in the Latino(a) community (Spencer-Rodgers, Gilber, & Peng, 2013). In addition, Latino(a)s tend to work in what many would consider to be the least respected parts of the workforce such as janitorial positions, waste management, and cleaning services (Lopez, 2013). Individuals in the Latino(a) population can also be the targets of jokes, inappropriate ethnic comments, and microaggressions (Schneider, Hitlan, & Radhakrishnan, 2000).

Latino(a)s may also have to deal with issues related to immigration whether they are immigrants or not (Torres & Wallace, 2013). Family members deal with the stress of their immigrant relatives even if the family members are already citizens. Perceptions can lead individuals to make false judgments based on the darkness of someone's skin or the thickness of someone's accent. Having darker skin or speaking with a Latino(a) accent does not mean that certain individuals are necessarily immigrants. They may come from a part of the country, particularly the more Latino(a)-populated southern parts of the country, where individuals may have darker skin due to the sunny environment or simple genetics (Quiros & Dawson, 2013). Latino(a)s may also have accents in their voices due to the geographical part of the country or to being from a family in which another language besides English is spoken (Fuertes & Celso, 2000). When these Latino(a)s enter the workforce, they are often pressured in both covert and overt ways to adhere to a European American standard for the ways in which they should speak and behave (Negy, Schwartz, & Reig-Ferrer, 2009). If Latino(a)s are expected to adhere to this standard in other work environments, it is possible they will have those same expectations in their jobs as therapists. They may also experience negative interactions with their clients in the form of microaggressions or inappropriate jokes.

Medical Settings

Gaining proper medical and mental health treatment has been problematic for the Latino(a) community (Rastogi et al., 2012; Stewart, Napoles-Springer, & Perez-Stable, 1999). Some Latino(a)s have experienced language barriers when trying to communicate

with their doctors which has led to poorer outcomes when receiving medical treatment (Diaz et al., 2013). Latino(a)s have reported difficulties across the board in the health care system that have included HIV treatment (Martinez, Lemos, & Hosek, 2012), plastic surgery (Gulbas, 2012), pain treatment (Chiauzzi et al., 2010), and cancer treatment (Betancourt, Flynn, & Ormseth, 2011) to name a few.

Stigmatization, discrimination, and stereotypes can play a significant role for different cultural groups. Some research has been conducted that has found that certain ethnic groups prefer to have medical professionals of their same ethnicity (Rouse, 2010). Rouse (2010) found that African American individuals can sometimes believe that White doctors are racist and will therefore have limited access to health care due to the negative experiences African Americans may assume they will have when they have a White doctor. Even though this article pertains to African Americans, it may also apply to the Latino(a) community if they feel uncomfortable seeing a White physician. While it is possible for some doctors to have racist beliefs, the idea that these beliefs can be generalized to a larger population is a serious concern when it is possible these individuals can receive excellent medical care from physicians outside of their own ethnic group. Just as in the medical profession, it is possible that clients may want a therapist of the same or similar ethnic background.

Latino(a)s also face difficulty in accessing and seeking proper mental health care (Wells, Lagomasino, Palinkas, Green, & Gonzalez, 2013). Ethnic minority college students have reported feeling stigmatized both by their ethnic groups and by themselves

for seeking psychological help (Cheng, Kwan, & Sevig, 2013). Even though ethnic minority students were found to experience more distress compared to European American students, ethnic minority students still do not seek professional help as often due to this stigma. Culture appears to be an important aspect of accepting mental illness and in the recovery process (Mizock & Russinova, 2013). This can be problematic in the Latino(a) culture, especially when other cultural factors are included such as low socioeconomic status, lack of education, and language barriers (Watson et al., 2013). Since mental illness, such as depression (Hwang & Myers, 2013) and eating disorders (Reyes-Rodriguez, Ramirez, Davis, Patrice, & Bulik, 2013), are becoming more prevalent in the Latino(a) community, it is important to acknowledge the barriers and stigma associated with mental illness so that proper interventions are utilized. It is possible for individuals to bring into therapy some of the preconceived stigma that tends to be held towards Latino(a)s and how this could potentially impact therapy has been studied in this research.

Colorism

Colorism is the way in which individuals are treated based on the color of their skin (Burton, Bonilla-Silva, Ray, Buckelew, & Freeman, 2010). Individuals face privilege and oppression based on their skin color and individuals with lighter skin tend to experience more advantages compared to darker-skinned individuals. People with lighter skin are closer in appearance to the White norm. Colorist practices and beliefs occur over different ethnic and racial groups as well as within ethnic and racial groups.

Many of the current studies on colorism have involved European Americans and African Americans (Cochran, Dhillion, Rabow, Vega, & Yeghnazar, 2012; Ryabov, 2013). There is a current dearth in the colorism research regarding Latino(a)s (Quiros & Dawson, 2013). Quiros and Dawson (2013) conducted a qualitative study on how the color of Latinas' skin impacts how they identify as Latina. Lighter skinned Latinas found they were sometimes at an advantage in some situations when they were perceived as European American. Those who had lighter skin reported having more fluidity in their identification as Latinas.

According to Tummala-Narra (2007), individuals will develop a sense of group membership according to skin color and similar ethnic backgrounds. Tummala-Narra (2007) also addressed the positive and negative aspects often associated with skin color. In general, individuals with lighter skin color will be regarded in a more positively while individuals with darker skin tones will be seen in a more negatively.

Positive Aspects for Latino/a Identity

While there are definite stigmas faced by the Latino(a) community, there are also many positive aspects of being Latino(a) (Ruiz, Gallardo, & Delgado-Romero, 2013). The Latino(a) culture is represented as a strong, prideful, and resilient community. There is a strong emphasis on the family unit and it is not uncommon to find multiple generations living together to make a large family where children will often have multiple caregivers (Kim & McKenry, 1998). Within these larger families, there is also a higher likelihood of individuals becoming fluent in more than one language. These skills

have proven to be beneficial when entering the workforce. Researchers are continuing to find that developing these language skills helps with more effective cognitive functioning in both younger and older individuals (Duran, Roseth, Hoffman, & Robertshaw, 2013; Marian & Shook, 2012). Young individuals are better able to adjust to their environments when they are bilingual and older individuals show less cognitive decline as they age when they are bilingual. Another benefit of having large family units is that many spiritual beliefs and practices are passed down to descendants (Koerner, Shirai, & Pedroza, 2013). These beliefs and practices help add meaning and purpose to those individuals living within the Latino(a) community.

While there has been an increase in eating disorders in the Latino(a) population, this community has also been more accepting of larger body sizes (Petti & Cowell, 2011). The ideal Latina body tends to be one that is curvier as opposed to the thin ideal most common among European Americans (Glasser, Robnett, & Feliciano, 2009). There is concern, however, that media influences may be changing the way larger body sizes are acceptable in women regardless of ethnic differences and that there is a general shift towards the thin ideal body size (Park, DiRaddo, & Calogero, 2009).

These positive aspects may help obese Latina therapists with their clients due to the higher probability that they will share similar cultural backgrounds (LeClere, 2010). Researchers have also shown that being bilingual, especially in highly populated Spanish speaking areas, is helpful to the Latino(a) community in being able to offer more mental health services to an underserved population (Rastogi et al., 2012). Often there is an

assumption that Latino(a)s immigrating to the U.S. lack education, but according to Portes and Rumbaut (2006), this is not correct. These authors stated that up to 13% of these immigrants are engineers, physicians, and other scientists or professionals who contribute a great deal to the professional climate in the U.S. Being aware that some immigrants are highly educated can help in reducing the negative stereotypes against Latino(a)s and their assumed educational status. This, in turn, can also be beneficial to Latina therapists.

Experiences in therapy sessions with obese Latina therapists may be impacted in a positive way due to potential cultural similarities. However, it will be important to consider how therapy sessions are impacted when meeting clients of different ethnic backgrounds. It is also important to consider if Latina therapists feel an automatic connectedness with Latino(a) clients and how these assumptions may be perceived in therapy of both their ethnic similarities and differences. Researchers recently found that when clients were matched on certain preferences pertinent to their own needs, they experienced more success in therapy and were more likely to continue treatment instead of prematurely dropping out regardless of their age, gender, ethnicity, education, or romantic relationship status (Swift, Callahan, Ivanoic, & Kominiak, 2013). However, other researchers have found that treatment outcomes may not be dependent on ethnic matching (Presnell, Harris, & Scogin, 2012). There was no mention of body size in either of these articles so addressing body size in connection with other cultural variables

such as gender and ethnicity will be a valuable addition to the current research on matching.

General Attitudes Towards Women

The Stigma of Being Unattractive

While there has been great progress in the women's movement, there are still stigmatizing issues that women face today. Stigmatization can negatively impact women's social standing and possibly lead to victimization (Fernandez-Esquer& Diamond, 2013) and discrimination (Botsford Morgan, Singletary Walker, Hebl, & King, 2013). Women tend to feel a large amount of pressure to be attractive (Davis, Claridge, & Fox, 2000). Women who are seen as unattractive based on dominant culture beauty ideals are often stigmatized for their lack of attractiveness. Unattractive women can be rejected in romantic relationships (Hill, Rodeheffer, Griskevicius, Durante, & White, 2012), friendships (Arnocky, Sunderani, Miller, & Villaincourt, 2012), the workforce (Johnson, Podratz, Dipboye, & Gibbons, 2010), academia (Sebastian & Bristow, 2008), and health settings (Patterson, 2013). Women are also highly stigmatized if they do not fit the thin ideal (Ferguson, 2013). Not only are they stigmatized by other groups but they are also stigmatized by other women (Sullivan, Landau, Branscombe, & Rothschild, 2012).

Individuals rate others based on physical attractiveness and being attractive can impact an individual's experiences in a multitude of settings (Puhl & Heuer, 2009). However, a study done by Johnson et al. (2010) was conducted to measure how women

may face negativity in their places of employment due to being attractive. These disadvantages tend to play out in more masculine jobs. The advantages of being physically attractive tend to play out in more feminine jobs. Women also tend to deal with harsher expectations than men when needing to fit that perfect ideal of physical attractiveness (Puhl et al., 2008).

Singlehood and Sexuality Stigma

Single women, especially in more traditional parts of society, can be seen in a negative way (Lahad, 2012). There is an expectation for women to get married and have children. When women do not do this by a certain age, they can face uncomfortable interactions where they are often met with stares, inappropriate questions, and sometimes sympathy (Koeing et al., 2010). Fortunately, these women in many cases are very happy with their lives.

Women also face a double standard when it comes to sexual freedom (Sakaluk & Milhausen, 2012). Men are often seen in a positive light when they have multiple partners; however, women are expected to have fewer partners in order to be viewed positively. Oftentimes women will encounter shaming comments (e.g., “slut”) when they are known or perceived to have many sexual partners in their lives and this also leads to further problems if women are victimized in a sexual way. Victim-blaming is still common in Western society and makes women even more unsafe if they are the victim of any sexual crime (Yamawaki, Dabry, & Queiroz, 2007).

Gender Roles in Medical Settings

Regarding medical settings, male doctors are seen as more respected compared to female doctors (Churchman & Doherty, 2010). People assume that men will be in power positions and may feel more comfortable seeking medical advice from a man. However, some studies have indicated that female patients may prefer to see female doctors when it comes to seeking treatment for more issues that seem more private (Johnson, Schnatz, Kelsey, & Ohannessian, 2005). For example, some female patients may feel more comfortable seeing female gynecologists and obstetricians (Makam, Saroja, & Edwards, 2009). Women sometimes feel that female doctors understand the female anatomy better than male doctors, simply due to the fact that these doctors are women, too. They understand what it feels like to be touched in certain body areas such as the vagina or breasts in ways that men cannot understand. This seems to be especially true in cases where a woman might feel pain in an area that a man would not understand. Women have been found to look at other qualities outside of gender when choosing an obstetrician (Howell, Gardiner, & Concato, 2002). Another interesting note from this same study was that participants did prefer a female nurse. This may have to do with the notion that people expect to have that nurturing and caring experience in a medical setting to come from a nurse. Since women are seen as nurturers (Fox & Quinn, 2015), this may be a reason why individuals would prefer for their nurse to be female. Clients in therapy may prefer a therapist of the same gender so this is another important factor to consider (Swift et al., 2013).

Positive Changes for Women

Women's rights have improved drastically over the last century by women gaining the right to vote with the 19th Amendment to the Constitution, earning the right to equal pay with the passing of the Equal Pay Act, having more opportunities for education, gaining reproductive rights, and more recently having more sexual freedom and spiritual freedom (Wyre, 2009). Women have become more independent and empowered not just by other women but also by men who have seen the injustice that women have endured (Katz, 2003).

Positive changes have been made in educational and career opportunities for women (Del Pino, O'Brien, Mereish, & Miller, 2013). More women are attending higher education each year (Ewert, 2012). Women are not only climbing the corporate ladder, but are also building their own businesses (Kephart & Schumacher, 2005). The number of role models for women is increasing and mentorship is proving to be helpful in women's advancement in the workforce (Morahan, Rosen, Richman, & Gleason, 2011). Women are learning that being supportive of each other and sharing knowledge helps to pave the way for the future of successful generations of women in any professional field, including therapists in a mental health setting.

Impact of Stigma

The impact of stigma is important to consider for this study. The messages people receive come from every aspect of their lives and individuals are constantly bombarded with these messages through their daily interactions with people, the media,

and the society in general (Smith, 2007). These messages and beliefs are taken into therapy sessions. First impressions are significant in building a relationship and there are certain parts of a person's identity that are immediately known upon that first meeting (Burke & Stets, 2009). In many cases, other cultural factors such as class, religion, sexual orientation, and education are not always immediately known without getting more information about the individuals. However, the diversity factors studied in this project - body size, ethnicity, and gender - are more likely to be visible when that first meeting occurs. Judgments and biases form very quickly for individuals and these biases may have a significant impact on obese Latina therapists, especially when they first come in contact with their clients.

Stigma and APA Guidelines

The APA has developed guidelines for working with clients of diverse multicultural backgrounds (APA, 2003). Guidelines have been written for working with Lesbian, Gay, and Bisexual clients (APA, 2012a), disabled clients (APA, 2012b), women and girls (APA, 2007), and clients of diverse ethnic and racial backgrounds (APA, 1993). What impact does the APA have on the current nature of how society treats overweight and obese individuals? There have been some discussion of developing these guidelines; however, nothing has been written and these guidelines may only be in the beginning stages of possible development (D. Burgard, personal communication, January 16, 2015). One concern with the idea of treatment guidelines is that it implicitly frames larger body

size as a disorder to be treated, and may not provide any supportive perspective for persons of size.

In psychology, there is great respect for APA and professionals look towards this professional organization to develop both future areas of research and ethical guidelines for working with clients (Vogel, McMinn, Peterson, & Gathercoal, 2013). It is noteworthy that even within the field of psychology, there has been a question as to whether guidelines are necessary and there may also be disagreement on how potential guidelines could be developed. By not developing these guidelines, it sends the message that obese individuals are possibly not seen as a significant group in which guidelines should be developed. It has been suggested that both researchers and feminists need to address why obese individuals face more oppression compared to other oppressed groups (Chrisler, 2012).

Media Influences on Perceptions

The Role of the Media

Individuals can receive messages from multiple sources on what is acceptable for women, Latino(a)s, and obese individuals. There are some common beliefs in Western culture that indicate what is appropriate (Denmark, Klara, Baron, & Cambareri-Fernandez, 2008). These beliefs are normally based on cultural and societal norms. For example, while men tend to be seen as strong providers, women tend to be seen as more submissive caregivers (Fox & Quinn, 2015). These beliefs are important to consider because they can apply in multiple settings, including work settings. It is also important

to consider one's perceptions of minority groups and how these perceptions can possibly lead to stigmatization and stereotyping.

Individuals normally engage in a process called social categorization (Wang, Zhang, & Zhang, 2015). Individuals categorize people based on their social perceptions. It is important for individuals to understand that in order to survive, people have to categorize (Reed, 2007). Since categorization is a basic cognitive function, it does not make sense to try to eliminate it; rather, it is critical that psychologists become aware of how, when, and in what ways they categorize in order to avoid unfair treatment and labeling. The mandate for self-awareness is supported in professional training (de las Fuentes, Willmuth, & Yarrow, 2005). Labeling can be harmful and can actually not just harm the person being labeled but also hurt the person doing the labeling (Wang et al., 2015). The goal is to bring more awareness to the forefront and address what people do with these labels in an effort to keep from putting these negative labels on other individuals.

The media includes television, magazines, movies, news programs, books, radio shows, and music (Newsom, 2013). The negative labels individuals use tend to be stereotypes (Yip, 2015). The stereotypical messages individuals learn come from many sources in Western society including family, friends, and the media, to name a few. The media, however, has a large impact that seems difficult sometimes for people to truly understand. The media can feel distant and intangible so individuals sometimes have difficulty making the connection of how media strongly influences us. Some of the

messages received are subtle, but it has more to do with the fact that individuals in society are bombarded with these messages every day that is the most disturbing (Kilbourne, 1999).

Portrayal of obesity. Watching television has been a factor that researchers have focused on in looking at the sedentary lifestyle of many obese individuals (Boulos, Vikre, Oppenheimer, Chang, & Kanarek, 2012). Not only are obese individuals influenced by television and other media but individuals of all sizes are being impacted. The role of the media can influence the perception individuals have of any given group. The amount of hours that individuals spend watching television and movies has continued to increase (Georgiou, 2012). The images in magazines continue to influence perceptions as well (Pankratow et al., 2013). People are constantly shown pictures, even if they are unaware of it (Kilbourne, 1999). These pictures build on the biases, stigma, beliefs, and views not only on how people should act but also on how they should look.

Overweight and obese individuals are often stigmatized by being stereotyped. Overweight and obese individuals are one of the last groups represented in the media where it is acceptable for them to be laughed at and ridiculed (Puhl & Heuer, 2009). They can be portrayed as individuals who face negative treatment in professional, social, and romantic situations (Boulous et al., 2012). Overweight and obese individuals are also shown eating more on television than their average-sized counterparts. These stereotypes are portrayed across different characters in television which can include both real actors and cartoon characters. Recently, researchers have found in reality television that obese

individuals are also judged in a negative way from viewers (Sender & Sullivan, 2008). Celebrities are often held to higher standards and individuals who follow the careers of celebrities will often internalize the pressure to fit the thin ideal that many celebrities achieve. Not only do celebrities achieve this desired look, but they also will go to extreme measures to maintain their looks and this is well documented in the media (Warren, Schoen, & Schafer, 2010).

Advertising can also be unforgiving when it comes to having excess weight. There is a common attitude demonstrated in the media that excess weight is something that individuals can control and can easily change if they simply work hard to lose the excess weight (Oliver, 2006). When individuals are portrayed in the media as having excess weight, they are often viewed as lonely, asexual, and inactive (Brochu, Pearl, Puhl, & Brownell, 2013). They are rarely shown as successful, independent, or in a loving and romantic relationship.

Portrayal of Latino(a)s. Latino(a)s in the media tend to be portrayed in more stereotypical ways than are Whites (Ramasubramanian, 2010). They are shown as less educated, of low socioeconomic status, animal-like, exotic, and hot-tempered. They tend to have lower status employment such as being depicted as housekeepers or a maintenance workers. Rarely are they shown in positions of power such as the head of a company or as a professor in higher education.

Latinas in the media tend to be represented as having curvier bodies compared to their White counterparts (Viladrich, Yeh, & Bruning, 2008). They are often hyper-

sexualized and portrayed as having feisty and fiery personalities. While there may be more leniencies in how Latinas are shown in the media, there is still a similar pressure Latinas face in achieving the ideal body that White women also tend to feel.

Portrayal of women. Women in the media are often sexualized (Kilbourne, 1999). Jean Kilbourne has done extensive research over the last few decades on the progression of women in media. There tends to be a misconception that women are being portrayed in a more respectful way; however, that is not the case. There are countless commercials and advertisements indicating the dehumanization of women into objects. There has been an increase in the rape culture among popular media outlets including music videos, song writing, movies, and television shows. This has been dangerous for women as it glorifies the rape culture and may lead perpetrators to view women in an objectifying way that is harmful and dangerous towards women (Katz, 2003).

For women in power positions, there is unfair treatment and extra scrutiny on how they should look (Newsom, 2013). If women have a more masculine appearance and more masculine mannerisms, then there is an expectation for them to appear more feminine. If women in power appear too feminine to viewers, then they are expected to look more powerful by taking on more masculine features. Researchers have discussed this no-win situation for women and have studied the unfortunate consequences of this injustice. This all-or-nothing mentality that is expected of women to either fit into one of two boxes, submissive or aggressive, has been shown to be harmful to women.

Positive Changes in Media Portrayal

One study was found in which the researchers found that obese individuals portrayed in a positive way were linked to a positive impact on other individuals' attitudes towards the obese population (Pearl, Puhl, & Brownell, 2012). Participants in the study viewed either positive or stigmatizing images of obese individuals. Participants who viewed the positive images of obese individuals were less likely to feel the need to socially distance themselves from obese individuals compared to those participants who were shown stigmatizing images. Participants who were shown the positive images were less likely to support negative views towards obese individuals compared to those who were shown the stigmatizing images. In addition, participants preferred to view the positive images instead of the stigmatizing images. These findings indicate that the media also has the power to perpetuate a more positive image for obese individuals just as a negative image has been perpetuated over the last several decades. Pearl et al. (2012) also acknowledged the uniqueness of this study since the vast majority of other studies on obesity portrayal in the media have on how negative images have impacted views and attitudes towards the obese population.

Conclusion on Media Portrayal

The media has been proven time and time again that it has a big impact on the beliefs and perceptions that people have of others (Mastro & Tukachinsky, 2011). These beliefs and perceptions can impact how individuals view different minority groups. It was found that having positive representations of different ethnic groups had positive

influences on the perceptions of different ethnic groups. The media has the ability to promote more positive and less stereotypical images to consumers. More current research was also found on the positive portrayal of obese individuals in the media (Pearl et al., 2012). It is important to consider that the mainly negative images in the media may have an impact on how obese Latinas are viewed. If individuals have negative views of obese Latinas, it could also impact how obese Latina therapists are perceived in therapy. Additionally, understanding how obese Latina therapists' attitudes and beliefs are impacted by the media may have an effect on how they present themselves in therapy.

Attitudes Towards Therapists

Cultural Aspects of the Therapeutic Alliance

The attitudes and views that clients have towards their therapists is an integral part of developing a healthy therapeutic alliance (Balmforth, 2009). A study of particular interest was conducted by Chang and Berk (2009) in which they did qualitative work and looked at individuals of different ethnic groups in therapeutic settings. More specifically, they looked at the different therapeutic relationships between individuals of different ethnic groups.

Chang and Berk (2009) used a phenomenological approach. Sixteen participants of different racial backgrounds, eight women and eight men, were each matched up with a White therapist. Each therapist differed in their ethnic backgrounds and identified as one of the following: German, Russian, Greek, Jewish, Ukrainian, American, British, or Yugoslavian. Each participant was interviewed in person with a semi-structured format.

Each interview started with the participant being asked to, "Please describe for me your experience of therapy, starting from the very beginning and taking me through that experience until the very end" (p. 524). Questions regarding race were eventually asked in the interview to get the participant to discuss more about the potential positive and negative aspects of different racial backgrounds in a therapeutic environment. Towards the end, the participants were asked how they felt therapists with different racial backgrounds from their clients should work with those clients in therapy. Chang and Berk (2009) found that those individuals who were satisfied with therapy tended to report that they accomplished their goals in therapy and had a connection with their therapist. Those who reported being unsatisfied said they were not engaged in the therapeutic relationship and felt that their expectations were not met. One of the reasons why some of these clients did not have a positive experience in therapy was because they felt there were some cultural barriers due to the differing racial backgrounds between the client and therapist. Another aspect Chang and Berk (2009) discussed is the discomfort that may be a common experience for White therapists when they are working with clients from a different race. This study is an example of how clients may struggle if they are not ethnically matched with their therapists; however, this is a qualitative study and is not meant for generalization.

Other cultural issues like class have played a part in affecting the therapeutic relationship (Balmforth, 2009). It is likely that differences will be brought into a room during a therapy session. The issue should not be the actual differences, but instead

should be how those differences impact individuals. Previous researchers have focused on a multitude of diversity issues in therapy, but there is a dearth in research when addressing obesity as a cultural factor in therapy. In the past, researchers have focused on salient issues such as gender, ethnicity, and sexual orientation (Lambert, 2004). Most individuals have a hard time discussing class and that has been brought to the forefront for consideration (Stabb & Reimers, 2013).

One of the important points made by Balmforth (2009) is that addressing these issues with clients also gives therapists the opportunity to truly explore their own beliefs, values, and viewpoints. Doing this self-evaluation has been crucial in being able to develop a healthy therapeutic alliance. Researchers have shown how important that therapeutic alliance is for clients to be successful in therapy (Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012; Horvarth, Del Re, Fluckiger, & Symonds, 2011).

Weight and the Therapeutic Alliance

A strong therapeutic alliance is incredibly important to most therapists when they are working with clients (Martin et al., 2000). Previous researchers have primarily focused on weight in the context of what many would consider to be the more common eating disorders such as anorexia (Isserlin & Couturier, 2011) and bulimia (Toman, 2002). The therapeutic alliance has been found to be important with families who had a family member suffering from anorexia nervosa (Isserlin & Couturier, 2011). Adolescents with anorexia nervosa who reached 85% of their ideal body weight while in

treatment also had a healthy therapeutic alliance with their therapists. Toman (2002) reported that different BMIs can have an effect on the therapeutic alliance. Toman (2002) found that clients with a higher BMI were rated by members of the study's research team as being more distant in the therapeutic relationship as opposed to those who were thinner. It was suggested that some potential issues with transference and countertransference could be contributing to different experiences in therapy. This study indicates that weight can impact the therapeutic relationship especially when the topic centers on eating disorder and body image issues. A critical question remains as to whether therapists of larger body size, especially those who are obese, may have a difficult time building a close and healthy therapeutic relationship with their clients. This could potentially be due not only to the differences in body size but also to the perceptions that clients have towards overweight and obese individuals.

Another important aspect to address is how clients of size may be perceived by therapists. While research has not been conducted with therapists, research has revealed that physicians who view obesity as a disease are more likely to view their obese patients as having more external factors that contribute to their obesity that are out of their control (Puhl & Heuer, 2010). Therapists will have their own biases and they are not immune to having negative thoughts about certain groups of people. Since there is a large stigma attached to overweight and obese individuals (Puhl & Heuer, 2009), it is possible that therapists can also view overweight and obese individuals in a negative way. Some of the beliefs may include viewing clients as lazy and stupid, which are common stereotypes

of this population (Puhl & Heuer, 2009). The way in which the therapist conceptualizes obesity may impact how they engage with their overweight or obese clients.

For obese Latina therapists, there may be some internalization process that leads to discomfort discussing weight negatively impacting the therapy experience. Although research has not been conducted with therapists, examination of physicians found that they were more likely to discuss weight loss treatment or diagnose patients with obesity when the physicians' perceptions of their own weight were lower than their patients' weight (Bleich, Bennett, Gudzane, & Cooper, 2012). More importantly, physicians with lower BMIs felt they were more confident in their ability to treat obese patients and that the patients would be more trusting in the information given by the physicians. Therefore, this study suggests that physician weight can impact medical options discussed, diagnosis, and confidence in the physician's ability to treat. It is important to understand whether the body size of obese therapists will be a factor in determining confidence and perceived competence in the therapists.

Client-Therapist Matching

Valdez (2000) indicated that individuals in a therapeutic environment may have a better experience or perceive that they have had a more effective therapy when their therapist is of the same ethnicity. Some individuals feel they can relate to their therapist more and may feel more comfortable talking about their own cultural issues when they see that they share this observable trait with their therapist. While it is important to discuss any cultural differences with clients, it is problematic when a client may be

closed off to therapy based on the ethnicity of the therapist. As more and more counseling programs are adding cultural and diversity courses to their curriculum (Donald, 2007), seeing how these differences can potentially impact a therapeutic relationship and eventually impact the therapeutic outcome are issues that have gained importance.

Other studies on ethnically matched dyads have shown different results. For example, Erdur et al. (2003) found that ethnically matched clients and therapists did not necessarily have a more positive outcome in therapy. Dyads in college counseling centers throughout the U.S. were assessed. Symptoms did not always improve when dyads were matched and there was a small trend showing indication of more improvement in symptoms when the dyads were mismatched. There were mixed results depending on how the data were collapsed in college dyads regarding how long clients stayed in therapy. Some Latino(a) clients stayed longer with their European American therapists while some stayed longer with their Latino(a) therapists. This study is interesting in that it is different from some of the previous studies where matching has been proven to be of benefit to clients (Sue, Fujini, Hu, Takeuchi, & Zane, 1991; Valdez, 2000). It is possible that with the increase in multiculturalism training (Donald, 2007), therapists are feeling more confident in their ability to treat clients of diverse backgrounds. However, it is still important to consider how competent therapists are when major parts of their own identities tend to be stigmatized by individuals in general. An area still needing investigation is therapists' perceptions of their own competence and

success when they are not ethnically matched with their clients. Another remaining question is how matching of other parts of therapists' identities including gender and body size may impact therapeutic outcomes. If obese Latina therapists are not matched with obese Latina clients, does this affect their experiences with clients with different identities?

Some individuals have also been shown to prefer therapists of the same gender (Sue et al., 1991). If a woman is dealing with domestic violence by a heterosexual partner, then it is not surprising that she may lose her trust in men (Robinson, 2003). When this occurs, it can potentially be difficult for a woman to trust a male therapist. Having a therapist with the same gender may be salient to particular clients depending on what their presenting concerns are when they come into therapy.

Other research was conducted to show that individuals of size were perceived to be more successful when they had a therapist of size (LeClere, 2010). This indicates that body size and other physical attributes may play a role in individuals feeling more comfortable with therapists that share similar physical attributes. While more research should be conducted on this possibility, it is difficult to dismiss the idea that individuals of a thin or average body size may feel more comfortable with therapists of thin or average body size and vice versa. This could potentially be another area where individuals may be denying themselves access to effective mental health care due to their own biases and negative attitudes they may have towards therapists of large body size. In addition, therapists of a large body size may have difficulty interacting with clients of

thin of average body size. However, it is important to consider that these issues could be more about matching and finding similarities and not necessarily about stigmatization or discrimination.

Relevant Cultural and Identity Factors to Consider in Therapy

Latino(a) Considerations

It is common in the Latino(a) culture for women to be submissive caregivers (Lindsay, Sussner, Greaney, & Peterson, 2010). This is important to consider for Latina therapists in case they find themselves acting as a caregiver to their clients. To be multiculturally competent, therapists must have awareness of what they bring into the room when meeting with a client (Fields, 2010). The awareness includes knowing that a multiculturally competent therapist does not know everything about a given culture. It is more about being constantly aware of her or his own biases as well as acknowledging that clients will have their own biases. For Latina therapists, it is important that if they hold on to some of the traditional Latino(a) gender roles, they be aware that this may impact therapy.

Another cultural difference to consider is that there may be acculturation issues for the Latino(a) clients and therapists (Raffaeli et al., 2012). Latino(a)s in general may be dealing with acculturation issues due to the push and pull of holding on to traditions and family values while trying to acculturate into U.S. society. Some individuals may have difficulty in trying to balance both worlds so that they do not lose the beliefs and practices from their heritage culture while trying to function in an individualistic society.

European American culture is individualistic and there can be intense pressure to conform (Schwartz, Zamboanga, Weisskirch, & Wang, 2010).

Obesity Considerations

Clients need to feel comfortable in their therapy sessions and this can mean many different things. Obesity can be an extraordinarily shameful experience (Puhl & Heuer, 2009). Not only do clients need to feel emotionally safe but they also need to feel physically safe. Many obese individuals understand the experience of what it feels like to constantly worry if they are going to physically fit in any given space (Mitchell, 2005). An example of this issue can be the media coverage of the size of airline seats and whether or not obese individuals should have to pay for an additional seat when they travel due to their body size and for the extra cost of fuel to carry a someone who weighs more (Guthman, 2013). Not only is the extra expense a problem, but many individuals do not understand the psychological difficulties that obese individuals face. Obese persons may feel any of the following: embarrassed, harassed, stigmatized, belittled, dehumanized, discriminated against, and other unpleasant and hurtful emotions. Individuals who are obese may experience a constant fear that they will not fit in a certain area or that they will be humiliated in front of other people. The shame can be paralyzing and can lead individuals to become isolated (Puhl & Heuer, 2009). Regarding therapy, it is important for both the clients and the therapists to have adequate seating. Something so simple could lead to a very awkward situation and could seriously impact the experiences of obese individuals in therapy.

Another shameful part of obesity is that there may be health issues for obese individuals that are not related to the extra weight; however, there may be assumptions that they are weight-related (Puhl & Heuer, 2009). Sometimes weight gain is a secondary problem due to these other issues that may have arisen well before the individuals gained weight. Society does not condemn individuals in wheelchairs or mobility scooters if the individuals are not overweight or obese. There seems to be a constant rush to judge obese individuals in a negative way when they need help with their mobility and it is common for shame to be involved in these instances. For example, an individual may have knee problems due to a car accident leading to several surgeries. Due to the surgeries, the individual may need a mobility scooter to move around and has gained excess weight during the recovery process due to inability to participate in physical activity. Without knowing all these details, other individuals may quickly assume that the individual in the mobility scooter is lazy. Again, this can apply to both therapists and clients when making judgments about other individuals and in turn, this can impact therapy. No research was found to support this consideration and it is a topic that should be regarded as part of this research and for future research.

Why is This Study Important?

Currently there is no research on obese Latina therapists. Considering that the population of obese Latinas comprises a significant portion of the U.S. population, it is surprising that so little research has been conducted. Since obesity is the last accepted form of oppression and stigmatization (Puhl & Heuer, 2009), it seems important to

address the reasons why obese individuals are some of the last to be acknowledged in the field of psychology. Obese individuals deal with very complex issues and may very likely benefit from counseling with size-sensitive therapists. It can be a very isolating and in some cases, a traumatic experience to live as someone who struggles with obesity. The world is not kind to those who carry excess weight and obese individuals are reminded of that every day as they walk out their front doors. Some individuals have developed strong coping techniques while others continuously feel the bashing from the society. Even though research has improved with the Latino(a) community and with women, it is important to address the intersection of Latino(a), women, and obese identities.

It is also important to note that studying obese Latinas therapists has added to the research not only on obese Latinas but also to the body of knowledge about therapists' experiences. Having research on the intersection of these particular identities and how this intersection is experienced has been an important addition to the field. The goal of this paper was to look at experiences from the therapist side regarding any cultural barriers related to ethnicity, gender, and body size.

Chang and Berk (2009) did bring forth an interesting idea with their study which involved the importance of racial matching in therapy. While there is an assumption that weight bias will be found in a therapeutic setting, it will be interesting to see if individuals find that body size matching is beneficial. For example, it is possible that overweight clients may report having a positive experience in therapy with overweight

therapists because they felt the therapists could relate to them. While it was expected that the participants in this study would have negative experiences related to the oppressed parts of their identity, there was hope that some positive experiences would be expressed as well.

CHAPTER III

METHODOLOGY

I conducted a qualitative study on the experiences of obese Latina therapists. Since no prior research has been conducted on this specific population, it was important to assess this group in a way that gets to the richness of their experiences. This was why I chose to do a qualitative study.

One of the significant aspects of qualitative research is credibility (Patton, 2002). This is attained by qualitative researchers reflecting on, exploring, and reporting their own biases. Other ways to help with credibility and trustworthiness in qualitative research are the use of triangulation, external reviews, and appropriate training, which were all parts of this particular study. These methods helped keep the study authentic and balanced so that researchers' personal views and biases did not sway the results in one direction.

My Qualifications as a Researcher

I am currently a Doctoral Candidate in a feminist/multicultural Ph.D. program in Counseling Psychology. I have learned a great deal about different diversity issues through my coursework, including the aspects of identity I addressed in this study. The knowledge I have gained has changed me significantly in how I look at others because I know at a deeper level that identity and diversity issues impact how individuals live and how they are treated. Multiculturalism has been integrated in the majority of my

coursework and I have taught a course that had a strong emphasis on multiculturalism and feminism.

During my years in my graduate program, I have taken a course in qualitative methodology. I have also been a part of other qualitative research projects. I have worked on a research team and helped to collect and transcribe interviews. In addition, I have helped three of my peers on their qualitative projects with coding and analysis of interviews. Lastly, I worked with other researchers from different higher education institutions on a project for the APA, Division 17, Section for the Advancement of Women. I have been exposed to different methods of qualitative research along with different aspects of the qualitative process including conducting literature reviews, conducting interviews, coding and analyzing data, writing results, and presenting at a national convention.

From a clinical standpoint, I have worked with clients for 5 years through my practicum placements, employment, and pre-doctoral internship. I have worked with clients on issues related to depression, anxiety, relationships, body image, eating dysfunction, substance abuse, childhood abuse, sexual abuse, rape, intimate partner violence, and multicultural issues. I have had several experiences of addressing my own body size, ethnicity, and gender with clients when it was relevant to the therapeutic process. I also understand what it is like to be vulnerable in therapy sessions knowing that clients have their own biases and are making judgments about me based on those biases.

Personally, I related to the participants in this study because I identify as an obese Latina therapist. I have been obese for at least the last 10 years of my life and I am constantly aware of my size in relation to how others may perceive me. I also know what it is like to be thin and average-sized since I did not start to gain a significant amount of weight until my 20s. I am not at my heaviest weight currently, but I still believe that I am the largest out of the individuals that I know in my life. I am fully aware there are other individuals in the world who are larger than myself; however, I believe I am in the category where it would be no question to others that I am obese.

My identity as a Latina has not been as salient until this past year while being on my pre-doctoral internship. I am from a large, diverse city and moved to a large town with a predominantly White population. I have also had to address my Latina identity on internship due to microaggressions I have encountered. My identity as a woman has also become more salient as I have also experienced microaggressions regarding my gender. It is unclear why these parts of my identity have not been more salient prior to this year but as I have progressed through my last year of graduate school while also working on this dissertation, I have experienced some significant changes in how I view my identities and these changes have impacted my views about myself significantly.

My Biases

As an obese woman, my biases seem very relevant. I believe that obese individuals, especially women, are constantly and negatively judged. While there is a pressure to attain the ideal body, I also believe there is absolute fear among women of

becoming obese. I believe that others view me as being lonely, depressed, lazy, stupid, and incapable of having a romantic relationship. Basically, I believe that the stereotypical view of obese individuals is often a misconception that others have of me.

Unfortunately, I have had many negative experiences as an obese individual. I have been embarrassed in clothing stores when salespeople treat me in a rude way. I have been the punch line of what were supposed to be harmless jokes; however, they were definitely harmful to me. I have experienced microaggressions from family members, friends, and peers regarding my weight. I have often been told that I have a pretty face which only implied that something was wrong with my body. People in my life have made inappropriate comments about others' body sizes and in an effort to make my discomfort to those comments known, my feelings were often trivialized and made to be insignificant. One of the most hurtful experiences that stands out to me was when someone called me a *fat bitch* and threw something at me in a public place. No one came to my defense and I remember feeling hopeless, humiliated, and dehumanized by that experience. It was at that moment I fully realized that not only did people view me negatively, but that it was acceptable to treat me in such a horrible manner because of my obesity. It was life changing for me. All of these experiences have led me to believe that being obese is a highly stigmatized and discriminated way of living. In many cases, people have failed to get to know me as a person.

As a Latina, I feel very proud of my both my ethnicity and my gender. I cannot recall a time when I wished to change either of these parts of my identity. Being from a

Latino ethnic background, I have wonderful memories of a very rich culture. Even though I know of the difficulties women face, I am incredibly proud to be a woman. While I am proud of these two aspects of my identity, the saliency of these parts of my identity has increased. I do not necessarily believe the saliency of my body size has decreased; rather, I am simply more aware of how I am impacted by my ethnicity and gender than I was previously. The weight discrimination I experienced is what initially led me to pursue this topic and then I later chose to add additional oppressed identity concerns by including ethnicity and gender.

Being a therapist, I was afraid to work with clients due to my assumption that they would all judge me negatively. I was surprised that I had to discuss my own body size during my first therapy session with my very first client. She expressed difficulty with her morbidly obese mother and it felt necessary to discuss how she felt speaking to me about her issues. I expected a negative reaction and instead I was able to have one of the most positive of my therapy experiences with this client. At termination, she informed me that I had helped her change her views on obese individuals not just through therapy but also in how I presented myself as an obese woman. This experience helped me to see that I could also have positive experiences with my clients in relation to discussing my own body size. There was a realization that my obesity would not always be a hindrance. So while I still assume that obese therapists will face negativity with their clients, I also believe now that there can be some positive experiences as an obese therapist.

Coming from a predominantly female university, I was used to working with predominantly female clients. I now have more experience working with men and have also had to have conversations about gender differences. I have noticed the most resistance from male substance use/abuse clients with whom I have worked. I have noticed that these particular clients have acknowledged they do not want to say anything offensive to me due to my gender. I have noticed that positive experiences have come out of my therapeutic relationships with men in general individual therapy. I have still had discussions about gender differences but being a woman has sometimes helped in building the therapeutic relationships, especially with some clients who have presented with relationship concerns.

My experiences with being a Latina therapist have also been positive. I especially can relate to other Latino(a) clients and I am also able to relate to other ethnic minorities in the community within which I currently work. Having conversations about cultural similarities have proven to be helpful in my work with clients and sometimes clients have been referred to me specifically in part because of my ethnic background. I have worked with several Latina clients struggling with the pressure to uphold their traditional family values while also working on making decisions that would not necessarily line up with traditional gender roles in the Latino(a) community. Overall, I have learned that identifying as an obese Latina therapist can have a positive impact on my work with clients.

Heuristic Inquiry

Heuristic inquiry was the qualitative approach chosen for this study. Patton (2002) stated the fundamental questions of using heuristic inquiry are: "What is my experience of this phenomenon and the essential experience of others who also experience this phenomenon intensely?" (p. 107). This method is appropriate to use when the researcher is trying to discover a deep meaning of an experience to help develop methods and procedures for future research on the said phenomenon. With this method, there is a question which the researcher tries to answer in order to better understand one's self as well as the environment in which one tries to function on a daily basis (Moustakas, 1990). The questions asked were personal to both myself and the participants; however, there were also social implications in trying to understand these issues at a macro level.

There are several parts to this process of qualitative research. The researcher must identify with the question being proposed (Moustakas, 1990). This way, the researcher is able to gain a clear understanding of the question by becoming immersed in the research.

Another aspect of this research is self-dialogue (Moustakas, 1990). With this, the researcher begins a dialogue with the presenting question and allows herself or himself to be questioned by the phenomenon. Researchers in this method must be open, honest, aware, and willing to engage in their own experiences with the studied phenomenon. As the individual researcher is able to engage fully, the problem is understood at a deeper level.

Tacit knowing is also involved in this method of qualitative research (Moustakas, 1990). This concept involves understanding that there is more knowledge than what can be verbally explained. For example, a woman can understand what it means to be obese but may not be able to fully explain how she became obese, the exact moment obesity occurred, or the complete list of her feelings at any given moment. However, there is an understanding of what that full meaning is by understanding other parts of an experience such as being able to explain certain feelings, describe particularly meaningful examples where obesity played a key role in those experiences, or recalling the offensive names someone was called due to her or his body size.

Indwelling is also significant in this study in that it involves the researcher becoming fully immersed in her or his experiences and the experiences of others to draw out full meanings and themes of the phenomenon (Moustakas, 1990). For example, an individual can sit with her or his own sadness over not having the ideal body size until there is a full understanding of what it means. The individual may go back to this experience of sadness over and over again so that the end goal of having great insight into the sadness is achieved. This process can become repetitive but it is a necessary part of heuristic inquiry.

Six Phases of Heuristic Inquiry

There are six phases to the qualitative method of heuristic inquiry (Moustakas, 1990). The first step is initial engagement. During this phase, the researcher discovers an interest and passion for a certain topic. The researcher engages in self-dialogue by

looking at her or his own autobiography and meaningful relationships within a social context. Eventually a research question is developed that holds meaning and power to the researcher in relation to the topic being researched. I engaged in this phase by thinking about my own experiences as an obese Latina therapist and seeing how those experiences affected my professional and clinical development and work. I am usually assessing the salience of my identities and have spent most of my adult life being strongly aware of my body size. In the beginning of this process, my body size was still the most salient part of my identity.

The second phase is immersion, which is when the researcher becomes completely involved in the research question at multiple levels (Moustakas, 1990). This could mean that the researcher experiences the exploration of the question at any moment of the day whether it is during any waking moment and even possibly through dreams. The researcher continuously looks at the question from multiple perspectives and tries to engage in any way possible to address the question whether it is in social settings, professional settings, or any other setting in which the researcher is able to focus and concentrate on the question. For this phase, I spent time exploring more precisely what I wanted to study and what types of questions I wanted to ask potential participants. While going through different drafts of the questions, I got feedback from committee members on how to change wording and to make sure that I was being more inclusive of the other identities I wanted to study for this project. This feedback ended up being significantly helpful in making me more aware of my biases and assumptions that others experienced

similar saliency to my own. I do not recall having any dreams about the questions, although I definitely had dreams about conducting this study as a whole. Also, I chose to transcribe the interviews myself with no assistance as a way to further enhance my immersion in the data.

The third phase is incubation (Moustakas, 1990). During this phase, the researcher pulls back from the intense focus that takes place during the immersion phase. Even though the researcher is paying attention to other things, there is still growth taking place in the exploration of the topic. When an individual takes a break from sustained concentration on the data, new connections or "aha" moments are likely to occur. This gives researchers the opportunity to come back to the material with a fresh perspective. I had two separate incubation periods. After my dissertation proposal, I took off a year in getting ready for my doctoral internship and then starting my internship for several months. I started to feel a shift in the salience of my identities while I was on internship and this affected how I viewed this topic. I also took almost 5 weeks off from looking at any of the data after all the interviews were completed. It was much needed time away, not just as a necessary phase of the study but also to allow myself time to rest from the intensity of collecting data and transcribing.

The fourth phase is illumination and in this phase the researcher reaches a new awareness of the topic (Moustakas, 1990). This may involve making corrections to previous knowledge on the topic or clearing up any prior distortions that may have existed. The researcher may uncover an aspect in this phase that adds something

essential to the meaning of the studied phenomenon. I was quite surprised during this phase. When I took the year off from this study, I felt what was occurring in my personal life was changing in major ways. I moved away from home to a part of the country that lacked ethnic diversity. I also started internship and immersed myself in that process which had a great impact on both my professional and personal identities. After taking the smaller break from looking at the data and any of the material for this study, I started to find patterns and came across some experiences from the participants that I had forgotten from the interviews. I remember early on in the data analysis process and after the incubation period, I understood the reasons for the incubation period. I felt like I was able to have a fresh perspective on the material.

The fifth phase is explication (Moustakas, 1990). In this phase, the researcher fully examines the topic's different layers of meaning. The researchers is expected to pay close attention to her or his own feelings, thoughts, biases, views, and judgments in order to better understand the conversations that are had with others, including their participants. Organization of themes and major aspects of the phenomenon occur during this phase so that the researcher is able to put everything together to create a cohesive product. The explication period happened partly when I collected the data and then also while I was coding. The participants in the study all discussed some difficult or challenging experiences that led to me feeling angry, sad, confused, and sometimes hopeless. I was also surprised to see how the coding was finalized and ended up finding some significant and deep meaning in the beliefs and experiences of the participants.

The sixth and final phase is creative synthesis (Moustakas, 1990). In this phase, the researcher takes all of the themes and components and develops a creative synthesis. The synthesis is normally in the form of narrative representation in which words, materials, and examples are expressed verbatim. Researchers will often take time to meditate on the material in order to find the inspiration on how to best present what is found. For this last phase, I definitely would not describe myself as creative. However, I paid attention to presenting the data in a way that told the stories of the participants in a respectful way. The stories are presented in the Results section.

Participants

Eleven participants were chosen for this study, who ranged in age from 24 to 58. All participants identified as obese Latina therapists. The therapists were in social work, counseling, clinical psychology, or counseling psychology. They held a bachelor's degree, master's degree or doctoral degree. Some were still in graduate school and completing their training and education. More detail is given in the demographics section of the Results section. One of the key characteristics of all participants was that they work with individual clients in therapy as a main part of their career. This was an example of criterion sample in qualitative research and it occurs when all participants meet some set of inclusion requirements (Patton, 2002). Obesity was based on the standards of the CDC through calculation of BMI based on the self-reported height and weight of the participants (U.S. Department of Health and Human Services, 2012a). The CDC required that a BMI of 30 or higher in order for a person to be classified as obese.

The reason I chose obesity instead of overweight requirements was because I believed the experiences of women who are obese are drastically different than women who are overweight. From personal experience, I found that when women are 10 or 20 pounds overweight, they normally can still function in society without much difficulty. When a woman is 75 or 100 pounds overweight, her experiences seem to be much harsher in a society where it simply is not acceptable for a woman to have that much excess weight.

Participants also identified as Latina and this included women of Latin descent. I reached saturation at 10 participants but decided to add 1 more when I kept getting requests to participate in the study. Saturation is defined as the point in which the information given by the participants becomes repetitive and no longer provides new and meaningful data (Mason, 2010). The common sample size for phenomenological research, which included heuristic inquiry, is between 5 and 25 participants. Developing a sample size in qualitative research can be an ambiguous process and researchers are encouraged to use their own judgment and peer review as the data are collected (Patton, 2002).

Triangulation

Triangulation is a part of qualitative research that helps to strengthen the study by using different data sources (Patton, 2002). This concept is based in the knowledge that a single method or data source is not sufficient to explain any given phenomenon. In addition to the interviews and the researcher's own experiences, a well known blog was analyzed for this study. *Dances With Fat* was created by Ragen Chastain and she has

chronicled her experiences of living as an obese woman since 2005 (Chastain, 2013). Her blog includes both positive and negative experiences she has encountered as an obese woman.

Instrumentation

Informed Consent

The participants were asked to sign an informed consent form (See Appendix A). They were told what the study was about, procedures and requirements for participation, and the approximate length of the interviews. They were also informed of potential benefits of the study including contributing to an area of research for an underrepresented population. Participants were given a token of appreciation in the form of a $20 gift card. In addition, participants were also informed of potential risks for the study. Risks included the possible loss of confidentiality since the interviews were recorded over the phone. Participants also could have experienced emotional discomfort due to the nature of the topic and the questions asked. Referral sources were provided (See Appendix B).

Demographic Questionnaire

Participants were asked to complete a brief demographic questionnaire for basic information. Participants were asked to self-report on height, weight, ethnicity, and gender. They were also asked to self-report age, education level, relationships status, sexual orientation, professional credentials, specific field in psychology, how many individual clients they see weekly, and the formats in which they conduct counseling. Participants were asked to specify the type of environment in which they practiced such

as a private practice, university counseling services, community mental health, or hospital settings (See Appendix C).

Semi-Structured Interview

Interview questions were based on addressing the experience of being an obese Latina therapist. Participants were asked to name the different parts of their identity and to discuss which identities were salient to them and at what times. They were asked to address both positive and negative experiences they have had with their clients. They were asked to describe what occurs when they have to discuss certain parts of their own identities when it is necessary for the therapeutic process. Perceptions of competence from both the participants and their clients were discussed (See Appendix D).

The interviews were semi-structured allowing the participants to have a say in the direction of the interviews (Patton, 2002). This also allowed the researcher to focus on certain parts of the interview depending on how the participants responded to particular questions.

Procedures

Following Institutional Review Board (IRB) approval, participants were recruited by posting an announcement on the NLPA listserv, the American Counseling Association (ACA), the APA Division 17 listserv and the POWR-L listserv. Participants were also found through snowball sampling in which this researcher searched for individuals based on personal contacts and asked if there were additional participants the contacts knew. Snowball sampling is often useful when accessing community members of specific

groups or when it is difficult to find participants that may not be randomly distributed throughout the population (Patton, 2002). The email announcement consisted of an overview of the study topic, the intended sample criteria needed, the study's potential risks and benefits, and contact information should an individual choose to participate or if there were any questions.

Participants went through an initial screening to make sure they identified as obese Latina therapists. Participants were instructed to read over the informed consent and complete the demographic questionnaire online through PsychData (2013). BMI was calculated by using the self-reported measurements from the participants on their height and weight. Participants were selected based on meeting the selected criteria of being an obese Latina therapist and were asked if they still wanted to participate. Times for the interview were set at the convenience of the participants and the interviews took place over the phone. Participants were given the list of questions at least two days ahead of time so that they could think of their answers prior to the interview. The interviews lasted from 22 to 53 minutes. All of the interviews were recorded using an online service and secure format called RecordiaPro (2013). All interviews were encrypted before being stored in memory and only the researcher and co-chairs had access to the interviews via a password-protected account. All interviews were conducted in English.

After the interviews were completed, post formal interview calls were made directly after the recorded calls ended. Participants were asked if they had any concerns or questions about the study. They were also asked about contact information for their

gift cards. Some participants continued to discuss the information discussed during the recorded interviews but this data was not used in the data analysis. After the interviews, the participants were sent a $20 gift card as a token of appreciation for their participation in the study. The participants were also given a chance to give their contact information if they wanted information regarding the results of the study.

Once an interview was completed and the phone call was terminated, I took down notes immediately about my own thoughts, feelings, and perceptions of the interview. During that time I immersed myself in the data to get a true understanding of what the participants were sharing in their experiences as well as thought of my own experiences and how they were similar or different. I transcribed the interviews verbatim.

A peer was asked prior to any coding to help in the data analysis. The peer asked to assist with the coding had also conducted two of her own qualitative studies and had completed a course in qualitative methodology. She was a graduate of the same doctoral program to which this researcher also belongs. It is important to note that the peer identified as a Latina woman but did not identify as obese.

All of the data from the interviews, notes, and additional demographic information were organized by each participant (Moustakas, 1990). Each participant was assigned an alias for confidentiality prior to coding. Each participant was named after one of my significant female family members.

Data Analysis

Coding

Coding is an essential part of qualitative data analysis in that it helps researchers organize data and find themes (Miles et al., 2014). A start list of codes was made prior to the coding process; when codes are created prior to examining the data, this is termed deductive coding. These codes came from the interview questions, the conceptual framework, and other important aspects from the study. This initial list of codes set the foundation for the coding process. As the interviewing progressed, other themes started to appear in the data and these were added to the list of codes as well. This process is called inductive coding due to the uncovering of important factors present in the actual data.

The peer who helped during the coding process was asked to make her own list of codes based on three interviews (Moustakas, 1990). Having a peer help with this process added to the validity of this project so that the analysis was more objective (Miles et al., 2014). Then we set up a time to discuss where we had similar codes and addressed the differences in the codes. An example of where we had discussion about some differences where when we were unsure of how to address the different ways body size impacted therapy. We were able to divide this by addressing what happens in clinical work and what happens internally for the participants regarding self-perceptions. We came to an agreement on the code list and I coded the remaining eight interviews. The code list

(Appendix F) was comprised of a list of numbers, each representing a specific code, along with the definition for each concept captured by each code.

Once the code list was determined, we started to code each interview (Miles et al., 2014). I coded eight of the interviews and my peer coded the other three. For triangulation purposes, sections of the blog *Dances With Fat* (Chastain, 2013) were also coded. Three randomly selected excerpts of the blog were analyzed. I decided to stay as current as possible with the blogs so I only chose out of the blogs from this current year, 2015. Blogs were chosen by randomly choosing a month out of a bowl and then choosing a number to indicate the date of the month. In the blogs, I looked for patterns and themes that best accurately described the data. I was the only one who coded the blogs.

Once the themes were formed, figures were created with the relevant verbatim part of the interviews. Every third transcript was coded by both coders as a reliability check on the primary researcher's potential coding drift. If codes were added to the code list, then iteration took place where the researcher went back through the previously coded interviews to re-check for the new code (Srivastava & Hopwood, 2009).

Individual Depictions

Moustakas (1990) emphasized the development of individual depictions for each participant. Prior to creating these individual depictions, I took a break from assessing the data for approximately two weeks. This is part of the incubation phase described earlier. This allowed me to come back to the data with the possibility of having a new

perspective to uncover any meaningful aspects I might have missed during the immersion phase. Individual depictions were developed using each participant's qualities and themes found in the data to accurately describe the participant's experience. Once individual depictions were complete, one depiction was chosen as an exemplar; this was the individual who most emphatically represented the themes that emerged in the prior analysis (Moustakas, 1990). A composite depiction was also generated, reflecting the common themes across all participants and served as a kind of summary or prototypical representation of the phenomenon.

CHAPTER IV

RESULTS

The results are displayed using three different forms in order to have a better understanding of the experiences of obese Latina therapists. The first is in the format of individual depictions allowing each individual voice to be heard as a whole. These depictions are formatted for each participant based on responses to each of the interview questions. The participants' responses are presented with passages from each question with a storytelling quality. Each depiction is each participant's story. These depictions are part of heuristic inquiry (Moustakas, 1990).

The next part of the results is displayed through figures to show themes across participants. This is shown with two figures. One figure is the exemplar depiction (Moustakas, 1990). This depiction indicates the best single representation of all the participants. The second figure is a composite depiction (Moustakas). This figure displays themes meant to represent more of the responses of the participants in order to move in the direction of being able to generalize. Even though there are not enough participants to make stronger generalizations, the themes found in this study give researchers directions for future studies, which will be discussed later in this paper.

The last part of the results sections is the analysis of the blog, Dances With Fat (Chastain, 2013). Chastain identifies as a fat woman and she writes an almost daily blog

about her personal experiences as well as her views on social justice regarding fat bias and weight stigma.

Demographics

Eleven individuals were chosen to participate in this study. Participants ranged in age from 24 to 58 with an average age of 35. All participants identified as women and all identified as Latina. BMI for the participants ranged from 29.6 to 56.8. The average BMI was 39.8. One participant reported having a bachelor's degree, seven reported having master's degrees, and three reported having doctorate degrees. Five participants reported being single, four reported being married, and two reported being divorced. Seven participants reported being heterosexual and four reported as bisexual. Participants saw anywhere from 3-40 individual clients a week. In addition to individual therapy, five participants also conducted couples therapy, four conducted group therapy, and two conducted family therapy. One reported conducting parenting classes. It is also important to note that during the interviews, some of the participants discussed being from the following countries: Cuba, Mexico, and Puerto Rico. This was not part of the demographics questionnaire and other participants did not mention other countries of origin.

Individual Depictions

Individual depictions were created as part of this study to give voice to each individual participant in the form of what I called stories. Passages were taken verbatim

from the transcribed interviews. The headers in bold throughout each depiction were either major themes or grouped themes that were found in the coding and data analysis.

Each individual depiction has nine components. Participants had different views and experiences with their three identities regarding ethnicity, gender, and body size. I wanted to address these initially in the depictions; they comprise components 1 through 3. Then, I chose to address how body size impacts both their clinical work and self-perception (component 4). I noticed that when asking questions about the three identities together, e.g, an obese Latina therapist, most of the participants focused on the body size aspect of this intersection with some leaving out the other identities completely. I then focused on how each participant addressed identity with her clients in session (component 5). This particular section of each depiction could have included cultural competency and addressing the role of context and intersectionality. The sixth component of each depiction pertains to body size and self-perception. The next part of the depiction illustrates how the participants felt there were interactions of identity (component 7). This included the perception of others on the participants as well as how they negotiated salient identities versus other identities kept more to the background. The next section is for how each participant may have viewed the language used to describe body size (component 8). This question was not directly asked of the participants but some participants responded to the word *obese* on their own after being asked a question with the word *obese* in it. The last section is about how each participant experienced

microaggressions, blatant comments, and/or mistreatment either from clients or co-workers (component 9).

Velma

Velma's Story

My views and experiences on identity as a Latina…
I have a lot of pride for sure.
I just love our culture and our heritage and what we stand for and I think it's very much a part of me. It gives me a lot of strength and motivation to, to keep going.
I think that the same way. Being able to hear some of their, maybe some of their concerns of being able to balance the cultural piece of being a quote unquote good Latina and still maybe balancing their professional life. I think just being the kind of modern day things that are stronger out there and I think just having that personal experience of being out there in the world and maybe being thought less than because we don't look like the stereotypical American person. Being children of immigrants who came from Mexico and being also bi-cultural and bilingual, being able to speak Spanish, and also kind of not having just the culture that doesn't match where I live, I think these are all things that I bring into the room when I'm a therapist.

My views and experiences on identity as a woman…
I'm very grateful that I was umm identify, identify as a woman. I think there is such beauty to it. I just think there a lot of awesome things about it.
If we can, there is motherhood and even if it's not like physically bearing a child, there is that, I very much embrace, I haven't been a mother yet but I very much embrace being able to nurture other folks.
I think we have gone through so much as women and we keep fighting. There are so many cultural things that we still have to continue to fight for like going to school and being able to still have a family if that's something that we want.
I think in being able to connect with them. Being able to understand maybe not their direct experience but being able to understand the more systemic way of how our society can treat women umm I think have been invaluable for me in working with them as a therapist.
I think being a woman, when I worked with male clients at times, they also stated I don't understand because I'm not male and what that would mean.

My views and experiences on identity as an obese individual…
I personally have a lot of shame with obesity.
I think that I do fit into those stereotypes that I should be able to fight this.
Do I strive to still fit into size 6? Probably. I think, I think it's something I still would want to strive to be even though I have never probably been that since I was probably ten.
I think the message that's pushed out there that we're lazy, we're not exercising enough, or we are gonna get diabetes. Why don't we just get on the treadmill or stop going to McDonald's?
I think that I definitely do internalize those things. I think I can consciously tell you, yes of course, I do think it's a disease that we should definitely fight or to problem solve. I think it's just some folks are coping skills, or genetics.

I think for the longest time I had a bias I would say towards folks who had a normal range of a BMI, thinking they wouldn't have body image issues and I think that's a bias I normally have to check myself on because I definitely feel for women and again there is my bias to assume that body image is only for women so I think the fact that messages are louder for folks who are overweight or folks that are women who have body image issues, I feel that is my own lens.
I think there is something so powerful about being able to be with folks who look like yourself.
I feel that obesity is such a hush hush thing that we normally, if we talk about it, it's normally our clients as something that we need to fix but never really talk about it as ourselves as clinicians and how does that impact ourselves.
I don't feel like I'm sexually attractive or every time I would hear that there might be like sexual attraction from your clients towards you, it's something that I would never consider
I don't think that gets talked about, being the, obese part, I think there has been some circles where you can talk about being woman therapist and I think there are aspects where you can talk about being a Latino professional or a person of color providing services but that's definitely, the obese part, I feel like that's, sometimes it feels like a stigma, or something that you shouldn't talk about, or something that you should kind of go deal on your own and think about it like the modern smoker, like it's something you should probably go fix if you are going to be a successful therapist.
I think just the experiences with my colleagues, like very much I've had the experience where they feel that they want to give me advice on how to lose weight or what are you doing to cope? Or…I realize I get a lot of advice, I mean even if I don't want it. What is the latest trend? How I can lose weight. I guess my assumption has always been, oh we are peers, we are clinicians, you are not going to bring that up but how permeated it is in our society that I must, because I'm obese then I must not move or I must not eat healthy and how still as clinicians we don't talk about that would mean or what are the implications about it.

How my body size impacts my clinical work
I've noticed clients sometime struggle talking about, talking about either their biases about overweight people because I'm sitting right in front of them. I remember a client specifically like just hating or, not talking very politely about her sister-in-law who was obese umm and she was like, oh my God, she was like over 200 pounds, and umm, she goes, no no no, she doesn't hold it as beautifully as you do. And I remember that stuck with me because yes, I'm over 200 pounds but the fact that she had to take care of me in that sense, like oh no, I just said something to offend my therapist. And while I tried to talk about it be like, what does that mean, and then there was also this shame that she didn't want to talk about it. She didn't want to keep going further what it meant for her sister-in-law to be overweight

How my body size affects self-perception…
I sometimes wonder what it would look like if I was thinner. I wonder if I would be able to connect with more of my clients more.
I do feel I have to try to seek outside of my identity to be able to see other parts where I'm not so competent, especially where I feel I use myself a lot in the room with my own experiences and judgments and biases.

These are my views on addressing identity in therapy…
I think I do it since day one, from our first individual meeting.

I feel like I try to open it as much as I can and I try to hold the ownership of talking about these kinds of things that might be a little more comfortable where I hold the privilege.
I mostly work with Spanish-speaking immigrant communities where are mostly women and I think for me, just being born here in the United States and not being an immigrant myself, even though I am a child of immigrant parents, I think I say that from the very beginning and just let them know that I'm not born here and we are going to have differences in language and my background is from Mexico and you are in front of me and you are from Guatemala so what is that going to look like and how is our work going to look like?
It's a part of my identity that, I normally do share a lot of my experiences with clients and I don't talk about that part as much.
I also try to talk sometimes even about educational access. I have a lot of clients that maybe have three years of training and here I am, you know, have my doctorate so what would that look like?

My interactions of identity…
I think I would be more open to sharing more parts of my identity outside in world, instead of the therapy room would be probably something because I don't have to see how that might trigger um my clients. I think I could be a little more open, maybe a little more selfish and self-absorbed. I definitely use my experiences a lot. So I think having, being a witness of domestic violence definitely impacts my work a lot when I was I child, I think also having a history of child abuse is definitely something I use in my work as well. Umm and I think also being umm a victim of sexual assault was also something that definitely has impacted my work and it forms how I am able to relate to my clients.

I feel the word obese is…[question not answered]

My experiences with microaggressions and/or blatant comments are…
I had a client who did not trust immigrant communities because they were taking resources from the U.S. and she would always have to retract what she was saying because, I mean, my name is pretty apparent of being of um Latino descent so I think that was something that was very hard for her to do and she would sometimes state, "well you just don't understand" umm "you don't understand because you don't know what it feels like to be in this country and then have people come take your resources."
When I did work with folks with substance use, I think they would blatantly just state, how do you know if you've never had an addiction and I, I think I would state, you're right, I don't know your experiences with being addicted to substances or struggling to keep your sobriety so I would try to open it up as much as I could and state how, how was that for you?

Figure 1. Individual depiction of Velma's experiences as an obese Latina therapist.

Chayo

Chayo's Story

My views and experiences on identity as a Latina…
It's very central to who I am as a person and to who I am as a professional.

I think being a Latina is much more salient in my outside world, in my non-work world.
I'm very tied to the cultural norms. I'm just this past month celebrating Mother's Day just on May 10th one time because technically we celebrate it twice for you know, I'm of Mexican descent so we usually celebrate May 10th regardless of the day that it falls on but this year, it happened to fall on the actual May 10th.
My Latina identity has also shifted as the years have gone by. For me it's something that is very positive. It's something that is very much what I hope to pass along to children in the future. It's something that I celebrate within my family system.
There is this generalizing, there is this perception and this image of the Latina woman as being like kind of the sultry and vivacious, kind of the sexy woman and I think when you transfer that sort of media stereotype to umm my professional stereotype, I think there is a professional identity.
I think it's been an interesting thing to kind of manage the media portrayal of Latina women and how that differs from my identity, not just as a woman in day to day life but especially in my professional identity.
Spanish is my first language, allows for me to connect with clients in a deeper way.
Being Latina but also being Spanish speaking is something that serves to open up, I think, a different connection with clients, one that they're seeking and one that is very fulfilling for me.

My views and experiences on identity as a woman…
I do really have a strong focus on equality for females. I would say I'm a feminist but at times it conflicts with some of the more traditional views of my family who is Mexican where it is more paternal headed household. But for me, it's very important to value and view each of the genders as equal importance and equal ability to make decisions. So for me being a woman and being a Latina woman has taken on a little bit of a different flavor in terms of being being a little contrary in terms of the typical marianismo or machista point of view and just really taking on the, the ability to take higher education, to take leadership roles, to make equal decisions with your partners.
I think being a female therapist is the primary part of my identity in my work.
I work with a lot of female clients and uhh families, I think uhh, they, they seek out and I think I fill that, that female role.
at times when there are trauma histories or issues with family, being a female is something that facilitates my work with them.

My views and experiences on identity as an obese individual…
In this stage of my life, it's something I've umm very much grown to own as a part of who I am right now.
I think in the past I have had those moments of not liking my physical appearance, of feeling, you know, why can't I just get it right as everything else is going well in life?
Well I do think, I remember a couple of years ago with me umm when obesity was officially classified as a disease, it was pretty controversial. I think for me that umm it is something that I view as a disease in general.
It comes along as a symptom of comorbid factors for other diseases, umm, so whether it is depression or anxiety or umm even biological or health symptoms like polycystic ovarian syndrome, or other things where obesity is also linked other diseases. I don't think that it exists

totally separate from other issues and I do think that it could be treated but a lot of times the treatment has to include treatment for other umm other issues going on for the person.
I think there is also this positive assumption about, like well, you are also heavy, if I am working with a client who is also obese, you know, you know that perception that there is this confidence that goes along with it.

How my body size impacts my clinical work…
Like I said, positive ways being that there is this maternal identity I think, this assumption about having had children, and that is very helpful in terms of my work with children and families. When I work with others kind of issue like eating issues, it's, it can be a negative issue at times but not always. I think I've had clients say, I wish I could be as confident as you are in spite of your weight.
I mean I think in a way I do feel connected at times to them because I feel there are different aspects of their identity I can relate to but at the same time I try to really remove my experiences from theirs and hear from them, you know, what is it that it means for them but I think that in general I feel that at times it's kindred spirits and I feel like there is something that is an underlying connectivity between us.

How my body size affects self-perception…
I think at times just being obese, just the part of being obese as the identity, I think at times might elicit some sort of perspective that, that maybe there is something not well with me or that I'm not as good at adhering to my own recommendations I give them about health and wellness overall.

These are my views on addressing identity in therapy…
I really tried to take an open-ended approach to bringing up my physical appearance with clients in order to facilitate that process.
I think that for me uhh it's something that I use in the therapeutic process anyway that we, it's discussed so I think it does come up with the therapeutic work I do, depending on the needs of the client.
I had this woman who had given birth and was post, was experiencing symptoms of post partum depression and a lot of that was centered on her physical appearance and her ability to drop down to her pre-baby weight and she called it. In that sense, I just asked her, what is it like to have this kind of conversation with me who I'm a fuller woman who, what assumptions do you have about my life? What do you think I might think about you in terms of your desire to lose weight?
As an example, the teenager, the young adult clients who are struggling with body image, it's something that they often don't bring up directly but it's something I strive to, to talk about with them and it is something that we work through together in terms of understanding any sort of implicit bias they might have towards me and working through those because a lot of time if there's anything coming up between myself and them in the therapeutic space, it's something that they also encounter in their day to day life outside of the office.

My interactions of identity…
I'm an early career therapist working on becoming a psychologist so there is this just the issue of being on the younger side and having less experiences of some of my peers and being in the field for 15-20 years and having, I think that as I continue to grow and develop in my career, and also

just in life, that my age will take on a different role and it will carry a different meaning for myself and also for my clients that I work with.
I think a lot of times there is also the assumption that I may have kids but when I work with families, I think there is this level of kind of respect for where I'm coming from because of the assumption that I might have had children so I think that in a way it does kind of create a more endearing setting where there is, where there is more warmth I think and especially if there is from the Latina culture with the importance of motherhood as a value, I think that it kind of helps that way in easing conversations about parenting and family structure issues because of my, because of my physical appearance.

I feel the word obese is…[question not answered]

My experiences with microaggressions and/or blatant comments are…
A lot of times there is that inherent racism towards, towards other ethnic groups, other racial groups and kind of working through for me how are the people's biases, I mean there is, there very much, the majority of my clients, all of my clients I think assume that I'm in a relationship with a Hispanic male and so just kind of understanding for them what that means and for me also, what comes up when I hear racist comments or just very negative perceptions of others has been something that's been interesting.
So I haven't had many of the racially directed, or racial ethnicity, ethnically racial microaggressions. I have had experiences and it happened even uhh a few months ago where I think there is this assumption of privilege. I've had one client as an example, who you know, depends, a lot of the clients I work with live in very high crime areas in the city and you know gang ridden and low resource schools and I think of because of the assumption I studied and am now a doctor, I don't know about their, their struggles and so I had one client say, well have you ever even seen someone actually be fought or pressured by a gang and umm in that moment, I think, I really had to take a step back because I think the client was pulling for this umm this conflictual type of interaction and in that moment I really tried to work to understand why he was wanting to challenge, where that defensiveness was coming from first and trying to understand if there had been something I had contributed to the space that would make him feel uncomfortable or make him feel like I have to.

Figure 2. Individual depiction of Chayo's experiences as an obese Latina therapist.

Vanessa

Vanessa's Story

My views and experiences on identity as a Latina…
The most salient part of my identity is my Latina identity.
We have a lot of strengths in a lot of different areas so I have only positive views of the Latina identity that I have.
I think they feel more comfortable and because I'm bilingual, they're able to really connect in that way.
I think the potential to not be taken seriously by either my colleagues or my clients. I don't know, there is something sometimes that I can't put my finger on it. It almost seems like people don't trust my knowledge and kind of question me.

My views and experiences on identity as a woman…
I start to wonder about the kind of stereotypical, you know being more emotionally connected, being more the caregiver, it makes you wonder about those kinds of views of being a woman.
I am a pretty big feminist, I think women have been changed for a long time and I think we have strengths that are often, I don't know, kind of looked over I guess by other people or maybe even seen as weaknesses at times but I think being a female therapist has only helped me in being able to relate to clients and kind of being who I need to be in the room for them.
I think it is allowed for therapeutic relationships to be more open.
To kind of portray my non-judgmental attitude, I think that has come out the most as a woman and I think it's allowed me to better connect with some clients, not with all but I think there is some comfort level that happens from me being a woman.

My views and experiences on identity as an obese individual …
I am pretty body positive so I wouldn't always say it's a bad thing but I do think there can be some pretty negative consequences associated with it.
I wouldn't say that it's a disease and while there can be negative health factors associated with it, that's not always the case.
I do think there is this systemic issue linked to obesity and I even grew up lower income, below the poverty line for most of my life and I think just being limited, my parents being limited to what kind of food they could afford really impacted how my development and now me being obese because I have been for all of my life.

I would say maybe just thinking that I can't relate to people to, like that I wouldn't be able to relate of an underweight White client.
And kind of thinking about the way male clients might view me and I guess, I don't know, it's funny because I feel a little bit more protected in terms of boundaries and inappropriate feelings happening for my clients towards me.

How my body size impacts my clinical work…
I think it's allowed me to feel more space with clients.
I actually have a client right now who is an obese Latina woman and I tend to feel more comfortable in session with her just because we share those aspects of identity.
I think sometimes like things that I've experienced in the past, if they parallel or similar to things my clients have or are going through, can give me better insight.

How my body size affects self-perception…
Being an obese Latina therapist has not had a huge impact in my being a therapist but I would say that it's made me hesitant to go to certain types of sites.
In the beginning of my therapeutic relationships with, one of my teenage clients, because I worried about that just kind of me having the stereotype of teenagers being judgmental and kind of what are they going to think of me and is this going to be ok so I think it's had both negative and positive impacts.
Of course I do feel hypocritical when trying to do a behavioral activation plan and that includes eating three meals a day when I don't always do that myself.

These are my views on addressing identity in therapy…
It would depend on how they identify first. So are they putting their obesity first, so that would make me wonder, is there body image stuff going on, if maybe they weren't very confident. If maybe they identify as a woman first, I would wonder if they view that as a strength or weakness, so I guess just kind of figuring out if their identification comes from a strength position or a weakness position.
I think even with my White clients, just kind of being able to be I don't know, I address it sometimes, how is it working with a Latina therapist so just being able to be more open.
I said to my client, I know you identify as LDS, I identify, I don't identify as LDS, I identify as atheist. How do you feel working with me now that you know that? to make it more of a conversation and so that they too feel comfortable and they're kind of in the loop as well so, yeah but I don't, I haven't talked about any other parts of my identity with clients in that way.

My interactions of identity…
I think the confidence I have because of those three identities would only kind of benefit my clients and feed into my strengths working even in that kind of a setting.
At times I wonder about, because I look, I look Latina, I'm, that's pretty a visible identity of mine, so in the first intake session, I worry that people won't think I'm competent, that they won't think I'm smart enough to be a therapist.
I would say my most salient identity all of the time is my Latina identity. I would say though that at times, so I live in Utah umm and I'm not from Utah. I'm from Wisconsin but dominant religion here is the LDS religion so my identity as an atheist is pretty salient sometimes just being in Utah but I would still my Latina identity comes first.
Definitely my identity as an atheist has come up working with several LDS clients so that the Church of Jesus Christ and Latter Day Saints. And that religion is pretty strict and pretty conservative and just kind of the opposite of everything that I stand for so yeah that's pretty impactful in my experience with clients. And even though I kind of say they are the opposite of everything I stand for, I have been able to gain a lot of compassion in that area too and kind of understand people who even if they may be struggling with things that are going on in their lives and what the church says about it, that the church is really important to them for whatever reason and it's not my place to judge them for and it's my place to support them in whatever they want to do and to be there to just help them kind of walk through the struggle that they are going through.
As a grad student, I'm still living with very little money and that has come up at times with a client who comes from a pretty affluent background, umm, and you know it's been an interesting experience for me learning to be more compassionate and to be able to leave my biases about people who are more well off or more affluent at the door.

I feel the word obese is…[question not answered]

My experiences with microaggressions and/or blatant comments are…
So that has not happened yet and hopefully if it does happen, I will have a great processing moment with my client in session. And you know I hope I'll be able to say something like, I'm curious what it is about like this topic, or like, I'm curious about why my being Latina is important when we are talking about X, Y, and Z or, I don't know. Something good and processy.

Figure 3. Individual depiction of Vanessa's experiences as an obese Latina therapist.

Monica

Monica's Story

My views and experiences on identity as a Latina…
I am very happy to be Latina.
I would say being Hispanic because of my accent is, is always in the room.
We are a very diverse group. I love the language, I am a writer myself too so I write in Spanish, I mean Spanglish, to, I am proud of I really cherish my heritage and my roots and the people from who I come from, the history, the connection to Spain. I also grew up in Spain part of my childhood, so I am very proud of it.
Some of my best connections in the United States who are friends or colleagues have been because the Spanish language so I really value having the Spanish language on my side and it's a shame that you know, people don't, in some ways, here because of the oppression, people rejecting their own language, a loss of a natural resource and things they could use in their own professional life afterwards but I had kept that for me and for my own child.
I was not born in the United Stated so I never had that of being Latino as a negative until I came here but in the United States, Latinos are seen as less so it, the stereotype is that you are not educated. The stereotype is that we take welfare the stereotype is that you are poor. You are lazy. I think as a Latina, I was more aware of class issues, being Latino American. It's about the history of oppression here in the states.
As a Latina it makes me more aware of the oppressions of the environment, how you know, governments, how they oppress us, how labels oppress us, access to resources, you know, that makes me more aware of how the environment affects my clients in a macro level.
I think as a Latina, the stereotypes of a Latina, they tend to be less, as a woman, Latina being more malleable or less threatening, less into power, I suppose that maybe, its sometimes its countertransference with some of my students, it may work against when I have a Latina and there are trauma issues, it may work against, they, meet with the mothers whenever was an issue for them, they reject me as a therapist but other people, other clients, they want me exactly because of that, because of being Latina and being a woman, and more, more relaxed, feeling more homey and they, I think that they, the most interesting thing is how you run the session, sometime it's in the bilingual ways, you know, a mixture of English and Spanish, and the, that feels comfortable for them, comfortable for me, but all the training we have a Latina, they would say that is one of the issues we are trained here in the State, we are trained here in the States, and all my, my language, my professional language is English but I don't have it in Spanish.

My views and experiences on identity as a woman…
Women have been oppressed all over the world.
I think the way of being educated as a woman in Latino America is very oppressive and we pretty much, we are blinded to how society thinks towards us, we tend to blame ourselves mostly. Increases my empathy towards my clients to be a woman. I think we have a much deeper level of empathy than males because in education males, in the education system, but mostly they don't allow them to express their emotions and be in touch with their inner selves so I think being a woman will make me a better therapist.

My views and experiences on identity as an obese individual…
I am an overweight person. I also attend OA[Overeaters Anonymous] meetings so that is a way of defining myself in other circles.
But I guess I am in that bracket, I'd say if you are looking into the charts, I am in that bracket. I don't look obese in terms of being the form or something like that but medically I would say that yes I would be in that bracket.
It has so many levels you know there are the social levels where they connect thinness with success and control and being obese with being a loser and lack of self-control. That is the American way of looking at it. Then there is the part of health. I do think it is an addiction. I do feel it is a way of calming your emotions through food and there are some substances that you get addicted to and they have proved that the food gets calmer with certain substance so the more that we know about the brain, the more we know about addiction processes. I do think it is a major health hazard that is happening in the states and because of, people are very lonesome too here. I think there is a connection with the TV and not enough human connections too. So the connections with people is with food too so it's very complex.
I really believe that we need to help to empower them and, so I think it depends, it depend, how they see, some people may see themselves as obese but in a, in a positive way so it depends how they see it, you know so but for some people being obese it may be very negative, the majority of the connotations is negative and health wise it is negative so it depends if it's part of her agenda or not to deal with that.
As a therapist, being overweight, I suppose that the role of sexuality gets a little more hidden so maybe the transference related to sexuality, they are not as apparent in the, in the room.
They open up more so I would say that would be an advantage you know, dealing with males than when you are dealing with any, any, any person that, I think they are less threatened. I think people who are overweight feel less threatened because the sexuality is not as apparent.

How my body size impacts my clinical work…
I do think there is a parallel process between your ability to master a part of your own, like that if you had not mastered that then you have less possibility of helping the other in that area so let's say if I have client and one of her issues is that she wants to work is being overweight, I don't think I can be of major help on that yet because I've been struggling on that.

How my body size affects self-perception…
I think you know, when you are, I am more aware when I am dealing with an eating disorder case, you know, my own identity of being overweight umm when you are dealing with a client that is, she has issues about food and throwing up or anorexia, it leads, you know you that you are, people are observing you and they are.

These are my views on addressing identity in therapy…
I have them only when, when, I'm aware of where the client is so if, if the client brings this issue to the table, I will address it and usually it depends on if they are on their search of identity, you know, for when most of the times when I address it, they minimize it or it's not an issue.

My interactions of identity…
I think I am very positive in my presentation. I am very cheerful and I'm very direct so, I think that I think I come across as a very competent woman.

I feel the word obese is…
I don't know if I would use the word obese. You know this word is interesting for me.
It was interesting; I must say that it felt a little bit uncomfortable to respond to that word obese. Your questionnaire, thanks to my boss that send it to me, and she was the one who said to me, [name], she identifies me as obese, that's being a woman, I don't, so it was interesting for me to see that other people see me as obese even though other people don't see me as obese.

My experiences with microaggressions and/or blatant comments are…
Yes, with colleagues. This happens all the time.
It has happened with colleagues and I pretty much, I had let it slide and then I had process with the one who was supposed to be my supporter and also did not address it and then we had processed that together but I, the most blatant type of jokes or something that, sometimes I had to verbalize my different views from what they shared socially, and it was pretty much, what I had achieved, it was pretty much pushed away from, it was not a good result.
Let's say being taken seriously in a professional environment, an accent also works against you. Let's say in a phone interview, it works against you or in a meeting, they just disregard you, and those are microaggressions that happen.

Figure 4. Individual depiction of Monica's experiences as an obese Latina therapist.

Lupita

Lupita's Story

My views and experiences on identity as a Latina…
If I'm in a professional setting or in a university setting, I identify myself as a Latina and if I am amongst friends or in my community where I grew up, I'm just Mexican you know. If I'm among other acquaintances or people I know or even family, you know I'm Mexican American or with some family members you know, especially those in Mexico, they don't see me as Mexican, they just see me as American.
There are so many layers of identity you know everything from you know, being mixed, you know just certain races, to indigenous roots, to how people identify you based on the color of your skin or eye colors or hair texture. I think it's so complex and it's complex and it's you know very dimensional.
Especially working with Mexican youth, and youth were you know sometimes we have brought up thinking about our ancestors and helping them see that in themselves as a form of resilience and strength.
Being a Latina woman or being a Mexican woman, I feel like, I think that maybe I understand more of the experiences or understanding the cultural pieces and values then I feel like that impact you know, maybe how my clients think about my own competence you know or, I know it impacts my own competence because I am able to connect and understand where they are coming from.
I think working with women or Latina women, I have because I've had different backgrounds of Latino identities, I think for me personally, it has changed my views and maybe some perceptions I've had or some misinformation I've had about particular Latino groups.

you know you can relate you know, you know maybe identify as Latina women or Mexican women or women of color you know and maybe some of the expectations, cultures, society that come in play and so when those things come up, just being able to have a conversation about that and normalizing their experiences.

My views and experiences on identity as a woman…
Women, you know, are strong people and I think as a woman I think we endure a lot of hardships in life including family and umm I feel like sometimes we have more responsibility than men in terms of like just being able to keep family, you know the family together, being able to problem solve issues in the family, taking care of people, I feel like women have more responsibility which is more added stress and in terms of like in society, so like, you know women are valued as less, they are not given the same opportunities even though they are deserving of them and then they are more vulnerable to violence you know and different forms of violence because women are seen as property you know or they want to control them so I just think women are more vulnerable to a lot of violence in general.
I think one is when working with small children, I think I come off as more warm and then maybe motherly-like you know I connect more you know with kids.

My views and experiences on identity as an obese individual…
I feel ashamed of it but you know and maybe that's why I don't necessarily see myself as that or I try to reject that piece of me.
Maybe with women that are not thin or struggling with weight issues or self image issues, I think an advantage is me being confident in myself and being able to say, yeah these are the messages we receive yet we can still be happy and live a healthy lifestyle you know, even if we are not thin or not as thin as maybe our families or society might want us to be so I feel like I could be like, I'm not like a great role model but like a role model with being ok with what you have, the body type you have.
The only other times that it comes in place for me is like when I'm you know shopping for clothing you know, you know I have to go look you know for bigger sizes.
I think it's you know more of an individual case you know like for me, like every time I go to the doctor, everything comes out normal for me so I think like that reinforces my own idea that you know I'm not unhealthy necessarily and so to me I think that maybe reinforced me being ok with my you know, body type.
I think maybe there are different levels of obesity and I think with that comes different risk factors and so I can see how it is a serious like, I guess, I don't know about disease but a health concern.

How my body size impacts my clinical work…
If I am working with somebody that's thin and is struggling with eating disorders or body image issues, I think that you know, I wonder sometimes if clients don't bring that up right away because they might look at me and say, well she knows nothing about this, or you know, or if there is a client that is trying to live a healthier lifestyle and they might look at me and think, well she doesn't know anything about that, you know, or somebody that is trying to lose weight
Once they see me, they might perceive, you know, that I don't understand where they are coming from or that I might even judge them for trying to, you know, work on you know maybe their weight issues

I understand that maybe you know, they might have some challenging views on how they view themselves or how others might be perceiving them or treating them.
The preoccupation or you know, feeling maybe depressed or anxious about it, I cannot relate to that because it is not something that is in my own, I guess, everyday life.

How my body size affects self-perception…
If I am working with maybe women that are struggling with weight issues or they want to lose weight or they are trying to make some changes in terms of their eating habits, then I feel like I am more competent because I have had my own sort of experiences with that and I can relate or I can at least see you know you know understanding where they are coming from and maybe validate their experiences.
I got really nervous about it, because how am I, a heavier woman being able to talk to a young adolescent girl about you know body image issues or you know eating disorders?
Personally I got a lot of anxiety even working with that client you know because, but I know it was more me than the client actually so it was my own anxiety, my competence, will they see me as competent?

These are my views on addressing identity in therapy…
Specifically for one client that was Caucasian, she has very negative views towards Latinos in general because she had a really bad experience, a traumatic experience as a kid and I remember you know working with her and once I, we were able to correct her negative views on how she felt about Latinos in general.

My interactions of identity…
I know for me depending on where the settings I'm in, my identity shifts.
So I think for me the major part of my identity is just being a Latina woman. I think that is the most salient. Like I know that is who I am and I know that's what I bring into the therapy room. I also think there are other aspects of my identity that impact or that might impact how my client see my competence and I think even being a woman, you know I think you know, working with young girls, I think that actually enhances my competence you know because you know they might be, we might be able to relate on women issues and even with mothers.
I think that there has been some maybe more difficulties when I am working with men for example, that are adults and I think part of it is you know because maybe their own views or I know for a while I was working with perpetrators of domestic violence and that was really challenging because you know they were perpetrating other Latina women. These were Latino men so I know that, that, that was difficult for me I guess. I am sure it was difficult for them. Sometimes I wonder like how effective I was being you know a woman and not only a woman but a Latina woman so I think that might have, like I am not sure how competent I might have been in that role, not necessarily because of my skill set and knowledge but just even who I brought in the therapy room as a woman, as a Latina woman.

I feel the word obese is…
People in the medical field call me obese.
I don't mind that you use the word.

My experiences with microaggressions and/or blatant comments are…
No one has ever said anything to me like blatantly for being a woman, for being a heavy woman, at least not in my face or around me so that I could say that I felt it or felt uncomfortable.
I had a client he is a young Latino boy and we were talking about this woman in their church and how she is a very heavy woman and during this session his mom kind of looked at him and she was like, she called him by his name and said , you do know who you are talking right or wrong, his mom is a little heavier too, and he right away looked at he said, I'm so sorry, not you, I'm not talking about you, you know, I said, I understand you know. and he was a young boy you know, like 9 or 10.

Figure 5. Individual depiction of Lupita's experiences as an obese Latina therapist.

Leticia

Leticia's Story

My views and experiences on identity as a Latina…
I think now I have a lot more positive views about my Latina identity.
Both of my parents are Cuban but I was born and raised in Puerto Rico which is one of the last colonies that exists in the world so a lot of colonial discourse I think when I moved here I had internalized a lot of that oppression and believed that the U.S. was either the greatest place on earth.
I came from privileged identities living in a country where I was the majority, I was middle class, all that stuff, and then moving here, I became a minority so I had a lot of initially acculturation umm and it was more assimilation, I was trying to assimilate to the American culture and I was trying to get rid of my own.
Back then I was getting a lot of microaggressions before I even know what the word meant and because again I internalized some of that oppression. I would laugh with people about it. I would put myself down.
I think there are definitely differences in the communication based on Latino nationalities and I consider myself Puerto Rican and Puerto Ricans are a lot more up front and politically incorrect than people from other Latino countries.
We all have internalized oppression too so Latinos discriminate against Latinos.
I live in a city where there is a lot of racial tension and a lot of segregation so when, when other clients come to the clinic that are not Latino because it's a very Latino clinic, there may be tension, like they may not even feel comfortable in the lobby being around all the Latinos.
I think Latino clients, as a rule of thumb but not everybody, tend to respect um like people like a clinicians, doctors, things like that, they tend to hold them up higher in esteem so I think that even though I am a woman, and you know sometimes people may not respect you as much in that identity, I think that they value the fact that I am a Latina and that I made it this far and have a degree and I'm also finishing up my Ph.D.
I also think being a Latina has been a source of strength but has also been painful when working with clients.
I think you know, overall, especially in my work right now working with other Latinos and being fully bilingual, I think it's definitely a strength because I can serve a population that is underserved and that really needs as many good clinicians as we can offer.

My views and experiences on identity as a woman…
I am very aware of identity as a woman, I mean it intersects with my identity as a woman of color but my, I am not the typical woman. I am not very girly umm, I'm more of a thinker than a feeler, I'm very rational, logical, so when I've been in positions of power such as being a teacher, umm, being an instructor at the university, or being a clinical supervisor, I think that people have challenged the way, my message because it's coming from a woman and the way I talk and I carry myself, it's almost like a guy.
The way I do things and talk, I think that if a guy did that, there would be no problem but because I am a woman, it's not always well received because I'm not adhering to gender norms.
Well, I think that I have a positive view about women but sometimes I catch myself with that internalized heterosexism (laughing) and I'm like, oh my God, am I, you know, slut shaming someone or doing things that you know just automatically come to you because that's what we learned.
I am guess you could say, a feminist, although I don't feel like I do enough to have that title.
I think most clients feel more comfortable talking to women than to men and I think that's the case for both male clients and female clients and transgender clients.

My views and experiences on identity as an obese individual…
I talk to people about my own journey.
I don't like being overweight and it's something that I struggle every day and right now I'm trying to lose weight again.
I had lost all that weight, I was so proud of it and had so much hope.
There are definitely genetic factors that impact weight so I do believe that it is a disease but I think that in our country it is a reflection of other social problems that are happening.
There is behavioral component to it but there is also an oppression component to it in particular with minorities and you know, having access to healthy food, being able to afford healthy food, internalized oppression, internalized racism, and you know, all the stresses of being a minority in the U.S. you know, impacts people, you know, health behaviors.
I think it doesn't exist in isolation. It's not just genetic but I think social and psychological factors impact it.
I think it can be strength to talking to clients about making changes and empathizing how difficult it is.
I'm pretty down to earth but I think it might contribute to making people also feel more comfortable when they are with me because I'm not perfect
I almost feel like a sense of safety when I've been more overweight because I don't worry so much working with clients that they might flirt with me or hit on me.
I don't think it affects me as much with clients as it is with peers or co-workers that, that's like a whole other level of injury, because with clients I always try to put it in the context of their problems but with people in my life, I don't feel like I need to put up with that shit.

How my body size impacts my clinical work…
He felt the need to tell me again what he told me… oh wow, what happened to you? and then I saw like, I, I felt like I needed to defend myself because I put on a lot of weight over the last year …but I'm ok, I'm healthy. You don't have to worry about me. I'm just trying to make changes. But then in my mind, I'm like, I don't need explain to this person what the hell is going on with me and I mean, I think it's just a distraction from his problems, too, so, but it definitely affected

me, like my desire to see him again because obviously you don't want to, you know, we had a good relationship before but it created some animosity.
Sometimes I wonder you know, if you dislike this aspect of yourself so much, you know, how might that be affecting your clients who are overweight or who you know, maybe I don't even realize it and you know judging them on some level.
I guess I am more self-conscious and that may, may be make me more careful about things when I'm working with clients now that I'm more overweight.

How my body size affects self-perception…
I work at a primary health clinic so sometimes when I talk to people about their health I may become hesitant about it because I'm think oh my God, am I being hypocritical? Because I'm not taking care of my health but I am taking care of my health.
But sometimes I worry that oh my god are they thinking, what the hell is she talking about? She's fat or you know, it's in my mind.
Being overweight, it just adds to that judgment that I'm very hard on myself
I really flat out try to stay away from working with eating disorders, period. That's been an area where I try not to get experience in or further training because I feel again, like an imposter.

These are my views on addressing identity in therapy…
It really depends on what their presenting concerns are, so I try to focus on that and then utilize their other identities as a source of strength for them, you know, oh and also to acknowledge too the difficulties in holding those identities.
Sometimes I talk to clients about you know, being a woman and the expectations and how that might relate to their presenting concerns or being Latina and their expectations as Latinas or Latinos, you know, like being an immigrant if they are.
In terms of the, the obesity part, I think that that's a shame, like I don't really have many clients that have proudly called themselves obese so I don't think that gets talked about as much and again that might be my own uncomfortability with the subject.
I think it has definitely evolved over the years again as I learn you know different, I've learned to look at things though different lenses so I think I am more affirming now.

My interactions of identity…
I think before a few years ago, where I was somewhere else in my ethnic identity development perhaps my ethnic identity was not as important in my personal life or in my role as a therapist but where I am at in my ethnic identity development I think that it's salient everywhere
I would say maybe my more privileged identities I'm not as mindful of them in my everyday life versus maybe like my marginalized identities might come up more in present day life even when I'm outside of the therapist role
Sometimes I don't think about middle class so much because it is a privilege so it's more like a standard thing I don't have to think about in my everyday life but when I'm in the therapist role I have to be more mindful about it.

I feel the word obese is…
I hate that word obese.
We were doing some work with some African Americans that, that was also an issue, using that word that some people prefer overweight or other terms.

I have been considered obese a few years ago for maybe two or three years and then I lost weight again and then more recently the stress of my doctoral program in the last few years, I've gained a lot of weight so I would consider that I fall under that category now so I, I have a distinction of how maybe things are different when I have been at a lower weight versus how they are right now.

My experiences with microaggressions and/or blatant comments are…
I've had clients come in, maybe white clients, these fucking Mexicans or these fucking Puerto Ricans, and I'm like, what do you think I am? Like they don't realize that I'm one of them you know?
that color blindness but you know that mentality of "but you are one of the good ones."
I've had to endure microaggressions when working with clients about my ethnicity, well intentioned comments that definitely were not helpful to me but were very painful at times.
The boundaries in communication are different so this Puerto Rican client umm told me, he told me in Spanish so I'm gonna kind of translate as best as I can so he came in to see me after not seeing me for like a year or two and then he's like, Oh my god [name]what the hell happened to you? you look so fat, you let yourself go.

Figure 6. Individual depiction of Leticia's experiences as an obese Latina therapist.

Carmen

Carmen's Story

My views and experiences on identity as a Latina…
I think for me it's being a biracial woman. So I'm primarily in the American culture but I'm also very close to my Hispanic side of the family.
Where I grew up, it was really small, primarily White town so it was never really safe to kind of be anything but White until I don't know, maybe 5 or 6 years ago when I went away to college and then I could really start delving into my Hispanic roots so that Hispanic part of me has become even more salient in recent years.
My initial views were obviously formed by my close family and then by some media influences but as I'm getting more exposures to different kinds of people from different areas, it's helped create a wider view of the Latina identity and everything that entails and different struggles that some of these women are going through but also some similar to mine.
I view them as like being very, very passionate, emotional, I also think that Latinos are very hard workers and very stubborn.
Well last year I had the opportunity to work with a lot of Latina clients and I think that even the way that I look has helped connect with me more than they might have if they were working with a completely European American therapist.
I've always wondered with my last name, it's a Hispanic last name, and so I've wondered with clients, will clients in the future come to see me just based on my name and expect that I will be able to give them some sense of their own upbringing when I probably won't because I was raised in the American culture and because I'm biracial.

My views and experiences on identity as a woman…
For me, I think it changes depending on the situation because at home, it, I, my Hispanic or White part of me doesn't really matter because I become a daughter, and a granddaughter, and a sister
I view women as incredibly strong and independent and I think that when they need to, they do just fine on their own
I also believe we were created for relationships and to be in partnership so I don't think we're meant, that most women aren't meant to, to stay alone and do everything by themselves
I've found that most of my clients feel pretty comfortable talking to a female therapist and I, I think it might be because it's a stereotype that females are wanting to talk about emotions and feelings anyway so maybe they're not so surprised when I keep getting them to talk about their feelings

My views and experiences on identity as an obese individual…
I don't look at it negatively because a lot of the times, the obese women I see are the mothers and in the apartment complex I'm in, I see them taking care of the kids all day and that to me is such a noble thing, so it's not like they are purposely not healthy, they are just doing something that's so much, that is so important.
I think there are some genetic predispositions. I also think it's a lack of education about nutrition and just not ever making the habits to maintain healthy eating because I know that when I'm busy, sometimes it's a lot easier to pick up fast food on the way home from
A lot of the Latina clients I see are overweight so I think it's actually kind of helped them to feel more comfortable, maybe helped them to think I'm not going to judge them.
Well somebody coming in with a negative bias towards obese people in general, they may find it hard to connect or they might be feeling, angry at me for not taking better care of myself.

How my body size impacts my clinical work…
I was working with this, a patient, who was struggling with anorexia nervosa, and I think for a variety of reasons, it was just really difficult to connect with her.
I guess because she couldn't get past my weight and how could somebody like you help me because I had never been in her situation neither but I don't know, it was like anything I tried to do, I was met with kind of skepticism and so I didn't really feel like I went anywhere in our relationship or even progressing through anything. I don't think it helped her at all.
Well something that I've thought about actually because I started this practicum last year. It was interesting because I swear ninety percent of my clientele were thinner females and (laughing) it was really interesting because I don't know if it was done on purpose or not.

How my body size affects self-perception…
It was nothing overt that she said about my competence but it seemed like there was an underlying, Are you sure you know what you are doing? Because I also didn't feel like I was helping her either.

These are my views on addressing identity in therapy…
I don't normally talk about my identity with clients but I remember one case in particular where I was even just talking about where my Dad was from in Mexico and talking a little bit about background because I don't know, I could tell that she was nervous and everything and then she

was talking about she was worried about her own parents, deportation issues, so it helped her open up but most of the time I don't on a client by client basis.

My interactions of identity…
Being a Christian, a daughter, a sister, being in a relationship and having a significant other, I think all of these things have impacted my understanding and my empathy for people who are also in these types of relationships or are going through certain struggles you might go through as you identify in these different parts.
When I'm at church, it doesn't really matter what my race is, I'm a volunteer and sub-care provider so yeah I think it really is situation dependent for me.

I feel the word obese is…
I know that I am technically categorized as obese but a lot of time I don't even see myself that way and so, like I know that I weigh more than what is quote unquote healthy, while I am striving to be healthier, I also don't feel like I look like other people who are obese so it's this weird, I don't know. It's a weird dynamic.

My experiences with microaggressions and/or blatant comments are…
It hasn't happened to me.
I would probably just try to stick to my training and say well I've been trained in this and I know the information about this and I know the resources to go to get this information to be able to talk to you about these things and if they are still making comments or having reservations, I would want to ask them more personally of what is going on for them in their life to have them reacting to me in this way because you know in my mind, it becomes an issue of transference, you know, what is going on for them.

Figure 7. Individual depiction of Carmen's experiences as an obese Latina therapist.

Raquel

Raquel's Story

My views and experiences on identity as a Latina…
I like working with Latinos. I embrace that side of my identity although I'm half Mexican, I still you know, I don't necessarily specify that to people when they ask, you know, are you Latina?, I just say yes because I embrace that side of my identity and I am proud of that.
There are people who are racist that because I have, am a Latina, question how intelligent I might be.
Other like, professionals look at me differently as opposed to how my other clients, sorry, my other colleagues umm Caucasian, how maybe they get viewed by people and I am not, I am honestly not sure if it's because of the fact that I am Latina, I am not sure if it is that or because I am still working towards being a fully licensed therapist and so they just think that I am not qualified in general. It is kind of hard to tell.
Specifically about being Latina, there is not a lot of non-White therapists in the area where I live so the few clients that I have had who were Latino, I think they felt more comfortable working with me, especially if some of them were describing experiences with like discrimination and I

think they felt that I was more receptive to hearing that than maybe a non-Latino therapist would be.

My views and experiences on identity as a woman…
There is of course just sexism that women aren't as intelligent.
In general, I feel women are just as capable, intelligent as males. They deserve the same opportunities. I think there are still a lot of sexism, maybe covert sexism, or blatant that women aren't aware of.

My views and experiences on identity as an obese individual…
I think in general some people just look down on, on people that are overweight.
In general, I think obesity has, it's an issue that probably has various different causes and factors that go into that but I think in general a lot of people will think that laziness is the reason and I don't personally feel that. I feel that it is a disease and again there is a lot of factors that go into it. I feel like it's you know not as easily solved as people who maybe aren't overweight think it is. Especially for individuals who are struggling with their weight, you know it can be helpful to, or less awkward maybe to talk to somebody who obviously is also overweight, about their issues.

How my body size impacts my clinical work…
I think for some people, they look at me and they see somebody that is non-threatening, especially individuals, I think individuals who themselves are overweight find it easier if they are talking about issues related to their weight that they are also talking to someone who also looks similar to them as opposed to someone who doesn't have a weight issue.
I think it helps put them at ease and makes them feel like I can understand more where they are coming from.
Attractiveness has been found to be one of the most important factors to influence how clients perceive their therapists as far as competent to building rapport. I work with a lot of young college students and I think that many people, at least initially, look at me and probably don't find me very attractive to their standards and so maybe that might, they might feel less, like I am less competent.

How my body size affects self-perception…[question not answered]

These are my views on addressing identity in therapy…
I usually won't necessarily bring up the differences in our identities but if clients do, I am fine to address them umm and I usually just try to keep them like short.

My interactions of identity…
I guess the most salient part of my identity when I am in the therapist role is just a human being that is there to listen and try to help the person.
At times I've felt like my identity as being obese, Latina, and a woman has definitely caused some clients to maybe look at me differently.
I feel that those aspects of their identity can put them in a position to face a lot of discrimination. In general, obese people are discriminated against, you know, Latino and women so having those three all together, I think puts them possibly at an even disadvantage in some ways. I can relate to

what they are experiencing and understand some of their struggles, so I think that that is helpful when working with them.
I think my identity has helped me to be more competent in some ways. I know that I am, I feel that I am more, I try to be more multiculturally sensitive to people in general than maybe some of my other colleagues that I have worked with because I know that it can be you know upsetting if you know someone isn't sensitive to your different aspects of your identity or your culture.
I think since I started working in the field and also gaining the higher education towards becoming a therapist in some of my classes, the multicultural aspects, my program really puts and emphasis on being aware of multicultural sensitivity and understanding your own identity as a counselor and any bias so I think I am just more aware in general now, more self-aware but I don't necessarily think anything has changed a great deal. I think I just pay closer attention now. I am still trying to find that balance in my professional therapist role, that balance of professional and personal so that I can be as authentic. My authentic self in session with clients while also still, you know, being professional. But for the most part I am, it's not too big of a difference between personal and professional roles.
Definitely, I think my age has an impact on my experience with clients. I'm in the age where I am old, kind of old in the eyes of my adolescent college age clients to where they are like, oh she doesn't know because she is old you know, but definitely I have some older clients that see me, I think as inexperienced and you know, too young to have a lot of life experience.
I do have my arm sleeved, like covered in tattoos and too small, two small lip piercings and I'm lucky that the place that I work doesn't require me to cover up my tattoos or piercings so I have definitely had, those are probably two of the, or my physical appearance has definitely had a big impact on my experience with clients in both good and bad ways. I've definitely had clients look at me and sort of, you can see them like scanning up and down my arm and, and wondering like, did she get her degree you know in a prison class or something and then on the other hand, especially with the young adult clients and a lot of the substance abuse clients, my tattoos are often, you know, a talking point that helps build rapport.

I feel the word obese is…[question not answered]

My experiences with microaggressions and/or blatant comments are…
I have had, there has been a few times where I've had court ordered clients that may have left my office that were upset because of my recommendations that they do treatment or whatever and I just, I am pretty sure they were thinking something like, oh that fat bitch, you know, she doesn't know what I am talking about, or it just, some people they look at you sort of with the look of disgust almost sometimes that I think even though it's, it's probably ignited because they are upset with what I am saying, I think that they automatically go to the easy target, oh she is overweight, she is unattractive, or whatever.
I've definitely had a few male clients that tried to intimidate me because I was a woman like try to use anger, hostility to sort of get their way or as a form of resistance. I've had guys say things like, well if you make me come back for treatment, I won't be very nice because I don't want to, or you know, it would scare you if you saw me get upset, and I used to be a lot more timid and sort, I was intimidated but I've sort of learned to stand up for myself more.
I mean I've also had clients who've made disparaging remarks about Mexicans or illegal immigrants and it definitely gets interesting because sometimes you, they will say something and

it, as soon as it comes out of their mouth they can kind of see the wheels in their head turning and they are like, oh crap I probably shouldn't have said that.
You also get people that are much thinner or in much better shape and they will comment on how fat they are and need to lose weight and it can get, for me, I think, and for them too it gets awkward because you know they'll say something or they're describing their friend and they're like, she's a bigger girl and, I am sort of sitting there wondering, well what do you think about me then?
I guess the one that comes to mind that sort of fits is that I had a client once who umm had substance abuse issues and he wasn't supposed to be drinking alcohol and so I was asking him if he, if he had drank while he was away, like working for a week, and he said, well I was with Mexicans, of course I was drinking, they're always drinking….and so I, as a joke said, "yeah I'm drunk right now" and just sort of tried to use humor and luckily he you know we had enough of a rapport that he kind of laughed and you could just see he was like, yeah well sorry, you know, he kind of embarrassed him.

Figure 8. Individual depiction of Raquel's experiences as an obese Latina therapist.

Gloria

Gloria's Story

My views and experiences on identity as a Latina…
I am very positive about the Latinas you know in the sense that we are very dedicated to families, as women, we are very dedicated to families and so we came to the United States or we are part of the generation that we want to do good and to not only to do good but to do the best for our families.
I think umm our identity as Latinas you know is an, it's very, very tied to roots and cultures. Values with having family values and also our identities are very tied to the part that we are part of very collective society.
A professional woman in the community and you know it's a role model to others.

My views and experiences on identity as a woman…
Women really trying to do the best of the home and their families.
Client to client, for example, if it's a male, I feel suddenly that they are questioning my competence because I am a woman.

My views and experiences on identity as an obese individual …
You know I can see I will say that it's a sense of insecurity in myself. I feel like I'm missing something or like I will say that I feel insecure about my own presentation, physical presentation. I experience bias about obesity. Me, myself. The part that I feel that I give myself you know that yes, it is me, I have this problem, me, I am very aware of that, makes me very aware of other people too.
I feel that I can, that I can empathize with them very easy and their struggles because I struggle the same way. I can empathize with them but I see them as people that they are, they are trying to do their best for their life. I can see very definitely, you know, in the middle of this situation, in the middle of the situation that they are facing, they, they are heroes, they are champions you

know, trying to lose weight, or controlling the environment, controlling everything that is around them, trying to use the systems in a better way to do better in their own life.

How my body size impacts my clinical work…
This is really, what makes me so aware of my body and that you know is more than anything that I am trying to, to be as a good role model for my clients and you know they are, in the area, well I can be, you can be, you can try to find your own goals, you can do this, you can be positive of the changes that are coming, you can do it, you know, and this is for me, yes I am trying to promote that and here I am trying to promote that better lifestyle to my clients and I don't feel I am doing good in that area of my body.
If I see a client that is extremely skinny or, I would, that maybe fitness or athletic body, I feel hmm you know, I have to figure out how to work with my own awareness of my obesity.

How my body size affects self-perception…
Well I would say my way to perceive people around me is a continuous change, you know, it's a continuous challenge to review my own, when I started doing therapy, I was so skinny, you know, like everybody else or even more. I was not obese when I started doing therapy you whether you know I am the other size you know, I am obese, yeah. I think the fact that I was not obese and now I am, it helps me to understand better my clients, I felt very confident about my body when I was skinny and fitness, you know. Now I feel also comfortable in my body. I feel comfortable in my weight-average clients but I am very aware of that. And even I use that in therapy, I can say something like you know, when somebody mentions about, well I am struggling with weight or something like that, I can say, well it looks like we have something to work towards.

These are my views on addressing identity in therapy…
I explore with my clients how my gender or whatever about my identity could affect them, that I would like to talk to them about that you know or for example, if they are clients that are, the first language is English, I will address my accent with them, say what about talking about the problems you have in relationships because my accent and we talk about that. I start with them how it could impact the treatment and we talk about that, this issue definitely, the first session.
I provided services in an emergency situation that I needed to take care and I arrived there and in this office, well its not my office, I arrived there but the chairs were very, well definitely they were for a fitness, for a fit people you know, and I realized that I sat in the chair and I was ok in the chair but I realized my client did not fit very well in the chair. The chair was really small for my client, really small, and I say that the arm chairs, you know, they were there really, and I felt uncomfortable for my client, I felt uncomfortable for my client, I was ok, I did not feel uncomfortable in my chair because I am very aware, very aware of body size, you know, and immediately my reaction was to, to make a comment about the chair, since this chair is not really what we need here, and she told me immediately, she started connected with me with that comment, she started making comments about how she goes on the airplanes and how, I realized then in the moment that my comment about no awareness of people when they put chairs in the offices, you know, that helped me to connect with the client immediately and we had a wonderful time.

My interactions of identity…
I would say, for example, I can see that for the Latino population when they see me, they prefer somebody that is not too young, that they can come, that they can be more comfortable, that more experience, something like that. It seems like that is part of the, it's a good thing that I am older than some of them or at least I am the same age as some of them. That is good being connected, I can feel this is good for my relationships with my clients, it's about age, for example, in the other side, when I am working with Latino clients and they are males, I can feel they are very aware I female.
I am very integrated in my identity and my approach. I think everything is a part of me but I don't see, I don't have any special, or something to say, well maybe because I am a woman or my age or maybe because, I don't really think of it that way.
I think that I can connect easily with some of the clients, women clients, for example, I can do that very easily. However, I need to be more aware that for men it can be more difficult to connect with me just because of the gender issues.

I feel the word obese is…[question not answered]

My experiences with microaggressions and/or blatant comments are…
If I have client who is 60 years old or 70 years old and he thinks he is coming to therapy and oh you are too young for me or something like that.
In my waiting area, I can hear a man tell another man, I came here to see this woman! But it's more about my gender than about my weight or anything like that.

Figure 9. Individual depiction of Gloria's experiences as an obese Latina therapist.

Irmalinda

Irmalinda's Story

My views and experiences on identity as a Latina…
I think very positively of the Latina and Latino community.
I identify as Chicana first and foremost and I feel like you know, being Latino or being Latina in the United States is very again complex. I think it is very complex because of our issues around race. Issues around race is you know, we are mixed, just like you know, there are multiple races within the Latino community and I think you know, I grew up as first generation here in the United States. Both of my parents were born and raised and Mexico. So I feel like you know I have really a lot of my identity has been shaped by being a woman of color trying to fit into like you know, White, you know European beauty standards, you know, American beauty standards and roles of what is successful and what is normal and all of that.
I think its helped them again, I think in overall with my Latino clients, I think it has helped them find connection with somebody who mirrors, who provides that mirroring of them, somebody who looks like them, I think like with folks who umm, in my private practice, I also have Latino clients. Umm and they specifically like sought me out because there is a grand majority of therapists in private practice are White and yes I think I get it from my ability to have a space where they felt like there is somebody who at least understands some aspects of who I am and you know there is some connection.

My views and experiences on identity as a woman…
I think being a woman, you know a lot, you know, I get this a lot from gay male clients or bisexual clients who are male they feel like they are going to receive more understanding so they purposely sought out somebody who was female and I feel with other females, they feel they can relate, they can relate or they are going to find ways to connect to me because I am female.

My views and experiences on identity as an obese individual…
I can say on certain days I am really you know ok with my body and on other days be like, I hate my body.
I know for a fact you know, even if I lost so much weight, I would never be, you know, and there is where I say heredity also, like as, I would never be thin, you know, that's not my body structure.
My main concern is like health and to me, being obese is not necessarily equate to being unhealthy.
I think there is this general perception that you know, at least again, I don't know what it is like in other environments, but there is a lot you know, focus on being healthy, there is a lot of focus on being fit and if you are not quote unquote whatever that definition of fit is, if you're not quote unquote um you know average weight or thin, you know there is some kind of you know, psychological problem with you, and, and then here you are you know, practicing therapy.
I think in general I have looked at it as very complex you know, I think that on the one hand like you know, there are different factors that play into it, there are hereditary, there is our food, there is, you know, all these different contributing factors. I do think that sometimes, not all the time, but I do think sometimes it is directly related to mental health. Sometimes I think we don't, it's like what came first? Are you, you know, obese and then become like depressed or are you depressed, you know? At least I can say for myself that, you know, I definitely feel like depression has contributed to my obesity, as has you know, lack of resources, you know, growing up, I was really impoverished, we didn't have access to great food, we didn't have access you know and so to things like you know Whole Foods or you know that markets that people go to, to buy the really awesome you know organic stuff. You know we bought stuff that was cheap and things that can be stretched and so I don't tend to look at obesity or you know whether it's you know other people as like, oh my god!, like how is that person doing that to themselves? I think it is a really complex and sociopolitical situation like in the or you know and the fact that you know there are a lot of reasons you know, why folks eat and there is a lot of lack of resources, there is a lot of lack of education around food, there is a lot of lack of education around or access to different kinds of food and I do think you know, again like I was saying that mental health plays a role into it.
I think that as a woman, clients you know I think certain clients are, feel more at ease disclosing certain things. One like I said earlier, being obese and being a woman, I think a lot of my female clients feel a lot more at ease to discuss body issues and body shame and you know struggles with weight.

How my body size impacts my clinical work…
I think that sometimes it has made some clients uncomfortable. I think like you know, the reality is that some people are uncomfortable with people who are overweight and I think sometimes definitely, my body weight has made some clients uncomfortable.

I feel like the advantage is before being like my weight, some people feel they can bring up issues around body, especially in working in the community clinic where there is a lot of Latinas and you know, majority of them are either overweight or obese, I feel like there is like much more easy disclosure around like, I am really struggling with this and you know, I am really like struggling with food or with my body or whatever and it seems like in that sense like people will almost feel like they connect with me in that way
I was telling her that in this period of like, you know, that I have been losing weight, all my clients who were hyper focused on it, it was really uncomfortable because I think somebody who you, I identify as fat positive and I was really trying to lose weight at the time because some health issues really came up around me being prediabetic and just trying to manage that and I didn't want to send this message that like, you have to, in order to be healthy, you have to be, you know, thin, and it became more where, my clients never commented on stuff before around my body, maybe my tattoos, I have tattoos. Other than that, it wasn't like they would make comments about my body but it was very obvious when I started to drop a lot of weight, especially when I was at 347 and started dropping weight, it was a lot of comments around, wow you look so great! You are doing so good! Blah blah blah like things like that, so that was really uncomfortable.

How my body size affects self-perception…
I have my own internalizes issues around my weight and my body but I can't say that is specific to other people.

These are my views on addressing identity in therapy…
Yeah I definitely always name the difference, you know if we, you know something comes up where clients are talking about race and you know it is a White client, we will definitely talk about you know what it is like in the room to talk to a therapist who is of a different race. Or what it is like to talk with a client of a different gender.
Clients who have brought up issues around weight, whether positive or negative issues around weight or whatever issue it is around weight, you know I have always brought it up you know as how uncomfortable it may be, you know bringing up the issue around this difference or you know what it is like you know, sharing that information when you know you obviously see me, and you know either I you know, I resemble who you are talking about or I resemble something you are fearing or discussing so what does that bring up?
Probably the one thing I always talk about or have more caution in talking about is my queer identity.

My interactions of identity…
I think that being a person, a woman of color is always in the room, so whether it is like something that is spoken or unspoken, it is always in the room, like that's just who I am and I can't necessarily put that out of the room. The same way with my body, like I can't necessarily hide that aspect. I can definitely, somebody who can pass, so somebody may not know my sexual orientation.
I identify as a feminist mujerista, specifically the word in Spanish, and umm so I am very, I feel very, very empowered as a woman, I am cisgendered, and so I try to kind of look at the ways, see there is a lot of cross sections and intersectionalities for me, you know like I identify as Latino, fat, Chicana, queer, cisgendered, fem, and there is a lot of complexities so it hard to compartmentalize all of them because they all intersect.

I feel like very empowered around my different identities but they ebb and flow and you know being part of a different system, you know, one that tells, you know, where there is sexism, where this is you know racism, where these is you know fat phobia and ideal images of body and there is you know homophobia and all these different things and you know I am part of that system and so yeah I experience moments and times when I feel really disempowered.

I feel the word obese is…
I don't really care as much. I don't normally say obese, I say fat, I say different things like I am really fat positive but I'm not like you know, I never like, I don't take offense to the word obese or anything like that. I think it is more a medical term.

My experiences with microaggressions and/or blatant comments are…
So just as far as with my peers, there is sometimes is kind of like, there is a judgment, like sometimes I know it is perceived but sometimes I know it is there, and it's hard because I think sometimes at conferences, there is a lot of talk around like food, there is a lot of talk around, oh I need to lose weight, usually these are folks who do not have weight problems and that, I will be honest, it always makes me uncomfortable because I am like, oh my gosh, just like skinny you know person, or average weight person is talking about needing to lose weight then how, how does that reflect on me? And a lot of times when we do clinical case consultation and they are describing the client and say that client is obese, it's usually not in a very, it's never in a positive light and so I always have to think about, like to me, I wonder what my peers are thinking about then me.
I definitely think that being Latina, I think when I am working in non-Latino environments, I have definitely experienced that folks will question me a lot more around my expertise and my experience, you know, I feel like I am questioned a lot, you know, sometimes in the White community, as a Latina therapist.
It's interesting because of the dialogue that will sometimes come up in private practice which is a lot around like either clients talking about folks that they know in their lives or not necessarily obese but overweight, or they themselves are gaining weight, so it's really interesting how that will come up you know but then you know as a negative but yet their therapist is like obviously obese so it's kind of like a weird dynamic.
It has come up with my male clients like they will say things like, oh like this is a guy thing, or yeah I have the experience of stuff like that, like you might not understand this, and usually I talk about what does that kind of like mean you know, first of all, what is it like for them to kind of assume that I don't have this kind of understanding around it and then I also kind of you know kind of hold that space they are talking about. But I also go a little further and let them know, you know, just because of my life experience and my work experience, I have a certain level of knowledge about you know, what they may be talking about, I may not know everything they are talking about, I may not know all of that but I may have a certain level of knowledge or experience in that so you know, if somebody says something like you know, I had a client who said a lot of sexist things and again it was holding the space in the room to really talk about like, where was that coming? What was it like sitting in the room with me?

Figure 10. Individual depiction of Irmalinda's experiences as an obese Latina therapist.

Exemplar Depiction

Choosing an exemplar depiction was actually quite difficult. I had several to consider from participants who, to me, felt more open in their responses compared to the rest and therefore, gave me more data and information. I chose Bonita as the exemplar depiction for several reasons. She was one of the longer interviews and I felt she was one of the most excited to participate in the study. While she had some experiences that were unpleasant, she spoke with such humor and life throughout her interview. She exemplified the strength and pride of being Latina and of being a woman that I felt were discussed throughout the interviews. She also understood, acknowledged, and discussed the complexity of systemic issues, internalized negative messages, and some self-acceptance regarding body size.

One of the difficulties with choosing Bonita's story as the exemplar depiction was that she did not address any issues with the word *obese* in her interviews. However, I spoke with Bonita for almost 20 minutes after her interview which was the longest follow-up call after completing the interview from all the participants. I took these experiences into account as well when making the decision about the exemplar depiction. With Bonita, she still had views and experiences to share and one of the things we talked about was the lack of research for this population. Bonita stated she had never seen anyone address this specific intersection with identity. We then had a discussion about the use of the word *obese* and she stated she did not normally use that word to describe herself but also said that it did not matter what word is used. She further explained that

any word would eventually get a negative connotation due to the negative attitudes that people have overall towards obese individuals.

I felt that Bonita's experiences with microaggressions were similar to others. She also discussed more of what she would do if someone did say something offensive to her. I felt this was representative of other participants. I also believe she explored not just her intersection of identity but also her interaction of identity in how she used her different identities to show up in her professional life. One area that stood out was when she discussed code switching. I felt this was implied or somewhat stated by other participants but Bonita was able to identify it more clearly. Overall, I believe she was the best single example to represent this sample of participants.

Bonita

Bonita's Story

My views and experiences on identity as a Latina…
I'm Cuban and I love my culture. I love everything just about everything about it.
I'm more aware of my Latina identity just because there aren't as many of me up here.
I can to some degree pass as White because I'm more fair skinned than sort of what people kind of expect a Latina to look like I'm very aware that I'm not like them, like I have brown hair, brown eyes, like talk differently from them, don't know all the sayings that they say or like all the colloquials, however you say that word, um, yeah, so I would say those are the things that I notice the most when I go out.
I love a lot of the values that we have like that whole, you know like being part of a group or a collectivist sort of mentality and I love being able, ironically, I love being able to be seen as, oh you're Latina, maybe you're exotic but I also don't like the pressure like the expectation that you are gonna be a certain way because you're Latina.
I also recognize all the systemic and structural sort of oppressive factors that have gone along with that and even within Latino culture, the expectation of women to be the caregiver or be like in a certain role or stuff like that.
I've always just thought of like I'm a Latina therapist as like what I do for a living and obese is just happens to be my size.
If I'm seeing someone who is Latino/Latina or who have come from like low SES, from other racial groups, or really from any racial group, I think in some ways they can, like I can connect with them in some ways that allows me to connect with, to know that a lot of us have struggled.

I feel like not being able to communicate with people clearly or sometimes I need to take a moment to think about what words I'm going to say in that setting or in my mind trying to translate it from one language to the other, I think may lead other people to think I'm not as competent and I don't always feel as competent.

My views and experiences on identity as a woman…
We're awesome! We're strong!
I have very feminist views about women.
I love being a woman minus whatever inequality comes with, of course I don't like that but, I don't know, it's just so powerful to be a woman in so many ways, we get to carry babies, we get to do, we're just built strong when I think of it in terms of our bodies, we are able to sustain like having a child in there for nine months or give birth.
I like that women have become more outspoken and powerful throughout the times.
Sometimes I think kind of like the Latina thing, you are kind of stuck in a certain box and we are always having to break free from that and we're not even the ones sticking ourselves in those boxes.
I had a transgender male to female and she was talking to me and kind of, when she revealed to me that she was transgender, it somehow just kind of opened things up and I felt like she could relate to me a lot more.

My views and experiences on identity as an obese individual…
I'm pretty aware of my size. I'm aware that I'm just bigger. I'm bigger than my friends; I'm like the biggest one of my friends.
Something I struggle with is acceptance, acceptance that it's ok that I'm not like how Latinas you know, quote unquote are supposed to look like or umm sort of having this sexy image and then being petite or like curvy with the curves in the right places.
I think my bias towards myself is that I shouldn't have been this way, I shouldn't have gotten this way.
Where I live there are also a lot of people are really in shape, and so in this environment, especially like even where I work now, everyone is really fit.
I think the fact that I can code switch. Code switching, like whenever, sort of, it happens a lot with minority groups when you are sort of out in public or you are going to be doing an interview and it's in all these White places so you try to sound more White, sort of as your way, it's kind of like your way of really surviving in whatever environment it is that you are probably trying to fit in.
I think it can definitely be biological or genetic or hereditary. I also think a lot of times, systemically, like the foods and how we process the foods and what's available to individuals who may not have the ability to grow their own food or sustain the land to maybe do things more organically, I think just so many ties across SES, your accessibility to resources.
I've wondered this too with being an obese, Latina therapist is that Latinas are supposed to be kind of like caregivers and nurturing and stuff like that and I certainly am that way and I've often wondered if being obese also has made me that way, sort of like I'm supposed to be the really warm person.
I mean if I saw a client who was an obese Latina and obviously a woman because you are saying Latina, but I would be like girl, it's twinsies!

I think in some ways I would think we had some sort of unspoken umm like bond or just like some unspoken commonality between us.

How my body size impacts my clinical work…
I sometimes wonder and think they are going to think of me, oh I'm going to feel really comfortable around this person because I don't have to worry about like what this person is going to think of me because they're fat, like, they have their own issues going on.

How my body size affects self-perception…
Being obese certainly when I've worked with individuals with eating disorders, that has also made me question, am I competent to do this? Like are these people gonna think I'm credible and it makes me think sort of in my own head and question those things.

These are my views on addressing identity in therapy…
I was gonna say I almost always talk to people about my identity but that's not true. I feel like I want to a lot of the times but I sometimes don't. I really just try to judge if it's relevant to what they are talking about or what they're struggling with or when I get some sort of intuition that they may be bothered by something.
I think I mentioned before with a client, with an eating disorder who was really restricting and sort of like engaging in like those over, over exercising, like being really rigid with diet and calorie counting, everything like that, I mean, we had a very fine conversation about what it's like to have a woman who is obese like be across from her and, and in some ways we talked about the commonalities because in the end you're both sort of, they both have to do with being dissatisfied. They both have to do with being like meeting some sort of sense of control or trying to like soothe something or trying to avoid things and so I think in those ways I try to find ways to bring us together.
I feel, especially in those moments when body image or eating concerns are the primary concerns the person is coming in for, I absolutely make it a point, I feel like it would not be congruent with who I am if I did not bring that up, like that would just be so weird to me to not bring up something like that.
I think when it comes to body image or any sort of like eating behaviors or things like that, I've certainly shared with some clients like, in a, it may not always be in the way that I necessarily am self-disclosing but it's sort of like that, like I will say, for an example, like, a client may come in and say, I've had a really tough time with eating and sometimes I overeat and sometimes it can be really hard to control. And I may just simply say like, tell me about it. That must be rough. And just for saying tell me about it, they know I overeat.

My interactions of identity…
I almost don't ever think of my size in there which is really interesting for me unless there is a client who is struggling with something like that, I feel like me as a therapist is just, I've become more aware of all of my identities because I have to be.
The thing about me and my identity as an obese, Latina therapist is that obesity is the most salient, is the most like observable so in my life, so for me being obese is the most observable. Maybe people can pick up the Latina, it just depends but if you didn't hear me talk or you didn't see me or I mean, like if you didn't hear me talk, I was just out wherever, you are going to know I'm big but you are maybe not necessarily know that I'm Latina and you're maybe not going to

know I'm a therapist unless you know I'm in that role for you and so it's, it's hard to not talk about that topic when that comes up.
The only thing I feel honestly is that context, your environment is the most important thing. Like I would have never thought about being Latina or woman or anything because I'm from Miami, I would have never thought about that down there but as soon as I left Miami, that's like all of this has been so salient and every environment I go into depending on who my colleagues are, who I am working with, whatever that, it all depends on who is sitting across from me and who surrounds you, for me, and that's like with the obesity, that's with my identity as a woman, that's with my identity as a Latina.
If I have a male client and they are talking about a lot of gendered stuff, they might not see me as competent and then I think anything could be up for grabs with clients, who knows when they are going to navigate towards what they are thinking about, all these different intersections of our identity.

I feel the word obese is…[question not answered]

My experiences with microaggressions and/or blatant comments are…
I just think that I am more process oriented and so I tend to process it more with the client or bring it up and sometimes I don't say anything. Sometimes I don't say things because it's not therapeutic. Sometimes I don't say anything because it's not the right time or we haven't built up that sort of relationship and sometimes I have to get my own supervision about that or vent or consult with someone.
I had a client who was very aware that I was Latina and that was the first comment she made to me when I was an intern and said, you're Hispanic aren't you? and I was caught off guard because doing an intake with her and being the first time I'd ever seen her and that was the first question to come out of her mouth when I asked her, so what brought you in? and I remember being caught off guard and, and I'm very upfront with my clients, yeah yeah, but I was like, what was behind that question, and she was like, no I could just tell with like your dark features, like with your dark eyes and dark hair and, and your accent and whatever, whatever else she said. It was summertime, it could have been darker, skin tone darker, but I said, yeah I am and so, she, and so in that moment I honestly felt like she just wanted to know she was right in her head part of me wondered well what does that mean for her, like what did it mean for her to have a Latina client. I mean I kind of followed up with that too, like does it mean something different for you to have a Latina client, I mean a Latina therapist? Umm. And she was like, no no, I just wanted to know.

Figure 11. Exemplar depiction of Bonita's experiences as an obese, Latina therapist.

Composite Depiction

The composite depiction was formed in order to display the common themes across all the interviews in one depiction as opposed to all of the individual depictions (Moustakas, 1990). This gives a more succinct view of all the data from the interviews at

one time. The same themes and headings were used that were used in the individual depictions. While making the composite depiction, I tried to use an equal amount of data from each interview. However, it is important to note that some of the interviews were longer than others and there may be a slight skew in the representation being equal of each participant. I still believe this depiction captures the general themes found among the participants.

Composite Depiction

Composite Depiction

My views and experiences on identity as a Latina…
I have a lot of pride for sure. I just love our culture and our heritage; for me it is something that is very positive. It gives me a lot of strength and motivation to keep going. It's something that is very much what I hope to pass along to children in the future. It's something that I celebrate within my family.

My Latina identity has also shifted as the years have gone by. There are so many layers of identity…it's so complex. My initial views were obviously formed by my close family and then by some media influences. As a Latina it makes me more aware of the oppressions of the environment, how you know, governments, how they oppress us, how labels oppress us, access to resources… I also recognize all the systemic and structural sort of oppressive factors that have gone along with that and even within Latino culture, the expectation of women too be the caregiver or be like in a certain role. I'm very aware that I'm not like them, like I have brown hair, brown eyes, like talk differently from them…those are the things I notice the most when I go out.

I think they [clients] feel more comfortable and because I'm bilingual, they're able to really connect in that way. You can relate you know, maybe identify as Latina women or Mexican women or women of color… just being able to have a conversation about that and normalizing their experiences. With my Latino clients, I think it has helped them find connection with somebody who provides that mirroring of them, somebody who looks like them…have a space where they felt like there is somebody who at least understands some aspects of who I am and you know there is some connection.

My views and experiences on identity as a woman…
We're awesome! We're strong! I am very aware of identity as a woman, I mean it intersects with my identity as a woman of color I'm more of a thinker than a feeler, I'm very rational, logical, When I've been in positions of power such as being a teacher or being a clinical supervisor, I think that people have challenged my message because it's coming from a woman.

Women have been oppressed all over the world. There is of course just sexism that women aren't as intelligent. Women are strong people and I think as a woman I think we endure a lot of hardships in life. Women are valued as less. They are not given the same opportunities even though they are deserving of them and then they are more vulnerable to violence.

I think being a female therapist has only helped me in being able to relate to clients. At times when there are trauma histories or issues with family, being a female is something that facilitates my work with them [clients].I think most clients feel more comfortable talking to women than to men and I think that's the case for both male clients and female clients and transgender clients.

My views and experiences on identity as an obese individual…
I'm pretty aware of my size. I'm aware that I'm just bigger. I can say on certain days I am really ok with my body and on other days be like, I hate my body. I personally have a lot of shame with obesity. Code switching, it happens a lot with minority groups when you are sort of out in public or you are going to be doing an interview and it's in all these White places so you try to sound more White. It's kind of like your way of really surviving in whatever environment it is that you are probably trying to fit in.

I think it is a really complex and sociopolitical situation. I think in general some people just look down on, on people that are overweight. I think the message that's pushed out there that we're lazy, we're not exercising enough, or we are gonna get diabetes. Why don't we just get on the treadmill or stop going to McDonald's? I do think sometimes it [obesity] is directly related to mental health. I do think there is this systemic issue linked to obesity and I even grew up below the poverty line for most of my life and I think just being limited, my parents being limited to what kind of food they could afford really impacted how my development and now me being obese because I have been for all of my life.

The experiences with my colleagues, I realize I get a lot of advice, even if I don't want it. What is the latest trend? How I can lose weight? I guess my assumption has always been we are peers, we are clinicians, you are not going to bring that up but how permeated it is in our society that because I'm obese then I must not move or I must not eat healthy.

A lot of the Latina clients I see are overweight so I think it's actually kind of helped them to feel more comfortable, maybe helped them to think I'm not going to judge them. I almost feel like a sense of safety when I've been more overweight because I don't worry so much working with clients that they might flirt with me or hit on me.

How my body size impacts my clinical work…
I was working with a patient who was struggling with anorexia nervosa, and I think for a variety of reasons, it was just really difficult to connect with her. If I am working with somebody that's thin and is struggling with eating disorders or body image issues, I wonder sometimes if clients don't bring that up right away because they might look at me and say, well she knows nothing about this.

Sometimes I wonder, if you dislike this aspect of yourself so much, how might that be affecting your clients who are overweight? Maybe I don't even realize it and [I'm] judging them on some level. If I have a client and one of her issues is that she wants to work on being overweight, I don't think I can be of major help on that yet because I've been struggling on that. I've noticed clients sometimes struggle talking about their biases about overweight people because I'm sitting right in front of them.

I sometimes wonder and think they are going to think of me, oh I'm going to feel really comfortable around this person because I don't have to worry about like what this person is going to think of me because they're fat, they have their own issues going on. I feel that at times it's kindred spirits and I feel like there is something that is an underlying connectivity between us. I actually have a client right now who is an obese Latina woman and I tend to feel more comfortable in session with her just because we share those aspects of identity.

How my body size affects self-perception…
Being overweight, it just adds to that judgment that I'm very hard on myself. Of course I do feel hypocritical when trying to do a behavioral activation plan and that includes eating three meals a day when I don't always do that myself.

Being obese certainly when I've worked with individuals with eating disorders, that has also made me question, am I competent to do this? Are these people gonna think I'm credible? It makes me think sort of in my own head and question those things.

It was nothing overt that she said about my competence but it seemed like there was an underlying, Are you sure you know what you are doing? Because I also didn't feel like I was helping her either.

These are my views on addressing identity in therapy…
I think I do it since day one, from our first individual meeting. I definitely always name the difference; you know if something comes up where clients are talking about race and you know it is a White client, we will definitely talk about what it is like in the room to talk to a therapist who is of a different race. Or what it is like to talk with a client of a different gender.

Specifically for one client that was Caucasian, she has very negative views towards Latinos in general because she had a really bad experience, a traumatic experience as a kid. We were able to correct her negative views on how she felt about Latinos in general.
In terms of the, the obesity part, I think that that's a shame, like I don't really have many clients that have proudly called themselves obese so I don't think that gets talked about as much and again that might be my own uncomfortability with the subject.

I had this woman who umm had given birth and was experiencing symptoms of post partum depression and a lot of that was centered on her physical appearance and her ability to drop down to her pre-baby weight. In that sense, I just asked her, what is it like to have this kind of conversation with me who I'm a fuller woman? What assumptions do you have about my life? What do you think I might think about you in terms of your desire to lose weight?

I think when it comes to body image or any sort of like eating behaviors or things like that, I've certainly shared with some clients; it may not always be in the way that I necessarily am self-disclosing but a client may come in and say, I've had a really tough time with eating and sometimes I overeat and sometimes it can be really hard to control. And I may just simply say tell me about it. That must be rough. And just for saying tell me about it, they know I overeat.

I provided services in an emergency situation that I needed to take care and I arrived there but the chairs were for fit people and I realized that I sat in the chair and I was ok in the chair but I realized my client did not fit very well in the chair. I felt uncomfortable for my client and immediate my reaction was to make a comment about the chair, since this chair is not really what we need here, and she told me immediately, she started connected with me with that comment, and we had a wonderful time.

My interactions of identity…
I know for me depending on the settings I'm in, my identity shifts. Where I am at in my ethnic identity development I think that it's salient everywhere. At times I wonder because I look Latina, that's a pretty visible identity of mine; so in the first intake session, I worry that people won't think I'm competent, that they won't think I'm smart enough to be a therapist.

I would say, for example, I can see that for the Latino population when they see me, they prefer somebody that is not too young. That is good being connected, I can feel this is good for my relationships with my clients; it's about age, for example, in the other side, when I am working with Latino clients and they are males, I can feel they are very aware I am female. The thing about me and my identity as an obese, Latina therapist is that obesity is the most salient, is the most like observable so in my life, so for me being obese is the most observable.

I feel like very empowered around my different identities but they ebb and flow and you know being part of a different system, you know, one that tells you, you know, where there is sexism, where this is you know racism, where there is fat phobia and ideal images of body and there is you know homophobia and all these different things and you know I am part of that system and so yeah I experience moments and times when I feel really disempowered.

I feel the word obese is…
I hate that word obese. People in the medical field call me obese. I know that I am technically categorized as obese but a lot of time I don't even see myself that way. I know that I weigh more than what is quote unquote healthy, while I am striving to be healthier, I also don't feel like I look like other people who are obese so it's this weird, I don't know. It's a weird dynamic.

I don't know if I would use the word obese. You know this word is interesting for me.
I don't really care as much. I don't normally say obese, I say fat, I say different things like I am really fat positive.

My experiences with microaggressions and/or blatant comments are…
I've had clients come in, maybe White clients uhh, these fucking Mexicans or these fucking Puerto Ricans, and I'm like, what do you think I am? Like they don't realize that I'm one of them you know?

I had a client who did not trust immigrant communities because they were taking resources from the U.S. and she would always have to retract what she was saying because, I mean, my name is pretty apparent of being of Latino descent so I think that was something that was very hard for her to do and she would sometimes state, "you don't understand because you don't know what it feels like to be in this country and then have people come take your resources."

I definitely think that being Latina, I think when I am working in non-Latino environments, I have definitely experienced that folks will question me a lot more around my expertise and my experience, you know, I feel like I am questioned a lot, you know, sometimes in the White community, umm, as a Latina therapist.

I had a client once who had substance abuse issues and so I was asking him if he had drank while he was away working for a week, and he said, well I was with Mexicans, of course I was drinking, they're always drinking….and so I, as a joke said, "yeah I'm drunk right now" and tried to use humor. Luckily we had enough of a rapport that he kind of laughed and you could just see he was like, yeah well sorry, you know, he kind of embarrassed him.

I had a client, a young Latino boy, and we were talking about this woman in their church and how she is a very heavy woman. During this session, his mom kind of looked at him and she was like, you do know who you are talking to? His mom is a little heavier too, and he right away looked at ne, he said, I'm so sorry, not you, I'm not talking about you.

It has happened with colleagues and I pretty much had let it slide and then I had to process with the one who was supposed to be my supporter and also did not address it and then we had processed that together.

Figure 12. Composite depiction made up of all verbatim responses from all participants.

Triangulation

Triangulation was utilized in this study in an effort to find overlapping themes between the interviews conducted and another method of information. In the Dances with Fat blog by Ragen Chastain, three posts were randomly selected from this year. While this blog is one of the more popular blogs written for individuals of larger weight in a more positive way, this blog does not incorporate all of the identities explored in this study. Chastain identifies as a fat woman (Chastain, 2015) but she does not identify as a Latina. She identifies as White. However, no blog of an obese, Latina therapist was

found for this study. Chastain is well known in the fat activist community, is a published author, and is a motivational speaker.

After analyzing the three randomly selected posts from the Dances with Fat blog (Chastain, 2015), several themes were found that were similar to the themes found in the data analysis of the interviews. The selected blog entries consisted of 501, 672, and 1,395 words, respectively. Chastain discussed microaggressions that fat women tend to face with comparing body size to negative personality traits such as being cruel, jealous, boring, and not good. An example of the negative personality traits was found with the following quote: "While I really enjoyed the *Harry Potter* books, this idea that fat people are bad/mean/lazy people does seem to come through in her writing. I think it's particularly important for her to speak out about this since the fat characters in her books (though not all of them) tend to be bad people" (Chastain, 2015, January 29). While the participants in this study discussed microaggressions they experienced, they did not report having experience where clients or co-workers implied or stated that the participants had personality or character flaws. She also discussed the systemic issues often associated with larger body size such as inadequate health care and having to shop at special stores to find appropriate clothing sizes. This is a quote about the systemic issues faced by obese individuals: "Since doctors often don't have properly-sized blood pressure cuffs, and since too-small cuffs can lead to artificially high readings, and since there is an assumption that fat people have high blood pressure, we have no idea how many fat people are on blood pressure medication (with all of its side effects)

unnecessarily" (Chastain, May 18). She discussed how women are taught to hate themselves and their bodies, regardless of body size. The following is a quote of women learning to hate themselves: "'Fat' is usually the first insult a girl throws at another girl when she wants to hurt her. The bigger problem isn't the quote, it's the fact that body size is used as an insult because weight-based prejudice is highly developed in girls" (Chastain, January 29). She also expressed frustration with the celebration and praise of weight loss. Here is a quote about the celebration of weight loss: "People tried to explain that the idea of celebrating having a smaller body, especially with a "before and after" shot, is problematic in a body positive space. They also pointed out that before and after pictures seem to be very much the beauty standards that the community purports to want" (Chastain, March 27). The last significant piece of similar information was the linking of body size to health. The following is an example of body size is linked to health: "When studies compare thin people and fat people, often reporters, health care professionals, well-meaning family and friends, not-at-all-well-meaning internet trolls, and sometimes even the researchers themselves act like it's a simple comparison – that if, for example, fat people have higher rates of a health issue than thin people, then obviously the health issue must be caused by their fat" (Chastain, May 18).

In summary, the themes found in Chastain's blog that paralleled those in the participant interviews included microaggressions, systemic issues, the celebration of weight loss, and correlating health to body size. One aspect that stood out from one of the blogs was the importance of individuals with power or individuals with privilege

pointing out stigma towards marginalized groups (Chastain, Janaury 29). This particular theme was not found in the participants interviews. Chastain (May 18) also discussed in more detail how obese individuals are often the butt of the joke in the media. This particular theme was not found in the interview data; however, some participants did discuss the role of the media more broadly across the three marginalized identities that were the focus of this study. One theme that seems apparent throughout all of Chastain's (2013) work is a need for body size acceptance. Some participants talked about fat positive work but the overall theme from the participants was body shame. Some even implied wanting to lose weight so that they would feel better about themselves. It is also noteworthy that Chastain's blog tends to use stronger language than that used by participants and to focus more consistently on societal aspects of weight.

Creative Synthesis

Moustakas (1990) believes that data collected throughout heuristic inquiry can be constructed in a way that the researcher is able to embrace and communicate the essence of the data. I do not claim in any way to be creative or an artist but I attempted to create a short story with no headings in order to combine all the data from this study with my own biases, views, and experiences of being an obese, Latina therapist. I decided to tell the person in first person but this is not my story. I felt that telling the story in first person would make the story sound more personal because even though there are some common experiences, there can still be this feeling of experiencing uniqueness.

Creative Synthesis

I love being Latina! I find meaning and connection in my ethnic identity, even when I am sometimes told by society that I should feel shame. I embrace my difference from the majority culture and I embrace all the stories, messages, wisdom, life lessons, and traditions passed on to me from my ancestors. Some of my ancestors are here in this country; others are from other countries. Sometimes, I may talk differently and people may not like this about me but I know I am intelligent.

I love being a woman! I find power and strength in my gender identity. I also embrace some of the traditional values of being a caregiver, whether that is for family members or for those whom are close to me. I also know that I am smart! I know that I am capable! I know that I am worthy of respect, just like men are.

I am conflicted with being an obese individual. I have moments when I am accepting of my body, even moments when I may celebrate my size. However, I know I have internalized deep shame and frustration with myself. I have been bombarded with messages since I was a little girl about what I am supposed to look like and unless I take some drastic and most likely, unsafe measures, I will never look the way society wants. I also feel like the world has decided to make life even more complicated by the systemic issues I face with my body size. I wish it was easier to buy clothes and to get proper health care. I wish people did not judge me negatively right when they first see me simply because my jean size is too big for their comfort. I wish I had a louder voice to say these things but I tend to find myself not talking, and sometimes not even being aware of these things.

All of these identities have affected how I function in my career as a therapist. I enjoy being able to help people. I feel I am able to connect to my clients based on all of these identities. I think people feel they can open up to me. Some may judge me but if they do, I will do my best to discuss any offensive comments so that our therapeutic relationship is not damaged. I want to be viewed as competent. I want to feel that I am competent, even if there are certain populations with which I am afraid to work . I am fearful of working with clients who have disordered eating behaviors. What if they take one look at me and think I cannot help them? I want to continue being self-aware so that I understand more of what I bring into the room when I work with clients. I want to promote pride as well as self-acceptance in both myself and my clients. I understand that my personal and professional identities are not mutually exclusive. I hope to continue working on my development and to help facilitate change for myself, clients, and social justice.

I am an obese, Latina therapist!

Figure 13. Creative synthesis of all data with my own views in the form of a story.

CHAPTER V

DISCUSSION

My intent with this study was to address some of the issues around a specific population who have multiple marginalized identities. As current researchers are moving towards looking at the intersection of multiple identities (Atewologun, Sealy, & Vinnicombe, 2015), this particular population of obese, Latinas therapists felt particularly relevant to study. It also felt relevant to include how this population may be affected in a professional world where understanding about multiculturalism and diversity development continues to expand. I hope this study will be added to the current research on obese, Latina therapists with the addition of addressing this intersection in a therapeutic environment where it is important to develop self-awareness of identity. Eleven women were interviewed for this study and their interviews were analyzed with the use of heuristic inquiry.

Integration of Results and Literature

One of the major themes that stood out even prior to conducting the data analysis was that the participants expressed a sense of pride for being Latina women. If there was an inclination toward shame with either of these identities, there seemed to be a type of protective barrier that kept the participants from internalizing negative messages. Previous researchers have shown that Latinas have a strong sense of pride rooted in the cultural messages passed down through generations (Dawson & Quiros, 2014). Even

though there is stigma, oppression, and discrimination experienced by many Latino(a)s (Velez et al., 2015), Latino(a)s often experience a sense of belonging and community within Latino(a) cultures and within Latino(a) families that help to give Latino(a)s a strong sense of self (Mendez-Luck, Bethel, Goins, Schure, & McDermott, 2015).

Women have also become more empowered and seem to be breaking away from living within traditional gender norms (Meisenbach, 2010). Meisenbach also discussed that women are finding more opportunities for themselves and the freedom to make the choices they want in order to build successful and fulfilling lives. Women may choose to be stay-at-home mothers or they may choose to enter the workforce full-time. They may also choose both, showing evidence for further movement in the stretching of traditional gender norms. However, it is important to acknowledge that most women who have children do not have a choice in whether or not they work. It is a privilege being able to have the choice. Even though some women experience more pressure and stress (Keleher & Franklin, 2008), women are still developing a more positive attitude about their gender.

The fat positive movement has been about body size acceptance, specifically fat bodies (Chastain, 2013). This is not specific to only women but includes all genders, though the present study focused on women. While the fat positive movement feels like a healthy step towards body acceptance, the acceptance of fat bodies seems to be quite difficult due to the deeply embedded messages women receive about the ideal body. Women are taught from a young age what an ideal body is and are also taught to go to

sometimes extreme lengths to attain the ideal body (Gaines & Burnett, 2014). When this ideal is not met, women are often shamed and may also internalize that shame (Harney & Bardone-Cone, 2014). In order to cope with shame, some of the strategies mentioned by participants included finding other areas in their lives where they may overcompensate and strive for perfection (Thomas et al., 2010). Participants in this study discussed both of these processes. Even those who had body positive attitudes also discussed some internalized shame. Chastain (2013) tends to focus more on body positive attitudes and addresses the shame individuals feel with larger body sizes (Chastain, May 18); she also talks about the pressure girls and women face to have an ideally thin body (Chastain, March 27). Some participants along with Chastain addressed the praise that comes along with weight loss. It is important to consider issues with shame and poor body image even after someone has lost a significant amount of weight (Gilmartin, 2012). While someone may experience shame with higher weight, there can be an assumption that the shame will disappear with weight loss and this may not be necessarily true.

Many individuals have a fear of fat and some researchers have focused on this in the experiences of thin people, especially women (Mainland, Shaw, & Prier, 2015). This fear of being fat also has negative impacts on fat and obese women (Fikkan & Rothblum, 2012). This is not to say that men do not experience weight bias; however, an individual's experience with fat bias and weight stigma can depend greatly on gender. When women do not meet the standards of having the ideal body, they can experience significant effects on their mental health, socioeconomic status, and quality of life

(Fikkan & Rothblum, 2012). Individuals can potentially experience a trickle-down effect related to job status that can impact access to adequate health care, means to find healthy relationships, proper clothing, higher food quality, access to education, and access to proper mental health care (Puhl & Brownell, 2003).

Participants also discussed their fear of being judged by clients in their therapeutic work or being viewed in a way that would lead their clients to question their competency as clinicians. It can be common for clinicians to experience some questioning of their competency, especially clinicians in training (Drake, 2013). However, when adding in the potential stigma of marginalized identities, this could lead to more significant fear. Clients could also choose to stop working with clinicians based on negative biases as opposed to whether or not clinicians are a good fit with relevant and strong experience in the field.

Some of the participants acknowledged contradicting thoughts and responses. For example, one participant expressed not feeling as though she was attractive to clients due to her body size. She then corrected herself and made a comment about people being attracted to all body sizes, therefore acknowledging that she may in fact be attractive regardless of her size or weight. Chastain (May 18) also discussed in her blog this concern fat individuals have of uncertainty with not knowing who will be fat-shaming in their daily encounters. Researchers have shown the stigma associated with having obese bodies and that obese individuals can be viewed as less attractive and as having less appeal in romantic relationships (Stephen & Perera, 2014). However, other researchers

have shown people to be attracted to individuals with larger bodies (Chithambo & Huey, 2013). Even though the thin ideal is still prevalent in Western culture (Swami, 2015), there has also been a shift in body acceptance regarding higher weight and larger bodies (Chithambo & Huey, 2013).

Participants in this study also discussed how their identities intersect and interact. Clients have often been found to prefer ethnic matching when they have sought out mental health professionals (Valdez, 2000). However, individuals seeking mental health treatment may experience biased and potentially racist views towards available therapists when making decisions on finding a therapist if the client and practitioner are not ethnically matched. This could contribute to individuals making decisions on outer appearance instead of experience or merit. Some of the participants in the study expressed their concern for clients making judgments based on ethnicity and or for having an accent. Bartoli and Pyati (2009) explored ways therapists can handle disparaging and offensive comments when experienced in a therapeutic setting. It is also important to consider that such comments could be related to a client's struggles with mental health although; this may not always be the case.

Participants faced a number of microaggressions and blatant comments from clients. While several of the examples were racist remarks or comments regarding ethnicity, there seemed to be more implicit struggles around weight stigma. However, it is also important to note that the interview questions initially were skewed towards body size. Individuals who face weight stigma can experience dismissiveness or a lack of

acknowledgement of their body size identity. This dismissive nature taken on by others can be related to anti-fat attitudes, dislike for obese individuals, or beliefs that all individuals with fat bodies are able to control to size of their bodies (Burmeister & Carels, 2015). Similarities were also found in Chastain's blogs. In particular, Chastain (March 27) addressed the praise women usually face when they lose weight. She also discussed the stigma fat people face in the media when statements made by famous individuals appear to be microaggressions (Chastain, January 29). Some participants also discussed experiencing microaggressions and potential issues of weight bias from their peers. In a recent study, individuals were shown to experience weight stigma from family and friends, but it was implied that due to having personal history with family and friends, these individuals were less likely to experience negative affect compared to what they would experience when being stigmatized by strangers (Vartanian, Pinkus, & Smyth, 2014). Researchers found that both implicit and explicit anti-fat bias is still widespread among medical doctors (Sabin, Marini, & Nosek, 2012). Sabin, Marini, and Nosek believe that the anti-fat bias they found in their study can also be found among the general public at the same rate. This phenomenon is problematic in that it may also be just as pervasive among mental health professionals. Thus, not only can these biases be prevalent in working relationships but these biases may also be impacting the rate at which overweight and obese individuals attend mental health treatment. This is yet another example of the systemic oppression faced by individuals of a larger body size like those that were discussed during the interviews.

Implications

Implications for Theory

Using the Multidimensional Identity Model (MIM), Reynolds and Pope (1991) discussed four different categories of identity development: identification with one aspect assigned by society, identification with one aspect that is consciously made, identification with multiple aspects of self, and intersecting identification with multiples aspects of self. This particular model was chosen to be integrated with the results due to it being the most current of the models discussed previously in the paper and it is also the best fit for the data that was collected. While the other models are also relevant, they were discussed as a way to build on the literature of the progression of identity development models. This model was also chosen as a way to address the intersection of identities that individuals tend to experience (Cole, 2009). These categories of the MIM were explained earlier in the paper. The results of this study supported MIM concepts, as participants' experiences were congruent with the model's categories.

Utilizing the MIM (Reynolds & Pope, 1991), the participants were in different categories of their identity development. The first two categories of the MIM involve an area of an individual's identity in which the individual will only identify with one aspect of himself or herself (Reynolds & Pope, 1991). The participants all seemed to be past this part of their identity development, especially as it was consistent throughout the data that the participants discussed feeling pride and acceptance with both ethnicity and gender. However, several of the participants discussed how they generally do not talk

about their body size. The pressure to suppress and not discuss body size could have been both external and internal. Miller (2011) discussed the privilege and oppression faced by individuals depending on whether they identify with a marginalized identity. Even though participants discussed their pride in ethnicity and gender, they still discussed ways in which they experienced marginalization regarding ethnicity, gender, and body size. The awareness of marginalization was apparent when they discussed their experiences with both microaggressions and blatantly offensive comments.

One of the participants specifically discussed being aware of her environment and then engaging in what she called *code switching*. This behavior of being environmentally aware was an example of the third category of the MIM model (Reynolds & Pope, 1991). The participant allowed different parts of her identity, specifically her Latina identity, to be more apparent when she was outside of professional settings. She further stated that she became *White* during some professional encounters. This also was indicative of pressures often faced by women of color to change their mannerisms so that White people feel comfortable (Chavez & French, 2007).

One of the participants described herself a *mujerista*. By using this description, I believe she was in the fourth category where her multiple intersecting identities contributed to the development of a new group. Being a *mujerista* means to be a Latina feminist. This participant was one who not only described being proud of her ethnicity and gender, but discussed being body positive. Body positive is part of the feminist movement (Stokes, 2013) and therefore, the participant seemed to integrate these

different parts of her identity. To me, she seemed to be the most progressive. She also seemed to be the most accepting of herself while also acknowledging that she still had difficult days when trying to fully accept her body size.

Implications for Practice

While some research has been conducted on obese Latinas (Wolin, Colangelo, Chiu, & Gapstur, 2009; Yeh et al., 2009), no previous research was found on the experiences of obese, Latina therapists. Looking at these three identities and how they may impact therapy sessions is an important topic for therapists to consider. Stigma and oppression have been present in all three of these groups: for women (Botsford et al., 2013), for Latinas (Morales, 2009), and for obese individuals (Brownell, 2005). These experiences will likely impact therapists who identify with these marginalized groups and therefore, will affect their interactions with clients. These identities have nothing to do with competene; however, clients may judge therapists based on their own biases of these three identities. Clinicians need to be aware of how their experiences could potentially influence their therapy sessions with clients. Clinicians also need to be aware of when they need to consult, refer, or in some cases, attend their own individual therapy in order to work through any difficult experiences and to find their own support. With a positive therapeutic alliance being demonstratively important for successful outcomes (Martin, Garske, & Davis, 2000), addressing some of these cultural and diversity issues will be needed for both clinicians and clients.

It is also important for clinicians to consider the multiple guidelines provided by the APA. The *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1993) would be an appropriate resource to use when working with Latino(a) clients. One of the guidelines to keep in consideration is Guideline 3 which addresses the importance of being able to recognize the significance of ethnicity and culture when working with clients (APA, 1993). Guideline 8 addresses the need for psychologists to be aware of their own biases, attitudes, and practices that could be discriminatory or stigmatizing to their clients. This particular guideline would also be appropriate to consider when interacting with co-workers. The *Guidelines for Psychological Practice with Girls and Women* (APA, 2007) would be appropriate when working with female clients. One of the guidelines that would be important to consider regarding this study is Guideline 9. This guideline addresses the need for psychologists to address the sociopolitical contexts of girls and women (APA, 2007). This guideline, too, would be important to address with both clients and colleagues. Guideline 5 seems appropriate as biases, socialization, and attitudes towards women and girls are addressed. Guidelines for working with obese individuals have not been developed; however, it is likely that obese individuals could benefit from working with obese therapists as they may perceive a stronger connection with a clinician of similar body type (LeClere, 2010). It would also be important for clinicians in general to use these guidelines in being able to work with obese Latinas in professional settings. Some potential guidelines could involve the acknowledgement of the systemic issues related to having obese bodies and

also to the stigma often associated with higher weight that individuals tend to experience. Another set of guidelines that would be appropriate to consider are the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003). Clinicians may want to closely consider Guideline 5 which addresses the need for clinicians to utilize skills that are culturally appropriate for their clients (APA, 2003). This particular guideline could be used in a broader sense so that it applies to all identities, including body size. Using these guidelines in conjunction would have the added benefit of being able to look at the intersecting identities of obese, Latina women.

It was expected that participants would discuss some of their struggles with how they experience their work with clients. It is possible the participants felt it was easier to discuss experiences related to their least marginalized identities compared to talking about their most marginalized identity. For example, the participants seemed more at ease talking about ethnicity and gender, which were more related to having feelings of pride and even having a sense of community. When discussing experiences related to body size, there was a sense of isolation from some of the participants. Some participants also clearly stated that they do not talk about their identity with body size, implying their experiences were related to shame. Other struggles discussed were with co-workers. Having a safe, supportive, and empowering work environment is crucial to having a productive, effective, and fulfilling work experience (Rupert, Miller, & Dorociak, 2015). Not only do clinicians need to speak up for themselves if they experience some kind of

oppression or stigma, but they also need to seek out allies in order to feel more supported. Dealing with oppression can feel isolating (Davis & Bowman, 2015). Also, there is a concern for burnout if marginalized clinicians are working in an intense or potentially hostile environment (Rupert et al., 2015).

Participants also discussed how their weight impacts their clinical work. They discussed competency, fear of hypocrisy, and lack of desire to work with clients struggling with eating disorders. Individuals who experience weight stigma can experience negative self-perception (Ratcliffe, 2015). Individuals can experience stigma in any setting but individuals who experience stigma in their work environments may begin to question their competency due to internalized negative messages. The stigma can come from working with previous clients and also from co-workers in the clinical field. Clinicians need to be trained in diversity development regarding body size identity in order to facilitate a more productive work environment. When assessing for competency, the focus needs to be based on skill and merit rather than external appearance. Once these foci are apparent, it is likely that obese clinicians will start to experience a decrease in competency concerns and fear of hypocrisy. They also may view clients with eating disorders as a population with which they work more comfortably.

Implications for Research

Therapists are getting more multicultural training as more focus is being placed on diversity issues in the therapy room (Zalaquett, Foley, Tillotson, Dinsmore, & Hof,

2008). Researchers may want to continue focusing on the identities in this study: gender, ethnicity, and body size. Body size in particular remains understudied in the context of the psychotherapeutic relationship. Researchers may also want to focus more on body size due to the internalized shame, not only experienced by some of the participants in this study but by clients and individuals in the general public who are overweight or obese. This would be important regardless of any other intersecting identity. Researchers should address other identities that were discussed with some of the participants such as age, SES level, country of origin, and sexual orientation. Two of the participants also mentioned having tattoos and sometimes this could potentially impact how clients view clinicians due to the stigma towards individuals who have tattoos (Larsen, Patterson, & Markham, 2014). The last piece researchers may want to consider and explore further is the effect microaggressions and blatantly offensive comments and questions have on practitioners.

Limitations to This Study

The sample size of this study was eleven and therefore too small to make any significant generalizations. The experiences of the participants are valid and are most likely similar to many others who did not participate in this study.

Another limitation of this study is the difficulty with using the word *obese* to identify body size. Some individuals may not like to use this word due to the stigma associated with using the word *obese*. While most participants simply did not respond to the prompt regarding the word *obese*, those that did were neutral, presented mixed neutral

and negative responses, or in one case, clearly disliked the word. It is possible others would have been more open to participating if more size accepting vocabulary was used in the study.

Participants were chosen through the use of specific listservs and through snowball sampling. These specific methods of finding participants were limited in that potential participants either had to belong to one of these listservs or they had to have some kind of relationship with someone already connected to either the study or the researcher.

Another limitation was that inter-rater reliability was not formally assessed. This was my mistake as I did not formally keep track of how many times my cross-coder and I were in agreement while we made the code list and coded interviews.

The post phone calls that occurred directly after the recorded interviews were not used in the data analysis. Some of the participants continued to share information and unfortunately, this information was not used in the data analysis.

The identities addressed in this study were marginalized identities and therefore, other privileged identities were not assessed. Also, gender, ethnicity, and body size are not the only marginalized identities. Other oppressed identities such as SES, religious background, and sexual orientation, to name a few, were not assessed. The lack of addressing these other identities could also be viewed as a limitation to this study.

The focus of this study was on Latinas. While qualitative research does not have a goal of generalization, results may or may not have been different with another set of

participants. While most women may experience the same pressures to attain the thin beauty ideal in western culture, different ethnic groups may not experience the same sense of pride that felt evident in this study with the Latina participants. Also, the intersection of Latino(a), female and obese identities may be quantitatively different that the intersections of obese and female identities with other ethnic groups.

Conclusion

Researcher Bias Revisited

When I first began to think of what I wanted to explore for this paper, I felt I was clear in the salience of my identities with the assumption that others would also have similar saliencies. My body size was by far the most salient of my identities due to the negative experiences I had had up to that point. I faced stigmatization, discrimination, and downright meanness from people. I had shared some of my experiences with others of larger body size and felt like others who were like me could relate. Through these interactions, I made the assumption that body size was the most salient identity for anyone with larger bodies.

I took a little over a year off from this project and instead focused on my doctoral internship. After moving to an area that lacked in many areas of diversity, I noticed other parts of my identity becoming more salient. My identity as a woman and as a Latina became more of my focus which felt a bit ironic considering the population I chose to study. I felt like I was going through my own journey of having to acknowledge and

become more aware of these identities, not just because of this study but also because of the timing in my life in the place where I chose to live.

When I started to interview the participants, I felt like I was better able to understand their experiences. While hearing their stories, it felt validating being able to relate to many of their experiences. There have been multiple times when I questioned my own feelings about certain experiences and would jump to the conclusion that I was being too sensitive in certain situations. Now to hear these women talk about their own experiences, I understand what it feels like to have self-acceptance and then to have that taken away because of the culture I live in where I know I do not fit the ideal, especially with body size. I also was able to relate to experiences of oppression based on being a woman and being Latina.

While conducting the data analysis, I remember feeling sadness, anger, confusion, and hopelessness, as well as happiness, pride, and excitement. I was surprised to feel such a range of emotions, especially after listening to each interview again as I transcribed. I felt the most intense emotion while I was constructing the composite depiction and then reading it after it was completed. Using heuristic inquiry, this research felt personal and therefore, I am sure the emotional effect I experienced most likely impacted how I interpreted the results. I also felt that I was able to connect to the participants in a way that would most likely not happen with quantitative and even with some other forms of qualitative research methods. Because I was immersed in the topic

of this study long before I even realized what I would study, the women who participated helped me to gain inclusion when I have felt alone with these intersecting identities.

The results that seem the most trustworthy to me are definitely the sense of pride that I understood from the women regarding ethnicity and gender. Even though these parts of my identity have not always been as salient for me, I can easily relate to having feelings of pride for being a Latina and for being a woman. Surprisingly, the one result of the study that is the most confusing to me is the shame the women felt about their body size. To clarify, I understand the shame; however, I am much more vocal and open to talking about my experiences. Some of the participants said they never talk about their body size. I also think what makes this particular part of the study more confusing on a personal level is that different areas in which people experience shame (i.e. intrapersonally, interpersonally, and systemically) make this identity incredibly complex. I understand ethnicity and gender both have their levels of complexity but these complexities are discussed more openly. The shame around body size appeared to run very deep, to the point of being almost unspeakable for some participants.

Other parts of the data that were shocking included the microaggressions and stories about offensive and blatant comments. Honestly, I hope there is always some sense of shock or surprise when I hear examples of microaggressions. I do not want to become desensitized to hearing offensive comments. I was not surprised that the women had negative experiences; I was surprised at the offensive language people continue to

use in Western society. Sometimes it can feel discouraging and hurtful, but it can also give me energy and reason to keep pushing forward and to speak up for social justice.

Last Thoughts

Overall, the findings from this study can be a contribution to the already existing and growing research on the population of obese, Latinas. This study will also contribute to research on therapist experiences. While the three identities of ethnicity, gender, and body size are marginalized, it is difficult to ignore the growing need for more research on body size identity, body size shame, and body size acceptance. Researchers and practitioners have a significant role to play in helping others recognize the importance of making body size a true diversity issue. Participants in this study discussed the pride they have for two of these identities and shame for the other. It is also important to address and explore further therapist experiences, especially those who identify with any marginalized identity.

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Appendix A

Informed Consent

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

TITLE: Experience of obese Latina therapists

Principal Investigator: Sonia Carrizales, M.A., email: sleclere@twu.edu; 970-xxx-xxxx
Dissertation Co-Chair: Sally Stabb, Ph.D., email: sstabb@twu.edu; 940-xxx-xxxx
Dissertation Co-Chair: Shannon Scott, Ph.D. email: sscott@twu.edu; 940-xxx-xxxx

Purpose of the Research:
You are being asked to participate in a qualitative study on the experiences of obese, Latina therapists. The purpose of this study is to address the experiences of an underrepresented population in a therapeutic setting. Past researchers have focused on therapist experiences; however, this study will focus on the intersection of three marginalized identities and how these identities may be impacting therapists' experiences with their clients.

Research Procedures:
If you agree to participate, will first be asked to complete a basic demographic questionnaire online to qualify for the interview portion of the study. It is possible that not every qualified person who completes the demographic questionnaire will be interviewed due to time and resource constraints. If you are selected for an interview, you will be called by phone to set up an interview time. During the interview, you will be asked open-ended questions on your views of being an obese, Latina therapist and the different experiences you have with your clients. All participants will be asked to use an alias for their clients and to refrain from noting any possible identifying information so that client confidentiality is assured. In order to participate, you must have access to a phone and be willing to be interviewed for 45 minutes to an hour. All interviews will be audio recorded and transcribed verbatim for analysis.

Potential Risks:
Confidentiality will be protected to the extent that is allowed by law. A potential risk is a loss of confidential information. Part of this study will initially be conducted online. All participants will be identified by an alias. Also, the online portion of the study and the phone interviews will be conducted through a secure website. However, there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions. All interviews will be deleted from the website within one year of the interviews being conducted and all downloaded interviews will be held in a secure, password protected file for up to seven years.

There is a risk of discomfort in this study. You will be asked questions about your

personal experiences as an obese, Latina. A resource referral list will be provided in the event that you need assistance after talking about anything particularly upsetting. However, you will have the opportunity to cease participation in this study at any time without penalty.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Benefits:
For your participation, you will receive a $20 gift card.

You will be participating in and contributing to research on an underrepresented population.

Questions regarding the study:
You will be able to print a copy of the informed consent that you see here on line. Clicking on the "I agree" button indicates that you have given consent.. If you have any questions about the research study you should ask the researchers; their phone numbers are at the top of this form. If you have any questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via email at IRB@twu.edu.

Thank you for your time in considering participation in this study. Your participation in this study is voluntary and you may withdraw from the study at any time with no penalty.

Please indicate whether you agree to participate in this study.

___Yes, I have read the informed consent and agree to participate.
___No, I do not wish to participate.

Appendix B

Referral Resources

Referral Resources

American Psychological Association Referral Service
http://locator.apahelpcenter.org/

National Register of Health Service Providers in Psychology
http://www.nationalregister.org/

American Board of Professional Psychology Directory of Specialists
http://www.abpp.org/abpp_public_directory.php

Psychology Today Find a Therapist
http://therapists.psychologytoday.com/rms/

American Association for Marriage and Family Therapy
http://www.therapistlocator.net/iMIS15/therapistlocator/

National Board for Certified Counselors
http://www.nbcc.org/CounselorFind

Appendix C

Demographics Questionnaire

Demographics Questionnaire

1. Age_____

2. Ethnicity
____ African American/African/Black
____ Asian American/Asian
____ European American/Caucasian/White
____ Hispanic/Latino
____ Native American/Pacific Islander
____ Other: Specify _____

3. Gender
____ Female
____ Male
____ Transgender

4. Height _____ ft _____ in

5. Weight _____ lbs

6. Age _____

7. Education Level
___BA/BS
___MA/MS/M.Ed.
___Ph.D./Ed.D/Psy.D.

8. Relationship Status (check all that apply)
___Single
___Cohabitating
___Married/Life Partners
___Divorced
___Widowed

9. Sexual Orientation
___Heterosexual
___Lesbian
___Bisexual
___Other: Specify _____

10. Specify type of credential (e.g. psychologist, LPC, social work, etc.)
    _____

11. Specify your field (e.g. clinical, counseling, school, social work, etc.)
    _____

12. How many individual clients do you see weekly? _____

13. In addition to individual counseling, what other formats of counseling do you conduct? (e.g. group, family, etc.) _____

14. How often do you conduct these other formats? _____

If you would like to be considered for the interview portion of this study, then please fill out the following contact information. This information will be used to contact you for setting up an interview time.
*Please note that time and resources may not allow for all possible participants to be interviewed.

Contact information

Name:

Email address:

Phone number:

Convenient time to call:

Please check whether you would like to receive information via email regarding the results of this study.

____ Yes

____ No

Appendix D

Interview Questions

Interview Questions

Self as Therapist Questions:

1. We all have multiple aspects of identity. Tell me about the most salient part of your identity when you are in the therapist role.

Follow up:
What, if any, differences are there in the salience of your identities when you are out of the therapist role?

2. One of the reasons you were selected for this interview is that you are an obese Latina woman therapist. Describe your experiences as an obese Latina therapist.

3. What do you feel are advantages to being an obese Latina woman therapist?

4. What do you feel are disadvantages to being an obese Latina woman therapist?

5. What are your own biases towards being an obese Latina woman?

6. What aspects (if any) of your identity do you believe impact how your clients think about your competence? Explain how.

7. What aspects (if any) of your identity do you believe impact your own competence? Explain how.

Questions about Clients

1. What are your views about obesity in general? (e.g. Do you think it is a disease?)

2. What are your views about the Latina/o identity?

3. What are your views about women?

4. What are your views towards clients who identify as obese, Latina, and/or women?

5. How have any of these views you have towards these identities changed for you or your clients since you started working as a therapist?

6. How do you think being a woman has impacted your experiences with clients?

7. How do you think being Latina has impacted your experiences with clients?

8. How do you think your body size has impacted your experiences with clients?

9. Some therapists talk about aspects of their own identities with clients, or talk about differences in identity between client and therapist; some therapists do not. If you have these kinds of conversations, describe how you talk about your identity with clients.

10. Some therapists have had the experience of clients asking them blatant questions such as, "What are you doing talking to me about food?" ….or making comments such as….. "you don't know anything because you are a Latina…"

-If this has happened to you, describe how you have responded to such questions
-If this has not happened to you, how might you imagine you would respond?

11. Some therapists may believe their own experiences with body image and eating are relevant to intervening with clients' issues in these areas. Other therapists do not see their own experience as relevant. How is it for you?

12. Tell me about any other parts of your identity that you feel have been impactful in your experiences with clients.

13. What else do you want to say about being an obese Latina woman therapist?

Appendix E

Announcement

Dear Potential Participant,

My name is Sonia Carrizales and I am doctoral candidate in Counseling Psychology at Texas Woman's University. I am conducting research to find out about the experiences of obese, Latina therapists. If you meet the following criteria, then please consider participating in this study:

- Latina ethnicity
- Identify as a woman
- Identify as obese
- Currently employed in a therapeutic setting with individual clients

If you know others who also meet these criteria, then please forward this announcement to them.

If you agree to participate and meet the criteria, you will be asked to read over an Informed Consent and to fill out a basic demographic questionnaire online about your age, gender, ethnicity, height, weight, and other questions about your profession. This should take approximately 10 minutes. If you qualify and choose to participate, a phone interview will then be scheduled. The interview will consist of open-ended questions on the views of being an obese, Latina therapist and your experiences with clients. In order to participate, you must have access to a phone and be willing to be interviewed in English and recorded for 45 minutes to an hour.

Participants in the phone interviews will receive a $20 gift card as a token of appreciation for participating. They will also be contributing to research of an underrepresented population. You will be given a chance to give your contact information should you want information regarding the results of the study.

There is a potential risk of loss of confidentiality in all email, downloading, and internet transactions. All data collection, including demographics and interviews, will be conducted via secure websites.

Another potential risk is discomfort due to the nature of the questions being asked regarding marginalized identities. A list of mental health resources will be provided to all participants.

For those who wish to participate, please go to the following link for the Informed Consent, demographic questionnaire, and contact information for a phone interview.

https://www.psychdata.com/s.asp?SID=165414

This research has been approved by TWU's Institutional Review Board (protocol # 10878)
Dissertation co-chairs:
Sally Stabb, Ph.D., email: sstabb@twu.edu; 940-898-2149
Shannon Scott, Ph.D. email:sscott@twu.edu; 940-898-2307

If you have any questions, please contact Sonia Carrizales at sleclere@twu.edu for any concerns you may have.

Thank you for your time.

Appendix F
Code List

Code List

1. Identity as Latina/o
    2. Disadvantage: Shame
    3. Advantage: Pride
    4. General Views of Latina/o Identity

5. Identity as Woman
    6. Disadvantage: Shame
    7. Advantage: Pride
    8. General Views of Women

9. Identity as Obese
    10. *Disadvantage:* Experience As Obese: Marginalization
    11. *Disadvantage:* Experience as Obese: Shame
    12. *Advantage:* Experience as Obese: Weight as Advantage
    13. General Views of Obesity

14. *How Body Size Impacts Clinical Work, i.e. Client Reactions*

15. *How Body Size Affects Self-Perception*
    Fear of Hypocrisy
    Self-Critical
    Lack of Desire to work with Eating Issues

16. Addressing Identity in Therapy (obesity, Latina, female)
    - often conveys cultural competencies; often addressing role of context and intersectionality

17. Style of Clinical Interventions: (e.g.Strength-Based Approach)

18. Negotiating Self in Therapy: Process of Self- Disclosure
    e.g. comfortable sharing when proud, but not shamed

19. Interactions of Identity (Flexibility)
    e.g. Perception of others on her
    -- negotiating how certain identity is salient, vs. in the background

20. Perceptions of Environment/Observations of Others

21. Attractiveness (could also be cross-coded with shame)

22. Experiences with co-workers

23. Language
    24. Negative use of language to describe the body (shame)
    25. Positive use of language to describe the body (body positive)

26. Weight loss or wanting to fix body due to excess weight

27. Microaggressions

28. Blatant discriminatory comments or questions