

DOES WEIGHT AFFECT THE PERCEPTION OF
MEN'S VIOLENCE AGAINST WOMEN?

A DISSERTATION

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DEDICATION

In loving memory of my grandparents Luke and Mary Belsky and Ann Yaworsky, as well my good friend Josh Singleton. Josh showed us all what true devotion was. In the year between completing my undergraduate degree and beginning my time at TWU, there were some who said I'd never return to school. I am eternally grateful to my grandparents for always believing in me. This one is most definitely for you!

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ABSTRACT

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Weight-based discrimination and men's violence against women are critical social issues, phenomena affecting the lives of countless women, men, and children. Rates of weight-based discrimination have been compared to those of racism and adverse effects linked to weight-based discrimination include decreased wages, social isolation, low self-esteem, and elevated rates of depression. Men's violence against women causes similar and more intensive effects, including lowered self-esteem, elevated levels of anxiety, broken bones, bruises, and death. Previous research has suggested a potential link between men's violence against women and weight, but no studies to date have explicitly explored the intersection of these phenomena. The current study proposes to fill this gap in the literature through the exploration of the perception of men's violence against women while manipulating the weight of the perpetrator and victim. Participants will be asked to read a vignette involving a man engaging in violence toward a woman and view photographs of the perpetrator and the victim. Participants will also complete four subsequent measures, including a demographics form as well as batteries assessing for attribution of blame, mindset, and sentence length for the perpetrator.

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CHAPTER I

INTRODUCTION

This introduction provides an overview of the two main areas of interest in the proposed investigation; weight-based stigma and interpersonal violence, both concerns that are more prevalent for women than for men (Alhabib, Nur, & Jones, 2010; Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). While the relationship between these two variables has almost never been directly examined, a compelling case can be built for why such a relationship might exist, and how the current study tested this possible association. A summary of the issues is provided and relevant terms are defined.

Weight-Based Stigma and Discrimination

Individuals of size, or individuals who are identified as either overweight and obese, are often highly stigmatized and face diverse forms of discrimination and prejudice as a result of their weight (Brownell, Puhl, Schwartz, & Rudd, 2005). These prejudices have been linked to individuals' work, social, and home lives, raising their likelihood of encountering weight-based discrimination across multiple settings. There is an increasing trend toward weight discrimination in the United States and the prevalence of weight-based discrimination is comparable to rates of racial discrimination (Puhl & Heuer, 2010). Additionally, researchers have also suggested that an outward expression of negative attitudes toward men and women of size is socially acceptable and at times

encouraged (Brochu & Morrison, 2007; Brownell et al., 2005). Persons of size have reported being the recipients of negative comments and discriminatory behavior regarding their weight most often from peers, friends, family, and physicians (Puhl & Heuer, 2009). Weight discrimination is not dependent upon age, as children as young as three have been reported to engage in weight-based prejudice (Cramer & Steinwert, 1998).

Research has indicated that individuals of size often face social injustices such as unfair treatment by healthcare providers, employers, peers, the media, bias in the educational system, and the perception that men and women of size are lazy (Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003). Moreover, Puhl and Heuer (2009) suggested that women of size are discriminated against at rates that far exceed those of men of size. The discrimination experienced by persons of size also has consequences for psychosocial and physical well-being, as well as affecting the quality of interpersonal relationships (Puhl, Moss-Racusin et al., 2008).

Weight stigma, or the devaluation of individuals due to their size, has been linked to deficits in individual psychosocial well-being by increasing the likelihood of depression, body image distress, developing a mental health diagnosis, and decreased self-acceptance (Friedman et al., 2005; Puhl, Moss-Racusin et al., 2008). Weight stigma has also been linked to negative implications for individual physical health and has been associated with detrimental eating habits and an avoidance of exercise (Storch et al., 2003). Weight stigma has also been reported to have a negative impact on interpersonal

relationships, especially romantic relationships for women (Smith, Schmoll, Konik, & Oberlander, 2007).

Interpersonal Violence

In addition to a greater likelihood that women will face weight discrimination, women are also more likely to experience interpersonal violence (Department of Justice, 2007). Furthermore, abuse by a current or former partner is a leading cause of death in women (Department of Justice, 2007). It is estimated that women accounted for 85% of reported intimate partner violence and that 12-20% of couples admitted to perpetrating or sustaining intimate partner violence within the last year (Moore et al., 2008). Moreover, this number was reported to increase two-fold when individuals were asked about an incident of intimate partner violence over the course of their relationship (Moore et al., 2008). While more research has been conducted on the prevalence of men's violence against women and the experiences of women, it was not until the 1970's that feminists introduced the term "wife beating," later followed by "violence against women" for the abuse women faced at the hands of their husband or partner (Denham & Gillespie, 1999).

Violence against women has been described as one of the most common, least recognized human right violations in the world (Krauss, Krauss, & Plichta, 2010). The phenomenon of men's violence against women has been linked to the earliest societies of the world, including the written records of the Sumerians (Ferry, 1992). Brownmiller (1975) wrote that men's violence toward women, including the act of rape, is a means by which men have been able to assert their dominance. The systematic ways by which men

have continued to rule over women is patriarchy, a set of interlocking structures and values that continue to place men in the center of the social order (Brownmiller, 1975).

Men's violence against women includes physical, social, and psychological consequences for the survivor (Kazdin, 2011). Women who are the recipients of men's violence may suffer physical consequences such as cuts, bruises, broken bones, dislocated joints, and head injuries (Briggs, Thompson, Ostrowski, & Lekwauwa, 2011; Kazdin, 2011). Women who are subjected to men's violence may also experience psychological consequences, including depression, anxiety, substance abuse, and posttraumatic stress disorder (Briggs et al., 2011; Coker, Williams, Follingstad, & Jordan, 2011). Women may also experience social consequences due to men's violence, such as the loss of a child to social services, reduced social support, isolation, loss of wages, and social withdrawal (Briggs et al., 2011; Coker et al., 2011; Kazdin, 2011).

Linking Interpersonal Violence and Weight Stigma for Women

As intimate relationships are often opportunities for weight bias, it was reported that women of size may experience difficulties in initiating and maintaining lasting intimate partnerships (Boyes & Latner, 2009). Moreover, college-aged students rated women of size as relatively unattractive, unlikely to be partnered, sexually deficient, and unworthy of an attractive mate (Horsburgh-McLeod, Lautner, & O'Brien, 2009). The intersection of the perception of women of size and the perceptions others have adopted regarding the qualities in a relationship of women of size tend to reflect the idea of weight bias in the United States. It was reported that in heterosexual relationships, 47%

of women of size reported weight stigmatization from their partners (Puhl & Brownell, 2006). While unsubstantiated by research, Royce (2009) suggested that there may also be an intersection a link between the oppression of women of size and violence against women. Royce (2009) commented that the diverse forms of discrimination that women of size have reported lower their levels of self-confidence and self-esteem as a result of the negativity associated with their weight. Individuals who batter their partner can also engage in weight discrimination by threatening their partner by stating that her efforts to reach out to others will fail due to the internalized fataphobic responses of others in society (Royce, 2009). Violent partners may also utilize a combination of physical and psychological means to control their partners. One such example is through the use of fataphobic insults and verbal assaults as a form of control of partners of size (Royce, 2009). When women of size do escape persecution within relationships, their efforts to break free from persecution are often met with further weight bias by family members as well as helping professionals. Health-care providers and mental health practitioners often exhibit an anti-fat bias and have been reported to mistreat individuals of size (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). This mistreatment acts as a re-victimization process for women of size who may be forced to establish new abusive cycles, not with an intimate partner, but rather service providers committed to helping (Royce, 2009). Both self-perceptions and the perceptions of others lead to the continuation of prejudice toward individuals of size and the perpetuation and continued acceptance of anti-size attitudes.

The concept that it is socially acceptable to express openly negative sentiments to men and women of size has been established through previous research (Brownell et al., 2005; Clarke & Lawson, 2009). People who identify as individuals of size, as well as those who are perceived as individuals of size, face systemic discrimination in the forms of established institutions (Brochu & Morrison, 2007). It appears that individuals of size internalize anti-weight prejudices, resulting in lowered self-esteem and lowered self-worth. As it is often acceptable to hold prejudices based on weight, it is important to explore if individuals perceive persons of size as more deserving of interpersonal violence.

Statement of Purpose

The primary purpose of the present study was to determine if the weight of individuals affects how individuals perceive men's violence against women. The question of whether or not individuals are more accepting of violence when the violence is committed toward an obese or overweight person versus a person of average size was explored. A secondary purpose of the study was to explore whether or not participant weight is significant in assessing weight bias toward individuals of size. Lastly, exploring the intersection of weight-based bias and perception of men's violence against women was critical in the current study.

Significance of the Study

This is the first known study to empirically examine the relationships between size and interpersonal violence. These results turned out to be complex, indicating that

more nuance may be needed by researchers, psychotherapists, health practitioners, and educators in understanding the relationships between persons of size and interpersonal violence. Findings and discussion are presented in depth later in this work. .

Definition of Terms

Attribution: “The process people use to understand the cause of events and behavior”
(Gulyn & Youssef, 2010, p. 93).

Attribution of Blame/Responsibility: “Implies that the violation of entitlement is perceived as having been caused by an action or omission of an actor who had control over his or her behavior and intentionally behaved in the given way
(Mikula, 2003, p. 795).

Bias: “The inclination to form unreasoned judgments” (Brownell et al., 2005, p. 10).

Body Mass Index: “Weight in kilograms divided by height in meters squared” (Stettler, Kumanyika, Katz, Zemel, & Stallings, 2003, p.1375).

Body image: refers to the satisfaction or dissatisfaction one has for his/her body (Cash 2002).

Explicit Attitudes: “Attitudes that shape deliberative, well-considered responses for which people have the motivation and opportunity to weigh the costs and benefits of various courses of action” (Wilson, Lindsey, & Schooler, 2000, p. 102).

Fat Phobia: “The pathological fear of fatness, the fear of the obese and the fear of becoming fat” (Latner, Stunkard, & Wilson, 2005, p. 1227).

Implicit Attitudes: “Attitudes that are manifest as actions or judgments that are under the control of automatically activated evaluation, without the performer's awareness of that causation” (Greenwald & Banaji, 1995, p. 6).

Individual of size: An individual who is either overweight or obese

Intimate Partner Violence: “Any gender-based violent act, resulting in or assumed to result in physical, sexual or mental injury on women, including threats of such acts, coercion, or captivity, whether it takes place in public or private premises” (The United Nation’s Fourth World Conference on Women, 1995, p. 48).

Obese: described as having a “BMI of 30 kg/m and greater” (Brownell et al., 2005, p. 9).

Overweight: described as having a “BMI between 25-29.9 kg/m” (Brownell et al., 2005, p. 9).

Sizism: “Attitudes, behaviors, and beliefs that subordinate or diminish or ridicule individuals because of their size or weight.” (Schoenfielder & Weiser, 1983, p. 5).

Stigma: “A social sign/emblem carried by individual who is victim of bias” (Brownell et al., 2005, p. 10).

Weight bias: “Negative weight-related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are altered because of a stigmatizing mark” (Fiske, 1998, p. 505).

Weight Stigmatization: “An attribute that conveys a devalued social identity across most

social contexts due to perceived overweight or obese status” (Puhl, Moss-Racusin et al., 2008, p. 347).

Weight discrimination: “Any restriction of individual rights, employment or academic opportunities, or biases against overweight persons” (Segen, 2006, p. 213).

CHAPTER II

REVIEW OF LITERATURE

This review of literature focused upon people's perception of body size and weight across numerous contexts (i.e., employment/work, healthcare, education, peer relations, and romantic relationships), as well as the attributions individuals make based upon weight. A link to Bronfenbrenner's (1979) ecological systems theory was established in order to highlight the diverse and pervasive nature of weight bias in Western culture. Bronfenbrenner (1979) established that the development of individual identity is affected by numerous external and internal systems. The aforementioned discrimination has been integrated with Bronfenbrenner's ecological systems theory to highlight the different contexts in which individuals of size may experience weight bias. Lastly, the review of literature has provided an overview of the research on violence in intimate relationships, with a particular focus on what little is known about the relationship of weight bias and intimate partner violence.

Ecological Systems Theory and Weight Stigma Theories

The Ecological Systems Theory

Bronfenbrenner (1979) suggested that individuals develop and are exposed to influences from many levels of their environments, including the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem is the primary context in which individuals live and derive the most direct, social contact. This

system includes interactions with family, peers, and neighborhood (Bronfenbrenner, 1979). The mesosystem refers to the connection that exists between the structures of the microsystem (Berk, 2008). This connection may include the interaction between the families and neighborhoods of individuals. The exosystem represents the greater social system in which individuals do not have a direct impact. An individual may be affected at the exosystem level when a component of their microsystem interacts with the exosystem, such as a children's experience of home being altered because their parent is facing a difficult challenge at work (Berk, 2008). The macrosystem encompasses the culture in which one lives. While traditional representations may include aspects such as gender and ethnicity, the macrosystem also extends to contexts like socioeconomic status, laws, and customs (Bronfenbrenner, 1979). The chronosystem includes events that occur within a specific environment, as well as transitional periods in life. This system can include events such as death or divorce as events such as these can alter the experiences individuals have as they continue to grow (Bronfenbrenner, 1979). This framework provides a foundation for a more comprehensive understanding of weight bias' permeation throughout the levels of society, as well as individuals' social and personal environments, as it conceptualizes individual development from an interactive versus static model.

According to the ecosystemic model, change or development cannot be explained or described without the inclusion of context, or the ecological niche in which the individuals are embedded (Davison & Birch, 2001). An individual niche or ecological

environment consists of the family (microsystem), which is then embedded in the larger community (macrosystem). Moreover and related to weight bias, characteristics specific to individuals of size, such as gender and weight, interact with familial and societal factors to influence development and perception of the self (Davison & Birch, 2001). Familial and community characteristics also interact and are affected by larger societal factors, illustrating the complex interplay of the systems (mesosystem).

The following theories and research illustrate the dynamic impact the mesosystem imposes upon individuals. Theories such as the stereotype content model help to illustrate the weight bias created and sustained by those in the larger society (Hebl & Kleck, 2002). Moreover, familial and intimate relationships can also act as an initial source of weight stigma bias (Hebl & Kleck, 2002). Together, factors such as familial and societal influences work to create weight stigma across individual, micro, and macrosystems, combining to form a more negative exosystem (Davison & Birch, 2001).

Theories Associated with Weight Stigma

Crocker, Major, and Steele (1998) categorized stigma as a characteristic that portrays a diminished social identity across a diverse array of social contexts. The authors narrowed their definition by stating that constituents of the devaluation of identity include being the object of stereotypes, social rejection, discrimination, and economic injustices. While other stigmas and discriminatory behaviors, such as those that are race-related, have been addressed more frequently, weight stigma is still regarded as socially acceptable and is upheld in the larger culture or macrosystem (Brownell et al., 2005).

The following review addresses multiple theories of stigma that help to explain the prevalence of weight bias in contemporary culture.

One theory relevant to weight bias is the Stereotype Content Model. Stereotype Content Models approach stereotypes by assessing more and less desirable traits such as warmth and competence that are developed through socialization (Fiske, Cuddy, Glick, & Xu, 2002). As the stereotypes associated with weight are visible, individuals do not have the ability control their situation in the moment. Whereas phenomena, including spiritual beliefs and nationality, may be concealed, size often cannot be hidden, leaving individuals of size more vulnerable to the stereotypical judgments of others. Hebl and Kleck (2002) stated that individuals of size are often perceived to be lazy and undisciplined, ideas consistent with a lack of warmth and competence. Brownell et al. (2005) stated that stigmas associated with low warmth and competencies tend to carry the most negative connotations and provide a potential explanation for the intensity of weight bias.

A second theory that may help to explain the negativity and pervasive nature associated with weight bias is the Intergroup Emotions Theory. The Intergroup Emotions theorists posited that individuals consider emotions during stigmatization by both appraising others and through self-categorization (Mackie, Devos, & Smith, 2001). If a certain object or idea is opposed, negative emotion can be linked to the idea or object. These ideas have a potential link to individuals of size and U.S. culture, as thinness is considered desirable, whereas being overweight is viewed as undesirable (Hebl, King, &

Lin, 2004). Identification with the privileged or high status group (i.e., thin individuals) may lead to the expression of emotions like anger toward the less privileged or lower status group (i.e., individuals of size). Hebl et al. (2004) stated that according to the Intergroup Emotions Theory, anger directed toward individuals of size may translate into negative or offensive activities such as a tendency to engage in conflict with or outwardly degrade individuals of size. Brownell et al. (2005) commented that the stereotype model and intergroup emotions theories appear similar, but differ in the emotional response that is emphasized. The Stereotype Model Theory suggested that individuals tend to express disgust toward individuals of size whereas the Intergroup Emotions Theory posited that individuals express anger toward individuals of size (Fiske et al., 2002). This distinction, while seemingly subtle, may be essential in addressing weight stigma. Strategies to lessen disgust would look different from those geared toward lessening anger and may be critical in attending to negative emotions directed toward individuals of size (Brownell et al., 2005).

Researchers in a third model, the Socio-functional Approach, investigated the specific emotions that arise as a result of intergroup relations (Neuberg, Smith, & Asher, 2000). The Socio-functional Approach contains a biocultural element and seeks to uncover the reasons as to why stigmatization occurs (Brownell et al., 2005). Neuberg et al. (2000) argued that those who engage in stigmatizing others benefit from their actions. The authors' conceptualization stemmed from the idea that humans harbor an inherent biological need to exist within groups, to propagate, and to protect their genetic code

(Neuberg et al., 2000). From this framework, those individuals perceived to threaten the safety and survival of the group will be stigmatized. Furthermore, Neuberg et al. (2000) proposed that individuals seek to diminish identified threats from stigmatized groups through emotional and behavioral means.

While this approach to stigmatization is applicable, Brownell et al. (2005) wrote that it is highly controversial. When applied to weight stigma and individuals of size, this approach could be interpreted to further the avoidance of and potential extermination of individuals of size. This idea would exacerbate weight stigmatization and could act to further serve the privileged group. Brownell et al. (2005) commented that while evolutionary and biological perspectives can serve the health care profession, weight stigma should not be considered from a Socio-functional Perspective, as this approach could be utilized to continue to scrutinize and stereotype individuals of size.

A fourth model, the System Justification Approach, follows the recommendations of Brownell et al. (2005), as it has been applied to relationships between groups, and was founded from the idea that individuals rationalize their own negative beliefs, which enables the continuation of negative beliefs perpetuated in society (Crandall & Eshelman, 2003). Rationales for participating and continuing in the justification of oppressive systems include cognitive and motivational aspects (Jost & Banaji, 1994). Whereas certain cultural factors (i.e., ethnicity) could serve as protective factors from these rationales, both perpetrators and those individuals who are stigmatized tended to convey a preference for the non-stigmatized (i.e., privileged) group (Crandall & Eshelman,

2003). This preference can lead to a perpetuation of stigmatization as both high- and low-status groups view the low-status group negatively. In the case of weight stigmatization, individuals of size tended to view themselves as inferior and may develop low self-esteem (Crandall & Eshelman, 2003). The System Justification Approach suggests that individuals of size may align their thought patterns with those who stigmatize them and help to reinforce the social structure that is permissive of weight stigmatization (Crandall & Eshelman, 2003). This theory suggested that change is necessary at a societal level (i.e., the privileged group) and also at an individual level (i.e., the thought patterns and beliefs of individuals of size).

Integration of Ecosystemic and Weight Stigma Theories

The four weight stigma theories that have provided a brief review of why weight stigmatization exists and how it is perpetuated in society. When these theories are considered in light of ecosystemic theory, overt links can be made. Stereotype Content Model and Systems Justification Approach overlap with the microsystem of ecosystemic theory, as each involves developing through social interactions with friends, family, and peers. Intergroup Emotions Theory, which involves emotions when appraising the self and others, shares similarities with the mesosystem, as the interaction of messages from school and the environment influence emotion. The Socio-Functional Approach is similar to the chronosystem in that individuals learn that there are benefits from stigmatizing others, thus altering future behavior.

Moving from a theoretical level to a more concrete perspective, the following sections describe how weight stigmatization manifests in the United States, as well as in selected other countries. Moreover, the following sections describe the different ways in which weight bias and weight discrimination affects individuals of size.

Experiences of Individuals of Size

Familial Relationships

In Bronfenbrenner's (1979) ecological systems theory, the most immediate environmental influence is the microsystem, which includes family, friends, and peers. Harassment and weight stigmatization have been reported to begin as early as nursery school (Cramer & Steinwert, 1998) and persists throughout childhood and adolescence (Latner & Stunkard, 2003). Early weight bias has also been found to occur across cultures, as Cramer and Steinwart (1998) reported that White children assigned more positive adjectives to thinner children and more negative adjectives toward children of size. Rich et al. (2008) found that Hispanic preschool children also exhibited weight stigmatization, as Hispanic children were more likely to pair negative adjectives with children of size and positive adjectives with thinner children.

While family can serve as a protective factor against stigmatization, these same relationships have been reported to include the stigmatizing of individuals of size. Puhl and Brownell (2006) explored the experience of weight stigmatization in a large sample of overweight and obese women. The researchers interviewed the women about the most frequent interpersonal sources of weight stigmatization in their lives. Participants

reported that the most common source of weight stigmatization came from their family and was followed by doctors, peers at school, sale clerks, friends, and co-workers (Puhl & Brownell, 2006). Seventy-two percent of the sample reported that family members were a recurrent source of weight stigmatization in their lives. Moreover, the women in the sample reported that they experienced increased levels in weight stigmatization from their family members as their BMI increased. Researchers suggested that, while individuals may experience an array of stigma associated with their size, they tend to experience a greater amount of weight stigma from their families as their weight increases (Puhl & Brownell, 2006). Women of size reported experiencing weight stigmatization most often by their mothers (45%), followed by their fathers (33%), brothers (29%), sisters (21%), sons (13%), and daughters (7%) (Puhl & Brownell, 2006).

Puhl, Moss-Racusin et al. (2008) also explored perspectives and experiences of individuals of size who had experienced weight stigmatization. The researchers obtained a sample of participants who identified as overweight or obese men and women. The participants were asked to recount their worst experience regarding weight stigmatization, the perpetrator of the stigmatization, their relationship with the perpetrator, and the setting of the event (Puhl, Moss-Racusin et al., 2008). The participants communicated that their worst experience of weight stigmatization occurred when they were adults by other adults and occurred most frequently in the home. Seventy-six percent described their experiences consisting of verbal abuse and included negative comments, insults, offensive name calling, teasing, and ridicule (Puhl, Moss-

Racusin et al, 2008). For example, a 57 year-old woman reported: “My mother telling me in a loud voice at a family gathering that I should buy my clothes at the tent and awning supply store” (Puhl, Moss-Racusin et al., 2008, p. 351). While much of the research to date has been conducted in environments such as employment and medical settings, 46% of the sample reported that their worst experience of weight stigma occurred in their home; this illustrates the importance of exploring weight stigma within interpersonal relationships, specifically familial relationships (Puhl, Moss-Racusin et al., 2008). Furthermore, Davison and Birch (2001) reported that fathers who had a history of higher educational gains and higher earnings were more likely to endorse and engage in weight stigmatization with both their children and others. The researchers also stated that both mothers and fathers who placed an emphasis on their physical appearance were also more likely to engage in weight stigmatization with their children as well as with other individuals of size (Davison & Birch, 2001).

While individuals of size, most often women, have reported instances of name calling, teasing, and ridicule due to their weight, individuals may also experience weight stigma in seemingly covert ways, such as lack of representation on television and avoidance (Rogge, Greenwald, & Golden, 2004). Rogge et al. (2004) referred to this more subtle form of weight stigmatization in their study of individuals of size as a “civilized oppression” (p. 301). Harvey (1999) described oppression as “the systematic and inappropriate control of people by those with more power” (p. 36). Both Harvey (1999) and Rogge et al. (2004) wrote that, while civilized oppression may not be as

apparent as other forms of stigma and abuse, the resulting effects are potent, degrading, and potentially destructive to the recipients. Insidious acts may be obscured in daily routines or encounters, but the effects are felt (Harvey, 1999). For civilized oppression to occur, a power differential must exist within a relationship (Rogge et al., 2004).

Attributes such as wealth, education, and attractiveness have the potential to skew the power in a relationship, thus potentially creating civilized oppression. Persons of size are likely to be in a subordinate position as a result of weight stigmatization (Harvey, 1999). This power differential may also be inherent within familial structure. This inherent power differential may create oppressions and while not overt, has the potential to denigrate, humiliate, or leave individuals of size feeling powerless (Harvey, 1999).

Lastly, Puhl and Brownell (2006) reported that individuals of size may experience weight stigmatization from family members outside of the immediate family and that this is particularly likely to occur when only one member of the family is of size. This finding may be especially true for children and women of size who may choose to eat separately from their immediate as well as their extended families (Falkner et al., 1999). Moreover, individuals of size may become the identified patient or the individual who receives blame for larger systemic, familial issues (Elizur & Minuchin, 1989). The identified patient is likely to be the recipient of criticism and negativity within the family (Elizur & Minuchin, 1989). However, family can also serve as a protective factor from mainstream society. Previous research has reported that families often serve as both a buffer and a source of weight stigmatization (Falkner et al., 1999). Factors associated

with protection versus stigmatization within the family have yet to be established (Brownell et al., 2005). Like family, friends serve as both support and a source of weight stigmatization for individuals of size.

Relationships with Friends

Friendship has been described as an essential component of social and psychological development of children and adolescents (Storch et al., 2003). As U.S. culture places an emphasis on physical appearance, body image, and athletic prowess, being perceived as individuals of size may have persistent and long-lasting implications for the development of friendships for overweight and obese adolescents (Storch et al., 2003). Latner and Schwartz (2005) wrote that the formation of friendships for individuals of size is often times more difficult, especially for women and children. Researchers have attributed this phenomenon to the fact that stereotypes about the perception of individuals of size begin early and are pervasive throughout their development (Latner, Rosewall, & Simmonds, 2007). Researchers have indicated that individuals of size often have fewer close relationships, fewer social skills, and are less popular than individuals of normal size, which has the potential to affect how individuals of size perceive themselves and how they are viewed by those individuals considered to be of normal weight (Davison & Birch, 2001). Faulkner et al. (2001) wrote that individuals of size have fewer friends and spend less time with their friends. The researchers also reported that this occurred more frequently with women and children, and that overweight and obese women viewed themselves as poorer students. Students of size were two times more likely to be held

back a year in school than those children identified as normal weight. This disruption may have an impact on the continuity of friendships (Faulkner et al., 2001).

Childhood and adolescence are times for individuals to learn about friendships and begin to form bonds with others. While some inconsistencies exist within the literature regarding the continuity of the effects of weight stigmatization on friendship formation beyond elementary school, a majority of the research has suggested negative patterns associated with friendship formation persist (Brownell et al., 2005). Janssen, Craig, Boyce, and Pickett (2004) reported that overweight and obese adolescents were more likely to experience negative friendship interactions. Due to the negative experiences of adolescents of size, they were more likely to withdraw from friendships, be targeted for rumors, and be the recipients of physical aggression (Janssen et al., 2004). While both adolescent girls and boys of size were reported to experience physical aggression, boys were more likely to be the recipients of physical aggression whereas girls were more likely to experience relational aggression. As relational aggression more often goes undetected, it may act to restrict access to peer groups, leading to greater isolation, and exacerbate weight stigmatization of girls of size (Janssen et al., 2004).

Regardless of the type of weight stigmatization, approximately half of all overweight and obese adolescents reported experiencing weight bias/teasing by their peers (Brownell et al., 2005). The development of social networks allows adolescents and adults to feel connected to groups and individuals. Storch et al. (2003) reported that individuals of size tend to be isolated from their peers, have smaller social networks, and

are less connected to groups than individuals of normal size. Moreover, Storch et al. (2003) stated that adolescents of size participated in fewer social organizations and belonged to fewer organizations as compared to adolescents who are perceived as thin or of normal size. Brownell et al. (2005) wrote that a similar pattern was found to exist in adults of size, as they lived alone more often and has less contact with friends and peers.

As social networks offer support to those who belong to them, more limited and less varied networks offered less consistent support (Brownell et al., 2005). Puhl and Brownell (2006) stated that weight stigmatization may lead to overweight and obese individuals being excluded from valued in-groups as well as difficulty with out-groups. The process of weight stigmatization resulted in less support for individuals of size. Brownell et al. (2005) commented that individuals of size may frequently turn to protective actions of social withdrawal in order to insulate themselves from harmful experiences. This overt act of social isolation has been shown to lead to fewer friendships and less social interaction (Brownell et al., 2005). Unsurprisingly, experiences of weight stigmatization extended beyond familial and friendship relationships and into interactions with romantic partners and in the greater community.

Intimate Relationships and Individuals of Size

Overweight and obese individuals have reported experiencing weight stigmatization within their families (Puhl & Brownell, 2006). It seems reasonable then to expect that intimate relationships would not be impervious to weight stigmatization and bias. Previous research has confirmed these biases as participants in research studies

have consistently exhibited weight bias regarding the prospect of partnering with a person of size (Boyes & Latner, 2009) or about the quality of intimate relationships that persons of size may have (Horsburgh-McLeod et al., 2009). Brownell et al. (2005) also reported that those perceived to be individuals of size or obese individuals were less likely to be selected as an intimate partner. It has been suggested that obese individuals, particularly women, have been perceived as less desirable, as well as less capable, in romantic relationships (Regan, 1996; Sobal & Bursztny, 1998). Regan (1996), commented that obese women experience more difficulty in entering intimate partnerships. Cawley, Joyner, and Sobal (2006) reported that girls of size begin the dating process at a later age, experience fewer dates, and date partners who are considered to be less physically attractive. Blaine and McElroy (2002), as well as Stack (1996) commented that advertisements and commercials are biased against individuals of size, further adding to the misconception of individuals of size within romantic relationships.

Horsburgh-McLeod et al. (2009) sought to further research pertaining to women of size by employing free response methodology similar to that utilized by Hiller (1981). Hiller (1981) generated descriptive paragraphs as well as photographs of men and women depicted as either normal weight or overweight. Participants were then asked to create a story about the depiction of the men and women with no guidance from researchers as to the information or the focus of the story. Hiller (1981) then assessed participants' written responses, coding whether or not the vocabulary tone was confirming or disconfirming toward individuals of size. The author reported that those creating a story for the obese

depiction of the men and women included more negative affect and wrote of less positive outcomes for the overweight men and women than those creating stories for the normal weight women and men. Those participants who received a photograph versus a written story expressed more negative views about their characters, with negative feelings most often stated when the picture was a women (Hiller, 1981). Horsburgh et al. (2009) utilized a similar research methodology and recruited 49 Caucasian/White women to participate in a study in which the researchers depicted either a woman of size or a woman thought to be of normal size. Twenty-four women received a picture of the overweight woman and 25 received a picture of the women judged to be of normal size. Participants were then given the instructions to write openly about what they thought would be a normal day for the woman in their picture. In addition to more negative comments regarding hygiene and eating patterns, participants who received the picture of the overweight woman mentioned an intimate partner far less often than those participants who received the picture of the woman judged to be of normal size, despite the fact children were mentioned more often for the woman judged as overweight.

Murray (2005) suggested that, as partners feel less confident that their partner perceives them to be a good mate, individuals may resist fully engaging in a relationship. This tendency to hold back can result in lowered self-esteem, a quality that is also associated with lower relationship quality (Murray, 2005). Boyes and Latner (2009) further explored the link between weight and intimate partnership by obtaining self-reports of women of size and reports of their partners, all of whom were men. The

overall results showed a trend for overweight and obese women reporting that they perceived themselves as weighing more than what their partners would have perceived as ideal (Boyes & Latner, 2009). Many of the women of size in the sample exhibited internalized weight bias and endorsed questions that were critical of their weight and self-worth. Furthermore, the results also suggested that women of size reported that they believed their partners would judge them as less warm and trustworthy, two critical components in mate evaluation.

Results also indicated that men viewed partners of size less positively than women who were reported to be of average weight (Boyes & Latner, 2009). The men ranked their partners of size as poor matches compared to what they perceived for attractiveness, vitality, and their perception of an ideal body. The ideal body item highly correlated with men's overall perception of the relationship quality, suggesting that this item was critical in men's perception of a healthy and happy relationship (Boyes & Latner, 2009; Murray, 2005).

It has also been reported that, as a result of the negative attitudes, stereotypes, and opinions, overweight and obese individuals may internalize the negative sentiments of society (Schwartz, Vartanian, Nosek, & Brownell, 2006). Individuals of size reported believing negative stereotypes, such as persons of size are lazier and less intelligent than those who are perceived to be of normal size, and that this hurts the image they held of themselves (Wang, Brownell, & Wadden, 2004). As a result, negative beliefs about

individuals of size were not only perpetuated by the individuals of society, but are often internalized by individuals of size.

Employment

Weight stigmatization occurs across a number of social contexts such as within the family or between friends and acquaintances. Just as weight bias occurs within these situations, employers participate in similar discriminatory practices. In 1987, Toni Cassista applied for a job at a health food store in California (Kristen, 2002). At the time she submitted her application for employment, Toni identified as an individual of size. After her initial interview, Toni was called back, as the store conducted a number of interviews. While qualified, she ultimately was not awarded the position (Kristen, 2002). However, Toni was persistent and when another position in the store became available, she once again submitted an application. When she was overlooked for a second job, Toni Cassista inquired as to what means she could take to increase her chances of being awarded a position within the store (Kristen, 2002). She was informed that her weight was a concern, even though she had indicated on her paperwork that she had no physical limitations concerning the potential job demands (Kristen, 2002).

Puhl and Brownell (2001) further explored the hiring process and also reported that there was a bias in hiring regarding overweight and obese individuals. The authors reported that persons of size often experienced discrimination due to their size, receiving fewer job offers than individuals perceived to be of average weight. Moreover, Puhl and Brownell (2006) reported that in a study of 2,249 overweight and obese women, 25%

reported experiencing job discrimination (i.e., being denied a job) due to their weight. Additionally, 54% stated that they faced weight stigma at the hands of co-workers and colleagues and 43% reported experiencing similar treatment from their employers (Puhl & Brownell, 2001). The sample of women reported weight stigma in the form of being ridiculed for their weight and often times were the target of jokes. Moreover, the women reported discriminatory practices as they were denied promotions and job opportunities as a result of their weight (Puhl & Brownell, 2001).

Blaine and McElroy (2002) wrote that bias toward overweight and obese individuals is embedded within U.S. culture, particularly with citizens valuing hard work. These were the same citizens who exhibit stereotypical beliefs that individuals of size are lazy or lack willpower. Roehling, Roehling, and Pichler (2007) reported similar discriminatory stigmatization based upon weight in their sample of 2,838 individuals of size. Consistent with previous reports, the authors found that women of size were approximately 16 times more likely to experience weight-related job discrimination than men of size. Roehling et al. (2007) stated that, as weight increased, so too did the likelihood that individuals of size would experience weight related discriminatory practices. Puhl, Andreyeva, and Brownell (2008) reported similar findings in their sample of 2,290 participants. The authors reported that 5% of men of size and 10% of women of size in their sample indicated that they had endured weight-based job discrimination. Among the men and women who reported experiencing weight-related job discrimination, approximately 60% had suffered from these practices at least four times

in their lifetime (Puhl, Andreyeva et al., 2008). Younger adults with a higher Body Mass Index were reported to be more likely to experience weight discrimination regardless of race and ethnicity. Individuals in the study stated that discriminatory practices included failing to be awarded a position due to their weight, being passed over for a promotion, and wrongful termination due to their weight (Puhl, Andreyeva et al., 2008).

Weight stigmatization and bias also affect the wages of overweight and obese individuals. Baum and Ford (2004) examined the relationship between individuals of size and vocational earnings. The authors reported a penalty in vocational earnings for both men and women. When controlling for socioeconomic and familial variables, obese/overweight men's earnings penalty ranged from 0.7% to 3.4% when compared to men reported to be of normal size (Baum & Ford, 2004). The gap was larger for women of size. When researchers controlled for similar variables, women of size experienced a wage penalty of 2.3% to 6.3% when compared with women reported to be normal size (Baum & Ford, 2004).

Most research has failed to account for the intersection of race and individuals of size. However, Cawley (2004) and Maranto and Stenoien (2000) explored the intersection of weight-based vocational discrimination, race, and earnings. White women of size were reported to experience a 9% decrease in vocational earnings when their weight was 64 pounds above what is considered to be average weight and that Black women of size received a 4.7% decrease in wages when their weight was 79 pounds above what is considered to be average weight (Cawley, 2004). This decrease in wages

was comparable to the difference of one and a half years of education or three years of work experience (Cawley, 2004). Maranto and Stenoien (2000) reported that both White and Black women of size experienced job-based weight discrimination in the form of wage decreases. When controlling for socioeconomic status, White women of size experienced a decrease in their wages ranging from 6% to 24%. When controlling for the same variable, Black women of size reported a decrease in wages of approximately 3% to 15% (Maranto & Stenoien, 2000).

Ethnicity

In Western, White society, a thin and lean body is most often portrayed as the ideal size for women. For a majority of women, this body type is unattainable and can often lead to great dissatisfaction with their bodies and often, internalized feelings of guilt and shame (Klaczynski, Goold, & Mudry, 2004). While this standard has been adopted to varying degrees across cultures, research has indicated that ethnicity plays a role in how body size is perceived (Latner et al., 2005).

Duncan and Robinson (2004) indicated that Latina and African American women were more likely to be more accepting of individuals and bodies of size as their cultures may act as a buffer from the Western ideal of the thin body. The authors also reported that the Latina and African American women in their sample displayed a greater appreciation for diverse body types. Latner et al. (2005) reported similar data and stated that African American women tended to be least susceptible to negative body images, and, instead, had higher levels of self-esteem and body acceptance than White and Latina

women. Roehling et al. (2007) found similar results when comparing White and African American women, reporting that White women were less accepting of larger body sizes. Latner et al. (2005) also commented that Asian American women indicated lower levels of weight-based discrimination when compared with White women.

Spurgas (2005) found that country of birth, as well as ethnicity, also played a role in the perception of body size. Spurgas (2005) commented that women, particularly Latina women, were more comfortable with their bodies when in their country of origin than when in the United States. Cachelin, Monreal, and Juarez (2006) extended this research and discussed not only the importance of ethnicity and country of origin, but also the level of acculturation. Cachelin et al. (2006) sampled Mexican American women and found that those who adhered to a stronger White identity exhibited a stronger bias for thin bodies whereas those Mexican American women who adhered to their Mexican heritage were more accepting of diverse body shapes (Cachelin et al., 2006).

Women's body images in developing countries such as India have also been impacted by Westernization through the media (Shroff & Thompson, 2004). For example, the internalization of the thin body ideal has led to increased rates of body image disturbance and eating disorders in Southeast Asian women (Menon & Pant, 2007). These studies and others noted above highlight the importance of variables such as acculturation, ethnicity, and cultural context in the understanding of sizism.

The trend of weight stigmatization has been established across multiple domains and was reported to affect the lives of individuals of size in diverse ways. Until now, this

literature review has focused on the perceptions of weight discrimination, as reported primarily by persons of size. The focus will now shift to the perceptions of others and the pervasive nature of weight-based biases across interpersonal and professional relationships.

Healthcare Practitioners' Perceptions of Individuals of Size

Overweight and obese individuals have reported experiencing weight based stigmatization across a number of areas of the healthcare. Examples include physicians, nurses, psychotherapists, fitness professionals, and dieticians (Puhl & Heuer, 2009; Puhl, Moss Racusin et al., 2008). As the healthcare field is dedicated to providing high quality services, recognizing the existence of weight stigmatization within the field is critical.

Physicians

In a number of research studies, physicians have consistently displayed weight bias in conceptualizing overweight and obese individuals. Researchers have identified these biases for seasoned doctors as well as residents in training. Davis, Shishodia, Taqui, Dumfeh, and Wylie-Rosett (2007) reported that first, second, and third year residents stated that they felt incompetent when working with obese individuals (Davis et al., 2007). Moreover, researchers also discussed that, while each class held weight-based biases, third year residents exhibited more negative reactions to obese patients (Davis et al., 2007). Previous research has addressed how negative attitudes toward obese patients may affect not only the quality of care received by the patient, but also the perception of care by the patient (Puhl & Brownell, 2006). As residents are still in training, it was

suggested that educating them on the effects of biases held toward individuals of size may assist in ensuring a higher quality of care for future patients (Davis et al., 2007).

Block, DeSalvo, and Fisher (2003) also conducted research regarding the attitudes of medical residents toward those patients identified as obese. Eighty-seven residents completed a battery of assessments created to measure their knowledge of weight-related medical issues as well as attitudes toward obese individuals (Block et al., 2003).

Beginning with knowledge about obesity, residents exhibited a deficit in their knowledge pertaining to the measurement of obesity. While participants reported moderate confidence in identifying obesity, previous research has indicated that many residents frequently misdiagnose obesity, thus affecting patients' medical record and treatment (Stafford, Farhat, Misra, & Schoenfeld, 2000).

Research has shown that in addition to deficits in knowledge, medical and dental students exhibit weight bias. Wear, Aultman, Varley, and Zarconi (2006) explored the attitudes of 54 medical students to a diverse sample of patients. A vast majority of the sample reported that obese patients were the most likely recipients of disparaging comments and humor by physicians, resident, and students. More specifically, the students in the Wear et al. (2006) study blamed obese patients for their weight and commented that obese patients created supplemental work for the students. Lastly, many of the students participating in the study concluded that their humor was not misguided nor was it inappropriate.

Researchers have also examined student attitudes through the use of vignettes. Wigton and McGahie (2001) randomly assigned medical students to watch either a videotape portraying actors of normal size or the same actors wearing padding or the manipulation of a secondary apparatus to look like an overweight individual. At the conclusion of the research study, Wigton and McGahie (2001) wrote that those students who viewed the tapes portraying the overweight individual judged such persons to be less likely to follow medical advice or observe guidelines of a treatment plan. Additionally, the medical students rated the actors of size to be less attractive and more likely to be depressed than their normal sized counterparts (Wigton & McGahie, 2001). Magliocca, Jabero, Alto, and Magliocca (2005) surveyed 420 dental students regarding their attitudes toward overweight and obese patients. Magliocca et al. (2005) noted that nearly a third of their sample had adverse reactions to obese patients and attributed their physical appearance to internal and controllable actions. Approximately 18% of the same sample reported feeling discomfort when examining and working upon obese patients and experienced difficulty in feeling empathy for obese patients (Magliocca et al., 2005).

Despite much of the negative sentiment exhibited by medical and dental students, some research has focused upon how best to train and educate medical students. Block et al. (2003) concluded that medical training programs must become more successful in not only increasing resident knowledge regarding obesity, but also in addressing negative attitudes toward obesity (Block et al., 2003). Efforts such as these were thought to

address both deficits in training and medical students' future interactions with overweight and obese individuals.

Negative attitudes toward overweight and obese individuals extend beyond residents to include doctors as well. Harvey and Hill (2001) wrote that physicians viewed obesity as a behavioral symptom caused by a sedentary lifestyle and individuals' choice to overeat. In the authors' study of over 600 hundred primary care physicians, greater than 50% viewed obese individuals as awkward, unattractive, and generally noncompliant. Approximately 33% of the physicians attributed obese patients' weight to the internal processes of their patients, stating that obese patients were weak-willed, incapable of change, and careless (Harvey & Hill, 2001). While weight based stigmatization and biases have been reported most often in the United States, Rothblum and Solovay (2009) wrote that the phenomenon of weight discrimination occurs across cultures, particularly in the medical field.

For example, in a study conducted in France, 600 general medical practitioners were asked about their attitudes toward obese patients. Bocquier et al. (2005) reported that approximately 200 of the medical practitioners surveyed identified overweight and obese patients as less motivated than a sample of individuals perceived to be of normal weight. The medical doctors also characterized the overweight and obese individuals as having less impulse control, ranking overeating as the most important risk factor of obesity, exceeding even the importance placed upon genetic and environmental risk factors. Similar sentiments were expressed by physicians in the countries of Australia

and Israel. Campbell, Engel, Timperio, Cooper and Crawford (2000) reported that the greatest frustration for general practitioners was their patients' noncompliance with weight loss programs and their lack of motivation to lose weight. At the same time, the authors reported that approximately half of the practitioners' expectations and their perception of clients' ability to lose weight were low (Campbell et al., 2000). Fogelman et al. (2002) found that 31% of Israeli family physicians reported that overweight and obese individuals tended to be more sluggish when compared with individuals perceived to be of average size. Approximately 25% of the sample of practitioners also endorsed the idea that overweight and obese individuals are deficient in motivation when it comes to losing weight (Fogelman et al., 2002). This knowledge helps not only highlight general practitioners' biases toward individuals of size, but to illustrate the way they conceptualize patients and their perception of successful strategies to lose weight.

Respect or positive regard for patients is a critical component of medical care and has been reported as paramount in the treatment of all patients (Beach, Duggan, Cassel, & Geller, 2007). Weight-related stigma often leads physicians to hold less positive regard for overweight and obese patients, particularly those patients identified as obese (Beach, Roter, Wang, Duggan, & Cooper, 2006). Researchers have consistently documented physicians' ambivalence as well as blatant avoidance in treating patients identified as obese (Huizinga, Cooper, Bleich, Clark, & Beach, 2009). In these ambivalent and avoidant situations, physicians have cited both personal and institutional reasons as a rationale for their behavior (Huizinga et al., 2009; Merrill & Grassley, 2008).

Weight-related bias has been linked not only to a decrease in the overall care of persons of size as well as obese individuals, but is also related to less preventative services including, but not limited to, cancer screenings (Merrill & Grassley, 2008).

Beach et al. (2007) reported that physicians who hold high levels of positive regard for their patients tend to be more pleasant, emotionally present, and share more medically relevant information with their patients. Conversely, those physicians who feel less positive regard for patients shared less medically relevant information and were less approachable. Weight-related bias not only affects physicians' attitudes, but the expectations and attitudes of patients, particularly women (Huizinga et al., 2009). Women indicated that they preferred respectful relationships with their individual physicians and reported missing physician appointments when respectful relationships were not present (Merrill & Grassley, 2008).

Huizinga et al. (2009) conducted research regarding levels of physicians' respect toward their patients. A total of 40 physicians were approached and asked to rate their level of respect for patients. While researchers asked both the physicians and patients to complete questionnaires regarding office visits, researchers were interested in the level of respect held by the physicians (Huizinga et al., 2009). Patient BMI records were calculated from their height and weight and researchers compared levels of physician respect for their patients. Huizinga et al. (2009) reported that higher BMI records were associated with lower levels of respect for patients. Furthermore, results were unchanged after researchers controlled for patient and physician demographic data. The data

coincided with previous studies and reinforced the power of weight bias, as well as the very real risks associated with weight stigma. These risks include avoidance of care and physicians providing less medical information to their patients (Beach et al., 2007; Huizinga et al., 2009).

Hebl and Xu (2001) reported a similar weight biased trend amongst physicians. Hebl and Xu (2001) provided family practitioners with six vignettes, which the researchers varied to depict men and women of various sizes. Hebl and Xu (2001) wrote that as patient BMI increases, the family practitioners indicated that the patients were most likely to be less healthy, were less capable of maintaining proper hygiene, and lacked discipline. Moreover, physicians asserted that they grew impatient, enjoyed their jobs less, and had less motivation to help their overweight and obese patients. Hebl and Xu (2001) further reported that as patient BMI scores increased, physicians reported that seeing heavier patients was a larger waste of time and that heavier patients were more vexing, less likely to follow-up on medical advice, and less likely to seek counseling.

Attitudes such as the ones expressed by Bocquier et al. (2005) and Vacek (2007) may not only affect the clinical judgments of healthcare professionals, but may discourage individuals of size from seeking treatment. Fontaine, Faith, Allison, and Cheskin (1998) reported an inverse relationship between BMI and the number of physician visits in women. These researchers discovered that, while controlling for variables including race, socioeconomic status, and age, women with a BMI of 35 kg/m^2

were a third more likely to delay medical procedures such as gynecological and breast examinations versus women with a BMI of 25 kg/m² (Fontaine et al., 1998).

The combination of physician attitudes and patient experiences has led to researchers concluding that overweight and obese patients are both less likely to receive medical advice and less likely to seek medical treatment (Beach et al., 2007; Hebl & Xu, 2001; Huizinga et al., 2009). Research has highlighted the barriers faced by patients of size in accessing and receiving quality medical care. However, research has also indicated that individuals of size experience weight bias in their interactions with nurses. The following section addresses the experiences of weight bias by nurses.

Nurses

General practitioners and medical doctors are but one source of weight stigmatization of individuals of overweight and obese individuals. Research has also been conducted on nurses and responses have varied from hesitance to working with overweight individuals to resistance to assisting and treating obese patients. Mercer and Tessier (2001) sampled nurses regarding their attitudes toward obese individuals. While reports did not indicate stereotypical beliefs regarding individuals of size, nurses in this sample exhibited ambivalence about working with persons of size (Mercer & Tessier, 2001). These beliefs were coupled with reports of low enthusiasm for working with obese individuals. The nurses reported that they felt the obese patients lacked the will and motivation to change (Mercer & Tessier, 2001).

Puhl and Heuer (2009) reported that nurses consistently expressed biased and stigmatizing beliefs toward overweight and obese individuals including, but not limited to, stereotypical notions that individuals of size are lazy, deficient in motivation and control, and are uncooperative when seeking services. In addition, Vacek (2007) reported that 24% of a sample of nurses reported that they were repulsed by obese individuals. Brown (2006) reported that when nurses treated both individuals of size and obese patients, they regularly expressed biased attitudes including that their patients were lazier, had less self-control, and were less compliant than patients of normal size.

Maroney and Golub (1992) reported that 31.3% of nurses surveyed in their study indicated that they preferred not to care for a patient identified as obese. Approximately 6% of the same sample reported that they were repulsed when working with an obese individual and 14.9% indicated that they felt impatient when caring for an obese patient. These numbers were even higher in an earlier study conducted in Canada where Bagley, Conklin, Isherwood, Pechiulis, and Watson (1989) indicated that 42.1% of nurses in their study preferred not to work with obese individuals, 8.1% agreed that they were repulsed by obese patients, and that 30.8% of nurses felt impatient when working with obese individuals.

Brown, Stride, Psarou, Brewins, and Thompson (2007) conducted a study with 398 nurses. When asked, 69% of nurses indicated that personal choices about what food to eat and a lack of physical activity explained how persons become obese. In addition, 33% of the same sample attributed a lack of self-control when eating as the cause of

sustained obesity, while only 8.2% stated that they believed obese individuals were motivated to change their lives (Brown et al., 2007).

Similar to research conducted with medical students (Block et al., 2003; Davis et al., 2007) and physicians (Hebl & Xu, 2001; Huizinga et al., 2009), nurses exhibited a weight bias in their perceptions and treatment of overweight patients as well as obese patients (Brown et al., 2007; Vacek, 2007). However, the medical field, more specifically physicians and nurses, comprise only a percentage of the healthcare field. The following is an example of the weight bias and stigmatization that occurs amongst dietitians, physical educators, and physical therapists.

Dietitians, Physical Educators, and Physical Therapists

As in the medical field, physical educators and fitness experts, as well as physical therapists, exhibited weight biases. Puhl, Wharton, and Heuer (2009) explored the possibility of weight bias amongst dietetics students. Puhl et al. (2009) sampled a total of 182 dietetics students from 14 universities. Participants received one of four vignettes depicting potential fictitious clients. Each vignette reported that the client was referred due to lactose intolerance and the participants rated how much they thought they would enjoy working with the clients as well as rating their dietary profile (Puhl et al., 2009). The researcher varied client BMI scores as well as client weight, but kept all other variables, such as caloric intake and amount of physical activity, consistent across all participants. Participants reported moderate levels of fat phobia. When compared to students who read non-obese profiles, those who read the obese profiles stated that diet

and health were worse even though those variables were consistent across the vignettes (Puhl et al., 2009). Furthermore, the students who read the obese profiles reported that they perceived the clients to be lacking in self-esteem, judged the clients to be unattractive and slow, and believed these clients lacked discipline and self-control (Puhl et al., 2009).

Berryman, Dubale, Manchester, and Mittelstaedt (2006) also reported that the dietetic students in their study, as well as the non-dietetic students in their study, exhibited weight bias. Out of the 76 students sampled, each group scored moderately on self-reported measures of fat phobia with 16% exhibiting high levels of fat phobia. As in previous studies (McArthur & Ross, 1997), students' responses aligned closely with pervasive stereotypes, as the participants reported that they thought that overweight and obese individuals were responsible for their weight, consistently overate, were unattractive, and maintained a low level of self-esteem. Just as Block et al. (2003) concluded that training and awareness must be increased and expanded, Berryman et al. (2006) suggested that dietetics students are likely not receiving the information necessary to address weight-related biases and myths.

McArthur and Ross (1997) sampled a total of 439 registered dietitians regarding their attitudes toward not only their clients' perceived BMI scores, but their perceived weight as well. Ninety-nine percent of the respondents were women. One-hundred and fifty-two dietitians marked that they perceived themselves to be overweight (McArthur & Ross, 1997). The sampled dietitians indicated that they blamed themselves for their

weight and harbored negative attitudes such as feeling unattractive as well as being concerned with their weight. Participants exhibited positive attitudes concerning personal goal-setting, which included exercise, maintaining weight loss, and willpower (McArthur & Ross, 1997). Two-thirds of the dieticians that perceived their bodies to be overweight were not overweight according to calculated BMI scores. This finding was important as it reaffirms the notion that dieticians exhibited a strong inability to correctly judge their bodies. Like other members of the U.S. majority culture, they may rely upon the perceptions of others, which could lead to unrealistic goal-setting as well as harmful self-perceptions (McArthur & Ross, 1997). Regarding their attitudes toward overweight and obese clients, the dieticians in the study exhibited ambivalent attitudes. However, the registered dieticians showed less favorable attitudes toward their clients than toward themselves, and stated that their clients' difficulties were most likely due to emotional issues and lack of goal-setting behaviors such as establishing a healthier diet and exercising regularly (McArthur & Ross, 1997).

Dieticians in countries other than the U.S. likewise exhibited weight bias. In a sample of 187 dieticians in the United Kingdom, researchers reported that obese clients were seen as less favorable than overweight clients (Harvey, Summerbell, Kirk, & Hill, 2002). Moreover, while many of the British dieticians attributed excess weight to a lack of personal responsibility, the participants were more critical of obese participants. While stigmatization was present throughout the study, it was reported to be much stronger toward obese clientele (Harvey et al., 2002). Australian researchers also reported weight

bias toward overweight and obese women and men amongst their sample of 400 registered dietitians (Campbell & Crawford, 2000). The researchers wrote that dietitians reported experiencing frequent frustration with overweight and obese clients. The dietitians in the study remarked that overweight and obese clientele often failed to comply with their diets, were unmotivated, and often held unrealistic expectations of their abilities (Campbell & Crawford, 2000).

Just as dietitians may be integral in addressing medical concerns and weight biases amongst practitioners and clients, fitness professionals could play a similar role (Hare, Price, Flynn, & King, 2000). Medical evidence has shown that physical activity is integral in treating and preventing obesity in some patients. In tandem with dietitians as well as other health professionals, fitness professionals may be able to assist some patients in the integration of fitness programs and healthier lifestyles. Hare et al. (2000) set out to measure physical fitness trainers' perceptions of weight and determine if their perceptions affected their work. Three-hundred and thirty-five exercise test technologists, health and fitness instructors, and exercise specialists were sampled during the study. A questionnaire adapted from one used to gauge medical and school experts' attitudes to overweight and obese individuals was utilized to assess the exercise and fitness specialists' attitudes (Hare et al., 2000). Overall, the respondents indicated that they believed sedentary lifestyles (89%), unhealthy eating habits (84%), and overeating (70%) were largely responsible for individuals becoming and remaining overweight. Contrary to earlier studies with nurses and physicians, fitness trainers and physical fitness

experts were more open to working with overweight as well as obese clients (Hare et al., 2000). However, 68% responded that they felt responsible for counseling individuals of size as well as obese clients about their weight (Hare et al., 2000).

Chambliss, Finley, and Blair (2004) explored exercise students' attitudes toward overweight and obese clients in order to assess level of implicit as well as explicit anti-fat bias. One-hundred and thirty-six undergraduate and 110 graduate students majoring in exercise science across three universities in the southwestern United States participated in the study. Chambliss et al. (2004) utilized the Implicit Association Test (Greenwald, McGhee, & Schwartz, 1998) an explicit rating scale, and the Antifat Attitudes Scales (Lewis et al., 1997) in order to assess student attitudes toward individuals of size and obese individuals. Regarding implicit anti-fat beliefs, the exercise students in the Chambliss et al. (2004) study displayed significant implicit anti-fat attitudes.

Caucasian/White women and those who reported being raised in rural areas exhibited higher levels of implicit anti-fat biases. For the most part, and as predicted by Chambliss et al. (2004), participants did not endorse high levels of anti-fat biases on the self-report scales. However, students did endorse common stereotypical beliefs such as assuming that individuals of size, as well as obese individuals, were lazy, less physically attractive, and were responsible for their weight (Chambliss et al., 2004).

Similar to exercise specialists, physical therapists utilized physical means in order to rehabilitate clients. Sack, Rigassio-Radler, Mairella, Touger-Decker, and Hafiz (2009) assessed physical therapists' knowledge and attitudes about obesity. The researchers

received 345 completed questionnaires and after examining attitude item scores on a Likert-type scale of one to seven, Sack et al. (2009) concluded that the participants' attitudes toward obesity fell in the middle of the Likert-type scale and were deemed neutral. Sack et al. (2009) also reported that 78.5% of the physical therapists sampled indicated that they felt overeating was a major cause of obesity and 70.4% stated that obesity was also likely caused by poor knowledge about nutrition (Sack et al., 2009). While attitudes were generally neutral, respondents reported a slight weight bias regarding obese clients, as over 50% of the physical therapists described obese individuals as awkward, weak willed, and unattractive (Sack et al., 2009). Moreover, approximately 40% of the physical therapists in the study categorized obese clients as lazy, bringing into question the researchers' assertion that the physical therapists' attitudes toward obese client were neutral.

Researchers have also conducted research pertaining to physical education majors. O'Brien, Hunter, and Banks (2007) conducted a study in which they explored the implicit and explicit attitudes of physical educators toward overweight and obese individuals. O'Brien et al. (2007) sampled 344 students in their study, 164 of which were psychology students and acted as the control group. Participants completed the Implicit Association Test, the Explicit Anti-Fat Measure, and other measures assessing participants' attitudes toward investment in physical attributes and self-esteem. O'Brien et al. (2007) reported that the physical education students exhibited a significantly higher implicit anti-fat bias than psychology students when controlling for age, educational

level, and reported BMI scores. Moreover, and similar to the results reported by Davis et al. (2007) that third year medical students reported higher levels of anti-fat bias than first and second year students, O'Brien et al. (2007) found that third year physical education students showed a higher anti-fat bias than students beginning their physical education training. Results indicated that explicit measures between physical education students and psychology students were similar except for the variable labeled willpower, as physical education majors indicated that they thought obese and overweight individuals lacked willpower (O'Brien et al., 2007). Researchers concluded that for physical education majors, a link may exist between investment in physical attributes and implicit/explicit attitudes.

Research on weight stigma has also been conducted with those who investigate obesity. Schwartz et al. (2003) reported that a sample of obesity specialists exhibited significant implicit anti-fat bias. Teachman et al. (2003) reported similar results, stating that their sample of obesity specialists illustrated similar implicit bias toward individuals of size. Obesity specialists in both studies exhibited both implicit and explicit anti-fat biases, including associating the stereotypical beliefs of laziness, incompetence, and worthlessness with individuals of size. Such a report was alarming, as the health professionals who understand that obesity and weight are linked to genetic and environmental factors exhibit biases they know to be false (Schwartz et al., 2003). Such reports underscored the strong presence of weight stigma. Most notably, health

professionals were engaging in stereotypical beliefs that are attached to central characteristics such as intelligence and self-worth (Schwartz et al., 2003).

The phenomenon of weight stigma has been found to occur across various health professions, most notably physicians, nurses, dieticians, fitness specialists, and obesity specialists (Beach et al., 2007; O'Brien et al., 2007; Puhl & Heuer, 2009; Schwartz et al., 2003). Researchers have suggested that, with specialized training, health educators can intervene and begin to prevent weight bias from occurring (Block et al., 2003).

However, individuals may choose not to share their beliefs with researchers or educators, thus preventing others from accessing their core beliefs. Individual mindset may have an impact on how individuals perceive and process information. Therefore, the next section has addressed implicit versus explicit beliefs and how researchers assess these beliefs. The following section has also addressed fixed versus growth mindset (Dweck, 2006) and the impact these mindsets may have on educators' efforts to decrease stereotypical beliefs regarding individuals of size.

Implicit and Explicit Beliefs

Dweck (1986) wrote about implicit theories, first describing them as the adaptability or inflexibility of character qualities, such as innate or learned abilities as well as intelligence. Those characteristics or beliefs individuals were willing to change or modify were labeled explicit, while those fixed, rigid, or deeply engrained were labeled implicit (Heslin & VandeWalle, 2008). Dweck (1986) labeled these phenomena as entity versus incremental theories of intelligence. Dweck (1986) suggested that entity

theorists believed that intelligence was a fixed entity or stable quality and therefore incapable of being altered. Those individuals who possessed fixed mindsets or beliefs were thought to strive for performance goals, therefore avoiding negative judgments while receiving positive judgments. Conversely, Dweck (1986) wrote that incremental theorists believed that personal attributes such as intelligence or character could be developed and could be shaped or modified. Those individuals described as entity theorists tend to believe people cannot change, and possess what Dweck (2006) referred to as a fixed mindset. Opposing entity theorists are those described as incremental implicit theorists, who believe that traits can be altered. Dweck (2006) labeled these individuals as exhibiting a growth mindset or one that is capable of and open to change.

Implicit and explicit memory is linked to Dweck's (1986) implicit theories of intelligence. Explicit or declarative memory is the conscious or deliberate reminiscence of information such as dates, experiences or specific facts (Tulving, 1989). In contrast, implicit or non-declarative memory is a type of long-term memory that has been linked to the unconscious recalling of skills, versus overtly and deliberately recalling information (King, 2010). Whereas explicit memory involves individuals' deliberate attention to recalling an event, implicit memory involves memories, in addition to beliefs, without awareness (Heslin & VandeWalle, 2008; King, 2010).

Implicit and explicit beliefs and memories are linked to the mindsets of individuals. Dweck (2006) wrote that those who believe that effort cannot change a situation or alter inherent personal traits display a fixed mindset. Those individuals

labeled as having fixed mindset exhibit implicit beliefs including seeing effort as worthless, as circumstances being unchangeable, or avoiding challenges, as they see challenges as fruitless (Dweck, 2006). Those labeled with growth mindsets believe that change is achievable through personal effort. Individuals with a growth mindset believed improvement in situations like academic achievement is possible through application of effort. Conversely, individuals with a fixed mindset believed personal attributes and abilities are fixed or innate and therefore static throughout a lifetime (Dweck, 2006).

Sears and Henry (2007) reported that individuals in the current social climate in the U.S. are more likely to present as publically unprejudiced, while harboring private prejudice beliefs at a personal level. While these public and private beliefs or thoughts may be conscious, it is also possible that their biases may also be unconscious (King, 2010). While biased and discriminatory implicit and explicit beliefs have been linked to phenomena like racism, research has also linked these beliefs to weight discrimination (Schwartz et al., 2003; Teachman et al., 2003). While overt weight biases stand to harm others, so do deeply held and potentially unconscious implicit beliefs.

Implicit and Explicit Beliefs: A Link to Weight Bias

Teachman et al. (2003) suggested that a lower quality of life and less access to health resources may be linked to weight discrimination. The researchers also commented that, while individuals of size are at a heightened risk for public weight discrimination, obese individuals may face weight discrimination amongst health professionals as they are perceived to be at a higher risk of health related issues.

However, as many health professionals may be willing to explicitly address and comment upon patient or client weight, others may remain silent. Individual people have the ability to choose in what ways they wish to express themselves, and the verbal messages they wish to convey. True feelings may be suppressed due to social desirability (Dweck, 2006; Teachman et al., 2003).

Implicit and explicit memory theories can assist in understanding the manner in which anti-fat attitudes can be expressed. Through implicit means, individuals engage in a process of evaluation that begins and ends without any conscious knowledge or awareness (Teachman et al., 2003). Schwartz et al. (2006) wrote that implicit attitudes include those beliefs that people are not only unable to access, but also unwilling to share due to concerns with how they will be received by others. Conversely, explicit attitudes are those beliefs that individuals consciously and publicly acknowledge (Schwartz et al., 2006). Explicit attitudes have been accessed through the use of self-report measures, but due to concerns about social desirability, self-report measures are susceptible to participants' response biases (Schwartz et al., 2006; Teachman et al., 2003). As a result, researchers have most often used a number of research tools such as the Implicit Association Task (Greenwald, McGhee, & Schwartz, 1998) to access implicit attitudes as they most accurately portray and convey participants' attitudes.

Teachman and Brownell (2001) investigated implicit beliefs amongst obesity specialists as well as other health professionals. They recruited 84 participants in an effort to test the implicit evaluations of the participants, while comparing these responses

to their explicit beliefs. Participants were given the Implicit Association Test (Greenwald, McGhee, & Schwartz, 1998) to assess implicit beliefs and a measure that assessed explicit fat/thin biases (Teachman & Brownell, 2001). Results indicated that participants held both strong implicit anti-fat and pro-thin biases, while explicit anti-fat biases were moderate. The researchers commented that, even within health professionals committed to assisting others, individuals of size were discriminated against, while thin individuals were implicitly preferred (Teachman & Brownell, 2001). In a related study, Schwartz et al. (2003) explored the implicit beliefs of obesity specialists as well as other health professionals. The researchers wrote that when negative attributes such as bad, lazy, or worthless were paired with so-called fat people, participants were quicker to associate the negative terminology than when positive attributes such as smart and valuable were introduced. Schwartz et al. (2003) reported that a strong weight bias was present in their participants, particularly amongst younger respondents who identified as women.

Schwartz et al. (2006) further explored the notion that overweight and obese individuals may exhibit more pro-thin and anti-fat biases. Schwartz et al. (2006) recruited 4,283 participants who completed the Implicit Association Test as well as questions regarding weight stereotypes. As with previous studies, Schwartz et al. (2006) reported that a majority of the participants associated the word “bad” with individuals of size and “good” with thin individuals (Schwartz et al., 2006). While individuals with higher BMI scores had lower implicit anti-fat attitudes as compared to those participants

with lower BMI scores, overweight and obese participants also exhibited anti-fat biases. Researchers concluded that group membership for individuals of size may affect liking for the group, but still failed to protect for stereotypical beliefs, including that individuals of size are lazy, less motivated, and less intelligent (Schwartz et al., 2006).

Other research has further indicated that individuals of size, as well as obese individuals, exhibit weight-based biases (Rudman, Feinberg, & Fairchild, 2002). Rudman et al. (2002) wrote that, while links have been made between weight biases and racial and ethnic biases and discrimination, anti-fat biases may be different, as individuals of size do not show in-group favoritism, which is often seen in individuals who are ethnically similar. Wang et al. (2004) found similar results, as the individuals of size in their study did not prefer other members of size. Implicit attitudes revealed that participants of size internalized weight biases toward other individuals of size, including belief in negative stereotypes. Wang et al. (2004) discussed how this lack of preference of in-group members may perpetuate weight biases, as in-group members may be less apt to contest negative and unfounded stereotypes and biases.

While many research studies have utilized the Implicit Association Test, researchers have also assessed implicit beliefs through other means. Bessenoff and Sherman (2000) tested the automatic or potentially suppressed implicit evaluations of research participants through the use of a lexical decision making task. Prior to the lexical task, researchers presented participants with pictures of women of size and thin women. The lexical task involved both positive and negative words and measured how

quickly the participants matched the positive and negative judgments based upon the presented words. Bessenoff and Sherman (2000) then measured response latency in an effort to accurately measure implicit beliefs. Bessenoff and Sherman (2000) reported activation for the negative words when first being presented with a photograph of a woman of size but not a thin woman. The researchers asserted that anti-fat biases also affected how closely participants chose to sit next to a woman of size. This phenomenon only occurred under implicit conditions, and did not occur when measured explicitly, suggesting that despite positive intentions, participants may have been suppressing biased evaluations or otherwise be unaware of these biases (Bessenoff & Sherman, 2000). Internalized implicit biases have affected the ways in which individuals of size view themselves and how others view them; these implicit biases have also likely affected women's romantic relationships, though studies of implicit weight bias in relational contexts have been mixed and inconclusive.

Researchers have linked implicit and explicit beliefs, as well as fixed and growth mindsets, to acts of weight-based discrimination. Miele, Finn, and Molden (2011) discussed the phenomenon of those individuals possessing a fixed mindset attributing performance to innate ability versus perceived effort. The authors also explained that those individuals with a growth mindset tend to attribute their performance to effort versus static ability. Blackwell, Trzesniewski, and Dweck (2007) explained that entity theorists, or those individuals believing that abilities are innate and therefore largely impervious to change, they see people as either having an ability or lacking an ability.

Conversely, Blackwell et al. (2007) explained that incremental theorists believe ends are achieved through effort and therefore changeable.

Similar phenomena occur when exploring mindset and weight. Rattan and Dweck (2010) conducted research with both people who believe change can occur (those identified as incremental or growth-minded individuals) and those who believe change does not occur (those identified as entity or fixed-minded individuals). Rattan and Dweck (2010) reported that those individuals with growth-minded beliefs were more willing to confront others, as they believed that mindsets were malleable, whereas those with fixed mindsets were more likely to remain silent when given the chance to confront prejudice. This research supported the notion that health professionals, such as doctors and nurses, who adhere to growth-mindset ideals are more likely to attribute blame to individuals for their size. Conversely, those individuals and health professionals with a fixed mindset are more likely to attribute less blame to individuals and place more emphasis on situational variables. It is therefore reasonable to conclude that those health professionals who maintain a growth mindset are more likely to attribute blame to individuals for their size, whereas those health professionals who maintain a fixed mindset are more likely to attribute blame to environmental factors.

Summary

This section has documented the existence of weight discrimination, weight bias, and weight stigmatization in the lives of individuals of size (Schwartz et al., 2003). The previous literature has also established that weight bias and stigmatization manifest in the

actions and perceptions of friends, families, and professionals (Teachman et al., 2003). Weight stigmatization has been reported to elicit feelings of hopelessness, self-doubt, and lowered self-esteem in individuals of size (Puhl & Heuer, 2009). As stated by Rothblum and Solovay (2009), these experiences often lead women of size to establish inadequate relationships with healthcare providers who adhere to weight biases. Likewise, the literature reviewed suggested that women of size may have poorer intimate relationship quality than their thinner counterparts (Boyes & Latner, 2009; Harway & O'Neil, 1999; Puhl, Moss-Racusin et al., 2008).

Because it has not previously been studied, there is no direct link in the literature regarding size and a greater likelihood of violence. However, it has been suggested that batterers exploit societal biases and prejudices such as aspects of identity, class, and gender as a means of abuse (Anderson & Anderson, 2008). Therefore, the important topic of men's violence against women has been reviewed as a backdrop to the primary purpose of the current investigation, which was to explore the perceptions of men's violence against women of size.

Men's Violence Against Women

Definition and Prevalence

Men's violence against women has been defined as:

...any gender-based violent act, resulting in or assumed to result in physical, sexual or mental injury on women, including threats of such acts, coercion, or

captivity, whether it takes place in public or private premises (The United Nation's Fourth World Conference on Women, 1995, p. 48)

The phenomenon defined as men's violence against women occurs globally and is often associated with medical, psychological, financial, and emotional costs (Nayak, Byrne, Martin, & George-Abraham, 2003). Harway and O'Neil (1999) wrote that it is estimated that the testimonies of women who have been physically assaulted are thought to represent less than 50% of the acts committed by men. Moreover, Harway and O'Neil (1999) also wrote that men's violence against women is the most common form of injury to women aged 15 to 44, outnumbering both automobile accidents and cancer. The term "violence against women" is often used to describe the physical act of harming women, and the absence of the term "men" tends to suggest that the violence is primarily a women's issue. While violence most certainly occurs with lesbian relationships and bisexual relationships with women (Miller, Greene, Causby, White, & Lockhart, 2001), men commit an overwhelming majority of the violence toward women. Katz (2006) reported that men commit more than 90% of violent crimes toward women each year. Stenson and Heimer (2008) wrote that approximately 25% of their sample of all women health workers reported experiencing physical and intimate abuse by men. Vung, Ostergren, and Krantz (2008) indicated that women in rural areas reported experiencing physical violence at rates of approximately 31% in their lifetimes.

For research, practice, and training purposes, the inclusion of the word "men" at the beginning of the phrase "men's violence against women" is important, as it helps to

establish men's role as the predominant perpetrators of violence against women. While the term "men's violence against women" may seem to encompass only a physical act, men's violence against women is a multifaceted and complex phenomenon, which includes violence and control (O'Neil & Harway, 1997). Examples of the forms men's violence may include physical, mental, economic, socio-cultural, and state violence (El-Mouelhy, 2004). El-Mouelhy (2004) stated that men's violence against women is likely the most prevalent form of gender-based violence worldwide and reiterated the importance of addressing men's role in violence against women.

In a sample of men attending a college or university, approximately 25% admitted performing sexual acts that violated a woman's right to choose, while Denmare, Briere, and Lips (1988) reported that 22% of undergraduate men admitted to contemplating various forms of rape in order to best serve their sexual fantasies. Regarding the occurrence of abusive acts toward women, Avery-Leaf and Cascardi (2002) reported high rates of verbal and psychological aggression in a college-aged population, while finding an elevated rate of physical aggression. Avery-Leaf and Cascardi (2002) estimated that between 21% and 40% of all women experience some form of physical aggression. Similarly, Stenson and Heimer (2008) reported that between 10% and 34% of women experience physical violence from men.

Explaining Men's Violence Against Women

Boys and girls receive multiple messages regarding gender roles throughout their development. Boys are most often guided toward and encouraged to adopt traditionally

accepted masculine roles, such as suppressing emotion, becoming independent of their parents, and being assertive with others (Smith, Ellis, & Benson, 2001). Conversely, girls are encouraged to adopt more traditional feminine characteristics, such as understanding the needs of others, being emotionally available, and maintaining relationships (Smith et al., 2001). While masculinity, anger, and aggression are often associated together in theory and in research, Messerschmidt (2000) offered a different way of understanding masculinity with his explanation of the term hegemonic masculinity. Messerschmidt (2000) defined hegemonic masculinity as the ways in which culture conceptualizes masculinity in a specific historical and social setting. Tharinger (2008) extended Messerschmidt's original definition by noting that all forms of hegemonic masculinities include similarities, particularly physical strength and a preference for cognitive thought process. Messerschmidt (2000) wrote that hegemonic masculinity changes over time and varies across cultures. U.S. culture has rewarded men for adopting and adhering to forms of hegemonic masculinity, which include being aggressive and assertive. Characteristics such as these are most often rewarded and even celebrated in literature and movies (Messerschmidt, 2000) Tharinger (2008) further added to the concept of hegemonic masculinity when writing about the authoritative pieces of masculinity, which recognizes the serious risk men run by refusing or refraining from conforming to masculine norms. Tharinger (2008) wrote that those men who resist adapting to the given principles of masculinity run the risk of becoming part of a marginalized culture.

As violence and aggression are often associated with masculinity, it has been suggested that continuing depictions of violence are associated with masculinity for adolescent boys, and that these depictions strengthen the dominant U.S. cultural norms of accepting violence as a part of masculinity (Katz, 1995). The connection between masculinity and violence strengthens and serves to normalize and encourage, rather than challenge, men's use of violence as a means of achieving success (Messerschmidt, 2000). Masculinity is socially constructed through these ongoing relationships and traditional cultural practices. Messerschmidt (2000) and Tharinger (2008) suggested that the association of masculinity, aggression, and violence is not intuitive but rather learned through social means. Katz (2006) agreed with this assertion, and added that the socialization of men in the U.S. further adds to an established system of ideals that encourages and rewards men for dominating and controlling women. For example, during adolescence, hormonal changes and societal pressures converge, and resisting culturally accepted masculine and feminine traits can be dangerous to individuals' identity.

While violence is perpetrated by both men and women within intimate relationships, women most often report suffering serious physical injuries. Furthermore, it is estimated that men tend to underreport instances of violence, while women tend to report accurately (Avery-Leaf & Cascardi, 2002). The underreporting of violence may highlight the notion that men have often tended to blame others for their behavior, failing to be accountable for their actions. Men's displays of anger and aggression have often

been reinforced and considered acceptable in our culture (Carr & VanDeusen, 2002; Katz, 1995). Anderson and Bushman (2002) asserted that men or women exposed to violence or violent media may adopt a more aggressive personality, thus raising the likelihood of acting aggressively. Anderson and Bushman (2002) explained the development of aggressive personality styles through their General Aggression Model, a framework that describes how aggression can develop through experience, influence individual perceptions, be linked to emotions and behaviors, and guide interpersonal interactions. The General Aggression Model has also accounted for anger, a variable that has also been associated with men's violence against women. Anderson and Bushman (2002) stated that anger plays several roles in men's violence against women. Researchers asserted that anger is utilized to provide justification for aggression and violence; men have choices about what to do when they experience the emotion of anger, and aggressive behavior is a culturally sanctioned option. Anderson and Anderson (2008) suggested that men who are hostile regarding their attitudes toward and beliefs about women are likely to target women in terms of both sexual and nonsexual aggression. Anderson and Anderson (2008) highlighted the dangers of aggressive and hostile acts, including provocation, sex of the target, and the opportunity to aggress as critically important situational variables. Additionally, when anger is present as men appraise interpersonal situations, the likelihood of men's violence against women has been thought to increase significantly (Anderson & Bushman, 2002). In failing to

become accountable for their violent actions, men have perpetuated the cycle of violence against women.

Activities such as hostile or physical encounters, which in dominant U.S. culture are associated with masculinity, have provided men with the opportunity to demonstrate their worth to other men (Messerschmidt, 2000). As physical violence is often paired with masculinity, specifically hegemonic masculinity, it serves as a resource for constructing identity. As a result, men who utilize violence as a tool to achieve or maintain their status or control over women have accepted aggressive tendencies as a part of their identity. This acceptance of violent norms acts as a resource for men and may push them toward committing violent acts (Messerschmidt, 2000). Beginning in childhood and adolescence, one such example of violence that occurs toward not only women but other men is bullying.

Bullying

Nansel et al. (2001) wrote that the act of bullying affects 30% of all youth in the United States. Methods of bullying have ranged amongst a large spectrum and included relational components such as social exclusion, verbal threats and name calling, and physical means such as intimidation, punching, hitting and slapping (Nansel et al., 2001). Vaughn et al. (2010) wrote that bullying can have severe effects on the victims such as social deficits, anxiety, and low self-esteem. The act of bullying was defined by Vaughn et al. (2010) as aggressive behavior repetitively utilized to harm or intimidate those perceived to have less power. As aggression has been linked with masculinity and men,

research has shown that while girls more consistently experience relational aggression, boys receive more physical aggression (Brownell et al., 2005; Messerschmidt, 2000; Vaughn et al., 2010). Moreover, those children with higher BMI scores were more likely than children of normal weight to experience both relational and physical aggression, with boys both perpetrating and receiving more physical or overt bullying (Brownell et al., 2005).

While physical bullying from boys to other boys of size has been documented in research and literature, physical aggression has also been reported from boys to girls of size as well. Schoenfelder and Wieser (1983, p.78) conducted an interview with a 15 year-old from Iowa regarding her experiences with bullying;

I think the one thing that got me mad was this one kid, Joe, the same kid who called me a fat blob. He used to hang around these guys who thought they were really cool and they were a year ahead of him. Joe told one of these guys that I had called him a dirty name. They asked me do you want to fight about it? And I go no, and I didn't call you any name or anything. And then the guy said after lunch, I'll meet you outside. And I said I don't want to meet you outside 'cause I'm not into fighting. So then I ate lunch and then I was just going to forget about it. I walked out the door and they were standing there waiting for me. Seven kids against me. What they did was just kind of pass me around and push me from one person to another and make me fall down and get scraped up.

This personal account highlighted the phenomenon that Lagerspetz, Kjorkqvist, Berts and King (1982) referred to as mobbing, a phenomenon which will be discussed in further detail later in the chapter. Like the children in the researchers' sample, the girl in Schoenfielder and Wieser's (1983) study became a victim of boys' bullying. Schoenfielder and Wieser (1983) continued to chronicle the young girl's experience as a girl of size, one that included social difficulties.

Researchers in Sweden explored experiences of bullying in 960 fourth-grade students (Frisén, Lunde, & Hwang, 2009). The children who participated in the study answered questions regarding bullying as well as body perception and peer victimization. Frisén et al. (2009) found that, while children's actual physical appearances were linked to teasing, their negative appearance perceptions reflected a wider array of bullying behaviors. This finding suggested that those children who struggle with peer relationships also struggle with negative self-views. Additionally, weight appeared as a constant variable in bullying amongst both boys and girls within the study (Frisén et al., 2009). Girls of size in the study reported having experienced weekly bullying at rates that far exceeded those of children reported to be of normal weight. The girls reported teasing about their appearances, threats, and overt physical violence toward them (Frisén et al., 2009).

Teasing and being the victims of criticizing are forms of bullying many children of size have faced. In addition to these forms of bullying, children of size have been found to have fewer friends than children of normal size (Brownell et al., 2005).

However, children of size have also been linked too much harsher forms of victimization as well. Lagerspetz et al. (1982) conducted research regarding youths' experiences with weight-related bullying, particularly mobbing. Lagerspetz et al. (1982) described mobbing as the consistent act of a group of individuals ganging up and most often physically intimidating or harming the same victim. Researchers sampled a total of 434 children in Finland whose ages ranged from 12-16 (Lagerspetz et al., 1982). Participants self-reported that they perceived approximately 4% of their classmates as being targets of repeated victimization. Researchers indicated that both overweight boys and girls were most often targeted as victims (Lagerspetz et al., 1982).

Wang, Iannotti, Luk, and Nansel (2010) collected data on 6,393 adolescents to further explore the phenomenon of weight-related bullying. Results indicated that both boys and girls of size received more relational bullying than children reported to be of normal size. Wang et al. (2010) also commented on the fact that gender differences exist between boys and girls, specifically that girls engage in more relational bullying, while boys tend to engage in more physical bullying. Griffiths, Wolke, Page, and Horwood, (2006) reported similar results in that obesity was predictive for involvement in bullying amongst both boys and girls. Younger children, those identified as pre-adolescent boys and girls, were at a greater risk of being bullied because they were perceived by classmates as different (Griffiths et al., 2006). Researchers also reported that, while obese girls were more likely to be bullied, as boys grew older, obese boys were more

likely to begin to bully peers. Griffiths et al. (2006) attributed these bullying behaviors to perceived physical dominance over their peers.

Pearce, Boerges, and Prinstein (2002) also explored the relationship between weight and bullying in a sample of 416 adolescents. Researchers were specifically interested in delineating the experiences of being bullied and collected data regarding overt and relational victimization. Pearce et al. (2002) categorized overt victimization as physical aggression and teasing, while relational victimization was defined as social exclusion and mistreatment within relationships. Adolescent boys of size reported receiving more overt victimization, while adolescent girls of size reported experiencing more relational measures of victimization. As a result, researchers concluded that girls are forced to manage less supportive and antagonistic relationships with peers (Pearce et al., 2002).

Previous research has indicated that children of size, both boys and girls, are bullied at a higher rate than when compared with children perceived to be of normal weight (Frisén et al, 2009; Griffiths et al., 2006; Pearce et al., 2002). For girls, a majority of research has indicated that interpersonal functioning is negatively affected, leading to lower self-esteem and emotional well-being (Friedlander, Larkin, Rosen, Palermo, & Redline, 2003). These findings, coupled with research indicating that boys and men tend to seek and fill more dominant roles, tended to suggest that overweight and obese girls may be targeted for bullying within relationships with boys (Brownell et al., 2005; Messerschmidt, 2000; Pearce et al., 2002). One way in which even male adolescents

have achieved these dominant roles is through weight-based discrimination toward girls and women. The following section addresses the experiences of obese women and women of size with men who have been sexually, emotionally and physically abusive.

Masculinity, Sexual Exploitation, and Emotionally Abusive Behaviors

As previously discussed, hegemonic masculinity is prevalent in the United States and often acts as an ideal that men aspire to achieve (Messerschmidt, 2000). Connell (1987) recognized this 25 years ago, and wrote that values such as aggression, dominance, and control underpin hegemonic masculinity in the United States. Tied to control and hegemonic masculinity is the phenomenon referred to as hogging, a denigrating practice through which men seduce or pursue women of size to fulfill sexual desires or through competition with their friends (Prohaska & Gailey, 2009). So-called hoggers are identified men who solicit women of size at bars or parties or make bets with their friends pertaining to who can attract and ultimately have sex with the largest or most physically unattractive woman (Prohaska & Gailey, 2009). Engaging in sexual acts is but one way that men in the United States are rewarded by their peers. Those men who adhere to hegemonic masculinity see sexual acts as a way to achieve status, and alcohol is often utilized when preying on women at parties and bars (Kimmel, 1996). While this aggressive style of sexual exploitation is dangerous to women of size, consuming alcohol and pursuing women is seen as acceptable in mainstream U.S. culture, reinforcing the devaluing of women of size through men's aggressive behaviors (Kimmel, 1996).

Griffin (1971) wrote that men's violence can be attributed to patriarchy through which men have exerted dominance and control over women. Patriarchy has been defined as male centeredness, where men hold more powerful roles in society than women (Johnson, 2005). This imbalance of power has been linked to the devaluing of women and women's roles. Battering, or the repeated physical violence by men toward women, has been conceptualized as being situated in the context of the historical and cultural devaluing of women (Harway & O'Neil, 1999; Jones, 2000). Additionally, sexism has been postulated to enable men's violence and control over women. As research has shown, many individuals have been able to take advantage of societal prejudices through means of bullying, stereotypical beliefs, and weight discrimination (Baum & Ford, 2004; Boyes & Latner, 2009; Puhl et al., 2009). Weight bias has been a strong social prejudice, which men have the potential to utilize this against individuals of size and partners of size (Royce, 2009).

Men have often used coercive forms of power and control in their interactions with their intimate partners (Schoenfielder & Wieser, 1983; Stenson & Heimer, 2008). Schoenfielder and Wieser (1983, p. 115) provided an example of the measures one man used with his partner of size to ensure that she remained subordinate to him and to control her behaviors:

My husband's always on my back to lose weight. But a few times when I did lose weight, I could tell he felt threatened. He wants me thin, and yet he wants me fat. He wants me to look skinny and glamorous for him. But, he wants me fat

enough so that he knows I'll be too self-conscious to leave home and run around. He used to be tactful about it. He'd say I don't want to hurt your feelings, but...and then he'd let me have it. But the last few years he's been really cruel about it. He'll just say, 'Do you know how disgusting you look?'

Accounts such as the one provided by Schoenfielder and Wieser (1983) have highlighted the existence of weight discrimination present within intimate relationships and the negative, longstanding effects such as low self-esteem, feelings of unworthiness, and the self-hatred that can develop within women (Rothblum & Solovay, 2009). However, this account does not explain men's violence against women of size in terms of either their weight or perception of their weight. The following section addresses what little is known regarding the current link between men's violence targeted at women of size.

Men's Violence Linked to Women's Size

Researchers have linked men's physical violence to weight gain during pregnancy (Moraes, Amorim, & Reichenheim, 2006; Reichenheim & Moraes, 2004). These results are troubling as this physical threat during gestational weight gain has posed threats to both women and their children (Martin, Mackie, Kupper, Buescher, & Moracco, 2001). As a result of men's violence during pregnancy, fear of physical abuse has also been linked to women restricting their diets in order to gain less weight during pregnancy (Moraes et al., 2006). Researchers such as Reichenheim and Moraes (2004) and Moraes et al. (2006) have provided a link that suggested the intensity of men's violence often rises while women are pregnant.

Stewart and Cecutti (1993) explored the rate of abuse during pregnancy in order to ascertain whether rates of physical abuse escalated during this time. The sample consisted of 548 women, all of whom were at least 20 weeks into their pregnancies. Stewart and Cecutti (1993) reported that 60 of the women in their sample were physically abused before their pregnancies and 36 reported being physically abused during pregnancy. Of the 36 women who reported being physically abused during their pregnancies, 23 indicated that the physical abuse escalated during pregnancy (Stewart & Cecutti, 1993). Twenty-four of these women sought medical attention as a result of the physical abuse with only one revealing the abuse, to her primary care physician. These women discussed being largely unaware of the social services that were available to them and also reported that much of the physical violence was directed at their abdomen (Stewart & Cecutti, 1993).

In another study that assessed men's physical violence against women during pregnancy, Janssen et al. (2003) sampled 4,750 women regarding their experiences of violence and fear of their partners during pregnancy. Seventy-nine women reported being physically abused before their pregnancy, while 57 women reported experiencing physical violence during pregnancy. Approximately 72 women expressed fear of their partners during their pregnancies. Results were similar to Stewart and Cecutti's (1993) findings in that much of the physical violence was directed at the abdomen. Janssen et al. (2003) concluded that physical violence, as well as the perceived threat of violence, could have lasting effects on women and self-esteem.

Reichenheim and Moraes (2004) also established that in their sample of 748 women in Rio de Janeiro, elevated levels of physical abuse during pregnancy compared to pre-pregnancy levels were evident. The Abuse Assessment Screen (McFarlane et al., 1992) and the Conflict Tactics Scale-2 (Straus et al., 1996) were utilized to explore the rate of physical violence during pregnancy. Approximately 19% of the sample of women reported experiencing physical abuse during their time of pregnancy (Reichenheim & Moraes, 2004). Further research revealed that, while men's violence against women continued to occur during pregnancy, elevated rates of physical violence may have been a result of weight gain.

Fear of physical violence by men and the act of men's violence against women during pregnancy have also been affected gestational weight gain. Moraes et al. (2006) studied 394 women who had delivered at term and were assessed for intimate partner violence as well as weight gain during pregnancy. Results indicated that, on average, those women who were either physically abused or feared abuse gained less gestational weight than those women who were not abused (Moraes et al., 2006). Researchers indicated that this may have occurred as a result of decreased appetite due to anxiety as well as partner restriction of food during pregnancy (Moraes et al., 2006). Newberger et al. (1992) also commented that, during pregnancy, it is not uncommon for men to restrict their partners' eating, leading to less gestational weight gain. Furthermore, Johnson, Hellerstedt, and Pirie (2002) reported that, compared to women with no previous history

of physical abuse, women with a history of physical abuse were 3.1 times more likely to experience inadequate gestational weight gain during pregnancy.

Regarding the perception of aggression toward women, Clarke and Lawson (2009) explored the perception of sexual assault scenarios and the impact that discriminatory beliefs and victim weight may have on participants' perceptions. The researchers recruited a total of 173 undergraduate students to participate in the study. Participants were presented with a fictional sexual assault scenario in which the researchers altered victim weight to portray either an overweight woman or a woman of normal weight. Participants randomly received brief descriptions of the victim and the sexual assault case where researchers only varied the victim's weight. Participants were asked to fill out a number of self-report assessments that measured rape myth acceptance as well as anti-fat attitudes. Clarke and Lawson (2009) reported that participants who exhibited higher levels of anti-fat prejudices more often attributed blame toward the victim and endorsed higher levels of disgust and anger toward her. These findings also suggested that those participants who had higher scores on the Rape Acceptance Myths scale (Burt, 1980) were more likely to exhibit more negative attitudes toward women of size (Clarke & Lawson, 2009). Regarding sentencing of the perpetrator of the sexual assault, neither anti-fat prejudices nor rape myth acceptance affected a sentencing decision when the victim was portrayed as thin. However, when the woman was depicted as being overweight, participants recommended longer sentences (Clarke & Lawson, 2009). Researchers wrote that this finding may have been due to participants'

perceptions that women of size are rarely chosen as targets for sexual assaults. As a result, participants may have been confused by the presented scenario and that their confusion and anger may have led them to render a harsher verdict (Clarke & Lawson, 2009).

The relationship between body size and being a perpetrator has also been documented in research. Janssen et al. (2004) found that individuals of size, particularly boys, were more likely to engage in bullying and physical violence. Janssen et al. (2004) suggested that physical intimidation and violence may be a means of exerting dominance, a potential consequence of being teased for their size and an avenue through which control can be achieved. Griffiths et al. (2006) commented that individuals of size may be particularly at risk for bullying during adolescence, when name calling and teasing is more prevalent, as slim ideals are particularly important to developing identities. Griffiths et al. (2006) stated that in addition to falling victim to weight-based bullying, individuals of size were also more likely to engage in bullying, presumably to exert their physical dominance. Furthermore, Rich et al. (2008) reported that a sample of pre-school children attributed the word “strong” with children of size. Size is often paired with strength and physical dominance for boys as evidenced by Janssen et al. (2004) and Griffiths et al. (2006).

Summary

Messerschmidt (2000) wrote that masculinity has been linked to men’s violence, and that the violent acts of men have severely affected the lives of women. As Griffin

(1971) highlighted that violence became permissible and was sustained through patriarchy and power, researchers have explored the potential link of weight and men's violence. Stenson and Heimer (2008) wrote that men tended to assert power and control through coercive acts while Schoenfelder and Wieser (1983) highlighted that men utilized threatening and coercive messages regarding weight that served to subordinate women of size. Moreover, Moraes et al. (2006) provided a possible link between men's violence and gestational weight gain which highlighted a potential connection with men's violence and weight.

Purpose and Significance of the Study

Weight discrimination against women of size and obese women is a phenomenon embedded within majority U. S. culture and cultures around the world. Perceptions of individuals of size affect how women of size feel, and weight discrimination exhibited toward women of size has serious consequences such as inadequate healthcare, lowered self-esteem, less pay, depression, and lowered self-esteem (Baum & Ford, 2004; Beach et al., 2007; Brownell et al., 2005). Men's violence against women is another phenomenon that widely affects women (Stenson & Heimer, 2008). Women have reported elevated rates of violence during pregnancy, a time when weight gain is normative (Moraes et al., 2006). Only one study was found that specifically examined some aspect of men's violence against women concurrently with weight stigma (Clarke & Lawson, 2009). No link with weight and violence was directly made, as results pertaining to violence and weight stigma have been mixed and inconclusive. Given that so few studies have

explored the potential effects that weight discrimination has on men's violence against women, the present study was designed to further knowledge regarding this possible association. The current researcher sought to uncover if weight and weight-related biases affect people's perceptions of men's violence against women.

Research Questions and Design Overview

The overall research question for this investigation was, Do victim and perpetrator weight affect the perception of men's violence against women? The question was examined using a 2 (male perpetrator weight, normal or overweight) x 2 (female victim weight, normal or overweight) analysis of variance design. See Figure 1 below.

Perpetrator (Man)→ Victim (Woman) ↓	Normal Weight	Overweight
Normal Weight	Condition 1(NN) (Perpetrator, Normal Weight) (Victim, Normal Weight)	Condition 2 (ON) (Perpetrator, Overweight) (Victim, Normal Weight)
Overweight	Condition 3 (NO) (Perpetrator, Normal Weight) Victim, Overweight)	Condition 4 (OO) (Perpetrator, Overweight) (Victim, Overweight)

Figure 1. Study design

Research Hypotheses

1. It was hypothesized that the attribution of blame for men would be significant and greatest in condition two (ON) followed by condition four (OO) and then condition one (NN) with condition three (NO) receiving the least amount of blame.
2. It was hypothesized that the attribution of blame for women would be significant and greatest in condition three (NO), followed condition four (OO) and then condition one (NN), with condition two (ON) receiving the least amount of blame.
3. It was hypothesized that the attribution of blame for society would be significant and greatest in condition one (NN) followed by condition three (NO) and then condition two (ON), with condition four (OO) receiving the least amount of blame.
4. It was hypothesized that the attribution of blame for situation would be significant and greatest in condition one (NN) followed by condition three (NO) and then condition two (ON), with condition four (OO) receiving the least amount of blame.
5. It was hypothesized that participants would assign the men in condition two (ON) with the lengthiest sentence, followed by condition four (OO) and condition one (NN) being equal, with men in condition three (NO) receiving the shortest sentence.

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CHAPTER III

METHODOLOGY

Participants

Seven hundred sixty-nine self-identified undergraduate students, ranging in age from 18 to 56 years old ($M = 21.11$, $SD = 4.29$), participated in the current investigation. Three hundred sixty-six (47.6%) participants identified as White or Caucasian, 163 (21.2%) identified as Black, African, or African American, 133 (17.3%) identified as Latino or Hispanic, 75 (9.8%) identified as Asian, Asian American, or Pacific Islander, 27 (3.5%) identified as multi- or bi-racial and 5 (.7%) identified as Native American or Alaskan Native. All of the individuals who participated in this study were college students at two large, co-educational, public universities in the southwest. According to reported height and weight, 42 (5.5%) were classified as underweight, 428 (55.7%) as normal weight, 190 (24.7%) as overweight, and 109 (14.2%) as obese. See Table 1 for descriptive statistics on the categorical demographic variables in this study and Table 2 for the descriptive statistics on continuous demographic variables.

Table 1

Descriptive Statistics for Sample Demographics: Categorical Variables

Variable	Frequency	Percentage	Cumulative Percentage
Gender:			
Male	205	26.7	26.7
Female	561	73.0	99.7
Transgender	3	.4	100
Race/Ethnicity:			
White or Caucasian	366	47.6	47.6
Black, African, or African American	163	21.2	68.8
Latino or Hispanic	133	17.3	86.1
Asian, Asian American, or Pacific Islander	75	9.8	95.9
Multi- or Bi-racial	27	3.5	99.4
Native American or Alaskan Native	5	.7	100.0
Reported BMI Category*:			
Underweight	42	5.5	38.7
Normal Weight	428	55.7	61.2
Overweight	190	24.7	85.9
Obese	109	14.2	100.0
Perceived BMI Category			
Underweight	46	6.0	6.0
Normal Weight	476	61.9	67.9
Overweight	231	30.0	97.9
Obese	16	2.1	100.0

n = 769 *Calculated from participant self-described height and weight

Table 2

Descriptive Statistics for Sample Demographics: Continuous Variables

Variable	Mean	Range	Standard Deviation
Age in years:	21.1	18-56	4.3
Reported Height in Inches	65.8	52-79	3.9
Reported Weight in Pounds	153.4	83-485	39.6

n = 769

Instrumentation

Participants completed a demographics questionnaire, read and answered questions pertaining to a vignette, and responded to two psychometrically valid self-report surveys and a prison sentencing form.

Demographics Questionnaire

The demographics questionnaire (See Appendix A) was created for the study to gather descriptive and pertinent information about the participants. The short questionnaire included questions regarding age, gender, ethnicity, height, weight, and perceived weight.

Vignette Text

A vignette created by the researcher was given to participants to read, which depicted the interactions between a man and woman in their home. After reading the vignette, participants completed a set of questions measuring attribution of blame as well

as sentencing the man for his actions toward the woman. A copy of the vignette text is available in Appendix B.

Vignette Images

Participants viewed one of four sets of pictures created by a graphic designer specifically for the study. The graphic designer, per the request of the researcher, created a picture of an overweight woman and a normal weight woman as well as an overweight man and a normal weight man. The participants then viewed one of the following four situations: The first depicted a man and woman of normal size, the second depicted a man of normal size and a woman of size, the third depicted a man of size and a woman of normal size, and the final situation depicted a man and woman who were both of size. Normal weight was defined as a score that falls between 18.5 and 24.9 on the BMI scale (Brownell et al., 2005). This assignment to a weight category was done to ensure uniformity as the overweight and obese categories were measured through the use of this scale. (See Appendix C).

Domestic Violence Blame Scale

The Domestic Violence Blame Scale (DVBS) was developed to measure the attribution of blame and whether or not this blame followed patterns established in cases of incest and rape blame (Petretic-Jackson, Sandberg, & Jackson, 1994). For the DVBS, Petretic-Jackson et al. (1994) limited the definition of domestic violence to physically violent relationships between a man and woman in an intimate relationship. The DVBS is 23-item self-report assessment originally normed on largely White, traditionally-aged

students (Petretic-Jackson et al., 1994). Researchers retained four specific factors through factor analysis, representing blame attributed by (a) the situation, (b) society, (c) the perpetrator, and (d) the victim.

Each individual question is scored using a six-point Likert scale with one representing strong disagreement and six representing strong agreement. One question that assesses participant attribution of blame for the man is “Husbands who physically assault their wives cannot control their violent behavior.” Higher scores toward the victim indicate higher blame for the woman and higher scores toward the perpetrator indicate higher levels of blame for the man. Petretic-Jackson et al. (1994) and Bryant and Spencer (2003) reported adequate reliability and validity. Specific to use with vignettes, Yang (2006) reported acceptable internal reliabilities for attribution of blame; for attributions to the man, ($\alpha = .80$) and for attribution of blame to the woman ($\alpha = .83$) (See Appendix D).

Implicit Person Theory Scale

The Implicit Person Theory Scale (IPT) was developed to assess measures of implicit and explicit beliefs that span the perceptions for individuals across personality and ability domains (Levy & Dweck, 1997). The scale is comprised of eight items, four of which measure entity beliefs or the belief that ability and personality are fixed and therefore unchangeable. The remaining four items measure incremental beliefs, the belief that personality and ability are malleable and therefore changeable. A sample item measuring entity or fixed beliefs is “Everyone is a certain kind of person and there is not

much they can really change about that.” A sample item measuring incremental or growth beliefs is “People can substantially change the type of person they are.”

Participants were asked to rate each item on a six-point Likert scale with anchor one representing strongly disagree and anchor six representing strongly agree. According to Levy, Stroessner, and Dweck (1998), entity questions are reverse coded while incremental items are calculated normally. Levy and Dweck (1997) recommend reverse coding the entity scale to produce one scale that best represents the unitary composition of fixed and growth beliefs. Levy and Dweck (1997) reported a test-retest reliability of the scale from one week to four weeks of .82 and .71. Levy and Dweck (1997) reported high internal consistency ($\alpha = .93$) and Heslin, Latham, and VandeWalle (2005) reported a high internal consistency ($\alpha = .94$) for the IPT (See Appendix E).

Sentencing Form

The researcher asked the participants to assign a prison sentence to the man in the vignette for his behavior toward the woman. Participants read the vignette and decided the length of sentence they deem appropriate for the situation. Possible sentences ranged from no time served (0 months, 0 years) to life in prison (99 years) (See Appendix F).

Procedure

Following Institutional Review Board approval, college undergraduates were invited to participate in the study through the SONA system. The assessments were administered online and each participant began the process by reading the consent form (Appendix G) and agreeing to participate in the study. To help ensure the anonymity and

privacy of the participants, the researcher explicitly described the risks associated with participating in a research study (i.e., the loss of privacy) and encouraged participants to complete the surveys on a private or secluded computer. Each participant was then asked to read the vignette text and view a vignette image. The particular vignette image viewed by the participant was randomized across the four conditions (normal weight perpetrator/normal weight victim, the overweight perpetrator/normal weight victim, the overweight perpetrator/overweight victim, or the normal weight perpetrator and overweight victim). This randomization was done to guarantee that each participant viewed two of the eight photographs by chance and in an attempt to ensure homogeneous groups, therefore further reducing potential biases. Participants were then asked to complete the DVBS, the IPT, and the sentencing form. After the participants completed the DVBS, the participants completed the demographic form. Following the completion of their participation, participants each received a debriefing form (See Appendix H) as well as contact information to mental health services (See Appendix I) should they have wanted to pursue counseling.

Analysis

The study design for the statistical analysis was a two-by-two factorial design. The major statistical analysis for the hypotheses consisted of a 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA on the DVBS (Petretic-Jackson et al., 1994) and the sentencing

form. Three levels of analysis were conducted in the current study: preliminary analyses, the analysis of the major hypotheses, and finally exploratory linear regressions.

Preliminary Analysis

Prior to conducting the series of ANOVA's, descriptive statistics on all variables were calculated. Analyses that examine the relationship between demographic variables and participant responses on the DVBS (Petretic-Jackson et al., 1994) and sentencing form were also be conducted. A series of correlations for continuous variables (i.e., age, height, weight, perceived weight) were also run. T-tests were conducted for variables with only two categories (e.g. gender) and one-way ANOVA's were calculated for categorical variables with more than two categories (e.g., ethnicity). These analyses were conducted to explore potential covariance that may have affected the dependent variables.

Hypotheses and Analyses

For the five primary research hypotheses, 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA's were utilized to test for differences between participants' attributions of blame on the DVBS (Petretic-Jackson et al., 1994) and the sentencing form. The independent variables were gender and weight. The dependent variables were the levels of blame as measured by the DVBS and sentence length. The researcher proposed to explore significant results with univariate analyses.

Hypothesis

1. It was hypothesized that the attribution of blame for men would be significant and greatest in condition two (ON) followed by condition four (OO) and then condition one (NN) with condition three (NO) receiving the least amount of blame.

2. It was hypothesized that the attribution of blame for women would be significant and greatest in condition three (NO), followed condition four (OO) and then condition one (NN), with condition two (ON) receiving the least amount of blame.

3. It was hypothesized that the attribution of blame for society would be significant and greatest in condition one (NN) followed by condition three (NO) and then condition two (ON), with condition four

Analysis

1. A 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA on the attribution of blame to the man subscale of the DVBS (Petretic-Jackson et al., 1994) measure.

2. A 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA on the attribution of blame to the woman subscale of the DVBS (Petretic-Jackson et al., 1994) measure.

3. A 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA on the attribution of blame to society subscale of the DVBS

(OO) receiving the least amount of blame. (Petretic-Jackson et al., 1994) measure.

4. It was hypothesized that the attribution of blame for situation would be significant and be greatest in condition one (NN) followed by condition three (NO) and then condition two (ON), with condition four (OO) receiving the least amount of blame. 4. A 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA on the attribution of blame to the situation subscale of the DVBS (Petretic-Jackson et al., 1994) measure.

5. It was hypothesized that participants would assign the men in condition two (ON) with the lengthiest sentence, followed by conditions four (OO) and one (NN) being equal, with men in condition three (NO) receiving the shortest sentence. 5. A 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA on the sentencing form.

Exploratory Linear Regression

Three regression analyses were originally proposed in an effort to discern and explore the specific relationships between the variables. However, upon conducting the series of ANOVA's associated with the hypotheses, it was determined that only a single

regression analysis with the length of sentence as the criterion variable and gender, mindset, participant group, and Body Mass Index as the criterion variables was viable.

CHAPTER IV

RESULTS

Preliminary Analyses

Descriptive Statistics

Means, ranges, and standard deviations were calculated for all continuous variables on measures used in this study (dependent variables). It should be noted that scores on the Domestic Violence Blame Scale were transformed from 0-6 to 1-7 in order for analyses to be viable. The 1-7 scale was used throughout all further analyses (See Table 3).

Table 3

Descriptive Data for Dependent Variables

Variable	Mean	Range	Standard Deviation
IPTS:	3.68	1-6	.918
DVBS:			
Situational Blame	3.13	1-7	.962
Victim Blame	1.07	1-7	.883
Perpetrator Blame	2.90	1-7	.805
Societal Blame	2.50	1-7	.918
Sentencing in Months:	45.22	0-1199	135.85

Note: IPTS = Implicit Person Theory Scale; DVBS = Domestic Violence Blame Scale

Scores on the DVBS reflect a continuum of prescribed blame. Higher scores reflect larger levels of blame whereas lower scores indicate little blame. Scores on the Implicit Person Theory Scale measure the extent to which individuals believe others can change. Higher ITPS scores representing incremental beliefs that suggest the notion that others can change. Lastly, scores on the sentencing variable reflect the number of months in jail the participants believed the man in the scenario should receive for his actions against the woman. Scores on the IPTS were slightly above average, indicating that on the whole, participants viewed persons as more capable of change than not. Overall scores on the DVBS were below average when compared to mean DVBS scores. DVBS mean scores show that the situation was ranked first as the cause of domestic violence, followed by the perpetrator, society, and lastly, the victim.

Correlations

Correlations were calculated between all continuous variables in the study, including demographics and scores on the ITPS, DVBS, and the sentencing form. These correlations are presented below in Table 4.

Table 4

Correlations for the Major Variables

	BMI	Age	Sentence	Situational Blame	Victim Blame	Perpetrator Blame	Society Blame	Mindset
BMI	1							
Age	.177	1						
Sentence	.072*	-.029	1					
Situational Blame	-.050	.099**	.021	1				
Victim Blame	.078*	.128**	.185**	.234**	1			
Perpetrator Blame	.067	-.073*	.126**	.329**	.271**	1		
Society Blame	.001	.114**	.064	.394**	.371**	.402**	1	
Mindset	-.018	.086*	-.034	-.032	-.079*	-.012	-.013	1

Note: BMI is defined as weight in kilograms divided by height in meters squared, ** Correlation is significant at the 0.01 level (2-tailed). *Correlation is significant at the 0.05 level (2-tailed).

Correlations measure the strength of the relationship between variables. Many of the correlations in the study were small, even if statistically significant. Correlations for the different levels of the Blame Scales were all moderately positively correlated with one another, which suggested that types of blame are overlapping constructs. Moreover, correlations regarding Society Blame, Situational Blame, and Victim Blame and age were significantly positively correlated, which suggested that an increase in age was associated with an increase in these types of blame. The correlation between age and Perpetrator

Blame was significant and negatively correlated, indicating that as age increased, victim blame decreased. The correlation for age and mindset was also significantly positively related, a result which suggested that as age increased so did mindset flexibility. Lastly, there was also a statistically significant, positive relationship between Body Mass Index and sentencing suggesting that participants with higher BMI scores may assign lengthier sentences.

Analyses for Major Hypotheses

For the following hypotheses, the first condition represents the Perpetrator weight status and the second condition represents the Victim Weight status.

Hypothesis One. In hypothesis one, the researcher predicted that the attribution of blame for men will be greatest in condition two (Overweight, Normal Weight) followed by condition four (Overweight, Overweight) and then condition one (Normal Weight, Normal Weight) with condition three (Normal Weight, Overweight) receiving the least amount of blame. This hypothesis was not supported: $F(1, 768) = .051, p = .882$.

Hypothesis Two. In hypothesis two, the researcher posited that the attribution of blame for women will be greatest in condition three (NO), followed condition four (OO) and then condition one (NN), with condition two (ON) receiving the least amount of blame. The hypothesis was not supported: $F(1, 768) = .593, p = .442$.

Hypothesis Three. In hypothesis three, the researcher predicted that the attribution of blame for society will be greatest in condition one (NN) followed by

condition three (NO) and then condition two (ON), with condition four (OO) receiving the least amount of blame. The hypothesis was not supported: $F(1, 768) = .115, p = .734$.

Hypothesis Four. In hypothesis four, the researcher hypothesized that the attribution of blame for situation will be greatest in condition one (NN) followed by condition three (NO) and then condition two (ON), with condition four (OO) receiving the least amount of blame. The hypothesis was not supported: $F(1, 768) = .899, p = .343$.

Hypothesis Five. In hypothesis five, the researcher hypothesized that participants will assign the men in condition two (ON) with the lengthiest sentence, followed by conditions four (OO) and one (NN) being equal, with men in condition three (NO) receiving the shortest sentence. Analysis revealed a significant difference in conditions $F(1, 768) = 5.3, p = .022$. However, results were not in the predicted order. See Table 5 for descriptive statistics on the dependent variable by category: See Table 6 for ANOVA results of hypothesis five.

Table 5

Descriptive Statistics on Sentencing by Victim and Perpetrator Weight Category

Victim	Perpetrator	Mean Sentence in Months	Standard Deviation	N
Overweight	Overweight	38.4	83.2	180
	Normal Weight	52.9	176.2	194
	Total	45.9	139.5	374
Normal Weight	Overweight	60.1	164.4	193
	Normal Weight	29.7	90.0	201
	Total	44.6	132.5	394
Total	Overweight	49.6	131.9	373
	Normal Weight	41.1	139.5	395
	Total	45.2	135.8	768

Table 6

ANOVA Table for Hypothesis Five

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	110868.9 ^a	3	36956.3	2.010	.111
Intercept	1570731.8	1	1570731.8	85.450	.000
Victim	117.2	1	117.2	.006	.936
Perpetrator	12106.7	1	12106.7	.659	.417
Victim * Perpetrator	96514.6	1	96514.6	5.251	.022

Error	14043824.6	764	18382.0
Total	15725412.0	768	
Corrected Total	14154693.479	767	

The ANOVA revealed there were no main effects. There was an interaction effect. Post-hoc t-tests were used to determine where the interaction effects occurred. The means for the four conditions compared in these post-hoc tests are presented below in Table 7.

Table 7

Mean Scores on Sentencing for the Four Victim and Perpetrator Conditions

Condition	Mean Sentence in Months
1 (NN)	29.68
2 (ON)	60.06
3 (NO)	52.90
4 (OO)	38.41

Note: The first letter in the condition represents Perpetrator weight status; the second letter in the condition represents the Victim weight status (N= Normal; O=Overweight)

Only the comparison between conditions 1 (NN) and condition 2 (ON) was significant, $t(392) = 2.29, p = .023$. This interaction showed that normal weight

perpetrators with normal weight victims were given shorter sentences ($M = 29.68$ months, $SD = 164.4$) than overweight perpetrators with normal weight victims ($M = 60.06$ months, $SD = 90.0$). This interaction effect is illustrated in Figure 1.

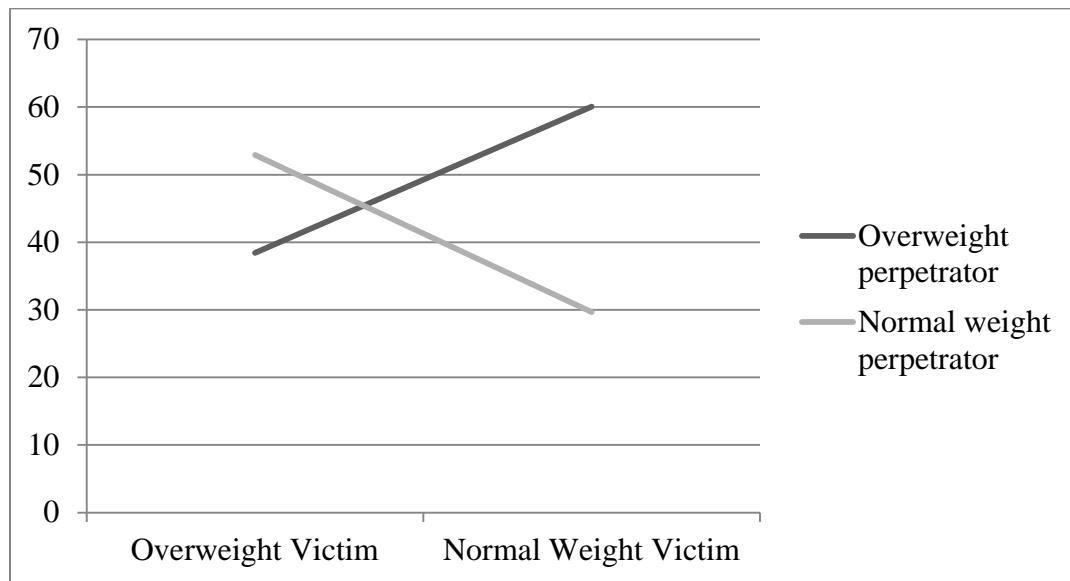


Figure 2. Sentencing interaction effects for hypothesis five. Note: Horizontal (y) axis represents average sentencing time in months.

Exploratory Independent Samples t-test

Based on a preliminary examination of Table 7, exploratory analyses were conducted to determine if the conditions in which the perpetrator's and victim's weight matched differed from the conditions in which the perpetrator's and victim's weight did not match. Therefore, data from conditions 1 (NN) and condition 4 (OO) were collapsed into a "same size" condition and data from conditions 2 (ON) and condition 3 (NO) was collapsed into a "different size" condition. An independent samples t-test showed that

participants assigned longer sentences when the victim and perpetrator were of different sizes ($M = 33.8$, $SD = 86.85$) than when the victim and perpetrator were of the same size ($M = 56.47$ months, $SD = 170.26$), $t(576) = -2.329$, $p = .02$.

Exploratory Regression Analysis

As noted previously, it was determined that only a single regression analysis with the length of sentence as the criterion variable and gender, mindset, participant group, and BMI as the criterion variables was viable. The overall regression model was marginally significant ($F(6, 761) = 1.89$, $p = .08$, $R^2 = .015$). The results are presented below in Table 8. An examination of the model components shows that only the interaction of the perpetrator and victim group and BMI variables reached significance. The interaction effect of the groups suggested that participants viewed violence differently depending upon perpetrator or victim weight. As participant BMI increased, the length of sentencing in months increased.

Table 8

Results for the Exploratory Regression Analysis

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	-2.805	39.693		-.07	.944
Gender	9.772	10.932	.032	.89	.372
Mindset	-5.375	6.049	-.032	-.89	.374
Victim	21.296	14.041	.078	1.52	.130
Perpetrator	15.136	14.034	.056	1.08	.281
Perpetrator * Victim	-43.639	19.574	-.141	-2.23	.026
BMI	1.753	.892	.071	1.96	.050

Note: Dependent Variable: Sentence in Months

Note: BMI is defined as weight in kilograms divided by height in meters squared

CHAPTER V

DISCUSSION

In the discussion that follows, a summary of the major findings of this study are presented, and are integrated with current literature and theory. Implications for research, training, and practice are noted, as well as strengths and weaknesses of the investigation. A final set of conclusions are given at the end of the chapter.

Summary of Major Findings

The purpose of the study was to investigate the potential effects of weight and weight-related biases on the perception of men's violence against women. As the exploration of weight-related biases in relation to men's violence against women is largely absent from the literature, the investigation is situated within the broader goal of addressing men's violence against women, acts that affect the lives of countless individuals and families (Nayak et al., 2003). The prospective link between the perception of weight and men's violence against women was measured through a series of 2 (male perpetrator weight status: normal weight, overweight) by 2 (female victim weight status: normal weight, overweight) ANOVA's. A secondary exploratory regression analysis was conducted utilizing length of sentence as the criterion variable and the predictor variables of gender, mindset, participant group, and Body Mass Index.

The results failed to confirm the first four hypotheses in which the researcher posited that the attributions of blame for men, women, society, and the situation would be

significant depending upon weight of the perpetrator and victims. However, the fifth hypothesis, which posited that participants would assign varying sentences dependent on perpetrator and victim weight, did receive some support.

Specifically, the overweight perpetrator with normal weight victim received the lengthiest sentence, and this sentence was significantly longer than that assigned to normal weight victims with normal weight perpetrators. There were no significant differences between any of the other comparisons. These results suggested that participants' perception of weight had an effect on the length of sentence assigned, but these effects were not as originally predicted.

An exploratory linear regression analysis was then conducted to explore the effects of the predictor variables. The results yielded a marginal model through which gender, mindset, and participant group were found to be non-significant. Group was a significant predictor, which reflects the previously highlighted interaction. The predictor variable, BMI, was significant; participants with higher BMI gave longer sentences.

Another phenomenon occurred in the study regarding differences in sentencing behavior. The results showed that participants assigned longer sentences to perpetrators when their size differed from that of their victims. This meant that perpetrators in conditions three (Normal Weight, Overweight) and two (Overweight, Normal Weight) received longer sentences. In other words, participants appeared to be operating within the cultural norm of "pick on somebody your own size."

Integration with Theory and Prior Literature

Hypotheses 1-4 were found to be unsubstantiated, a result that may be linked to the finding that the types of blame were correlated with one another. The correlation between the differing types of blame may have led participants to view events as being caused by heterogeneous factors such as differences in environment. The manner in which ratings were constructed for the study may have encouraged this type of response pattern as participants were asked to rate levels of blame across differing platforms versus choosing a particular type of blame. In creating a diverse platform upon which participants could address blame in a more nuanced fashion, the use of multiple forms of blame may have created a more ambiguous and complex response pattern.

A second explanation as to the unsubstantiated hypotheses is the consideration of the phenomenon of choosing to abuse someone who is (supposedly) capable of successful fighting back or defending themselves. In constructing the hypotheses, the notion of an individual of a similar size striking an individual of a similar size as being more acceptable to participants was not examined or explored. As this trend was not identified at the outset of the study, and subsequently explored after the results, it is likely that the researcher would have asserted a different order in which effects would have been seen previous to collecting and analyzing the data.

Additionally, it is also possible that the Blame Scales pulled for response bias or response sets (Messick, 1962). Response sets refer to the tendency for participants to respond in a particular way independently of the content or questions. It is therefore

possible that participants neither agreed nor disagreed on items, instead answering neutrally due to response bias. To that end, it is conceivable that due to response sets, participants agreed that blame was warranted, but in tending to agree out of bias, answers appeared more uniform (Messick, 1962).

The result that participants assigned the lengthiest sentence when an overweight perpetrator battered a normal weight victim supports previous research that suggested physical dominance and acts of violence can be associated with boys and men of size (Griffiths et al. 2006; Janssen et al. 2004; Rich et al., 2008). Griffiths et al. (2006) wrote that boys whose weight was heavier than their peers were more likely to engage in violent acts toward others as a means of exerting their actual or perceived physical prowess over others. Rich et al. (2008) found that pre-school children associated strength with weight, creating a potential link between weight and power. When the results of the current study are interpreted through a similar lens, it is possible that participants may have received and internalized messages that larger or overweight men pose a greater threat, particularly to women partners. Size may have been linked to power, therefore warranting a longer sentence.

The finding that normal weight perpetrators who battered overweight victims received the second longest sentence is also linked to previous research with two potential explanations. The first coincides with Clarke and Lawson's (2009) research exploring sexual victimization and sentencing. Clarke and Lawson (2009) found that participants assigned significantly longer sentences when the victim of a sex crime was

overweight. The researchers cited confusion as a potential explanation as participants were shocked that perpetrators would have chosen overweight women as targets of sexual crimes.

This outrage and confusion parallels the idea that overweight women are often viewed as less able, less intelligent, and lazier than women of normal weight (Schwartz et al., 2006; Wang et al., 2004). It is possible that participants in the present study viewed the overweight female victims as less able to defend themselves or act in other effective ways in the domestic violence scenario, thus leading them to assign a longer sentence to the perpetrator.

A second interpretation of this finding revolves around the proposed idea that overweight individuals, notably women, are pitied. Boyes and Latner (2009) and Brownell et al. (2005) wrote that overweight individuals can be viewed as lacking strength or the ability to control their weight. This association extends beyond weight and can also include job performance and interpersonal relationships (Janssen et al., 2004; Puhl & Brownell, 2006). When adopting a view such as the one presented above, individuals may view an overweight individual as someone to be pitied. As a result, it is possible that participants who have adopted such a view assigned longer sentences to the perpetrator.

The two interpretations above likely highlighted the idea that participants more readily accepted men's violence against women when the man and woman were of similar sizes. As longer sentences were noted when the perpetrator and victims were of

different sizes, it would appear that participants responded in a way that was consistent with the idea that fighting or violence is more tolerable when the aggressor and victim are not separated by weight and a perceived strength difference.

Another notable associated weight-related trend involved participants' reported BMI scores. A pattern emerged within the data that more overweight participants assigned longer sentences to the perpetrator. This trend opposed the one found by Schwartz et al. (2006) that indicated overweight individuals held less anti-fat biases. While other researchers (Rudman et al., 2002; Wang et al., 2004) wrote that anti-fat biases may differ from other biases in the sense that overweight individuals do not show in-group favoritism, the current study yielded results that suggested those individuals with higher self-reported BMI scores assigned lengthier sentences to perpetrators. Rudman et al. (2002) and Wang et al. (2004) wrote that overweight individuals tended to show much less in-group favoritism and association than other ethnic and minority groups. This idea may be due in part to the notion that anti-fat biases are permissible and encouraged by social and interactive media (Boyes & Latner, 2009). The current study was self-report in nature and therefore may have allowed overweight individuals to answer honestly, devoid of social pressure. It is therefore possible they felt free to align with other overweight individuals. Overweight participants may have seen it fit to defend the overweight victim, thereby expressing discontent with social oppression and stereotyping. Additionally, a history of victimization may also be associated with harsher sentences for those with higher BMI scores. Previous or current experiences with

bullying or weight-based stigmatization and trauma might have led participants with higher BMI to more readily consider weight in the context of men's violence against women.

While the researcher's predictions regarding mindset were not met, the theme of mindset, age, and blame emerged as noteworthy. As previously discussed in the results, older participants exhibited a more flexible mindset, greater blame of society, the situation, and the victim, and a decrease in the blame for the perpetrator. One potential explanation for older participants showing greater flexibility in their mindset toward situation and society is that older adults may view situations and society with a greater sense of complexity. In living their lives, gaining experience with the subtleties and nuances of societal values and situations, older adults were likely viewing these constructs with a more critical eye and greater flexibility. Rather than viewing situations and society as static constructs, older participants were likely able to consider the larger environment as playing a critical role in the incidence of violence.

A second explanation for the disparity in older participants and their designation of higher levels of blame for the situation, society, and victims could be that they more readily engaged in counterfactual thinking. Counterfactual thinking would represent older participants' tendency to imagine or create alternative explanations to an occurrence or phenomenon (Galinsky, Liljenquist, Kray, & Roese, 2005). Engaging in counterfactual thinking may be particularly salient in helping to understand higher levels of victim blaming, in addition to higher levels of society and situational blame. Rather

than consider the responsibility of the perpetrator engaging in a violent act toward the victim, older adults may have more readily assigned blame to the victim as a way of creating an alternative explanation for of an uncomfortable act of men's violence against women. In engaging in counterfactual thinking, it could be that older participants were protecting their own cognitive worlds and thoughts that the man portrayed in the study was decent and therefore the victim, society, or the situation must have pulled for his violent reaction. Victim-blaming has a long-established and pervasive history as regards domestic violence, based in the "just world" hypothesis, which states that victims get what they deserve (Hammond et al., 2011).

It is also possible that the themes of higher levels of victim-blaming and less perpetrator blame occurring within older participants could be a result of generational influences. Older adults are likely to be the products of a time in which the normative view was to blame the female victim for an act of men's violence. Viewing men or the perpetrator as responsible for an act of violence would have gone against values of the majority culture, a culture driven from a primary male perspective (Johnson, 2005).

Implications for Research

The intersection of weight and men's violence against women has received little attention in the research literature and therefore serves as a rich context for future research. The finding that participants assigned longer sentences when perpetrator and victim weight varied seemed to suggest that participants held the belief that it was more appropriate for perpetrators to target those who are similar in capability and ability to

defend themselves. In the case of an overweight perpetrator and a normal weight victim, it was likely that participants reacted to the discrepancy in size as being harsher and less fair with the perpetrator's size acting as a marked advantage. Moreover, for those participants assigning longer sentences to a normal weight perpetrator and an overweight victim, the results suggested that participants may have felt a sense of pity for the overweight victim. It is possible those participants assigning longer sentences to perpetrators committing a violent act toward the overweight victim were devaluing the victim due to her size, paralleling the results seen in Clarke and Lawson's (2009) study. It is also possible that participants may have viewed the overweight victim as less than a normal victim and therefore deserving of protection or feelings of sorrow (Clarke & Lawson, 2009). It may therefore be important to further explore the effects and perception of differences in size and weight and their impact upon violence.

It is also conceivable that those participants assigning longer sentences to a normal weight perpetrator and an overweight victim could have been operating under a belief that those who are similar in weight were better suited to defend themselves. This response pattern could be indicative of a greater acceptance of men's violence toward women when the man perpetrating the violence is of a similar weight to the woman, aligning with an older belief that those engaging in a fight should attack those of a similar size. One example of this thought pattern is the evidence of weight classes in professional sports, such as Mixed Martial Arts and boxing. In the sport of boxing, fighters are split into 17 categories (i.e., flyweight, welterweight, heavyweight) in an

effort to mediate the advantage weight can give a fighter (Sugar, 1982). While sanctioned violence is subject to further scrutiny as to its effects on men and women, that research is beyond the scope of the current study. However, the delineation of classes in sports reinforces the widely held notion that individuals should engage others that mirror them in size as to not have an advantage in a fight. This idea is one popular in the United States and is defined in the McGraw Hill Dictionary (2002) as “to abuse someone who is big enough to fight back.” Such an idiom appears to be entrenched in the culture and aid in explaining the longer sentences when a discrepancy in weight was present.

The data from the study were also complex in nature, particularly surrounding the variable of ethnicity as well as the discrepancy between reported height and weight versus actual BMI. While the five major hypotheses did not directly address these facets of diversity, nor did the hypotheses address the differences in perceived and actual BMI, data could be analyzed retrospectively in an effort to explore these variables. It is possible that retrospective explorations may also highlight differences in culture and the ways in which men’s violence and size are viewed by individuals from diverse cultural backgrounds.

Related to the finding that a higher self-reported BMI was associated with longer sentencing, future research may involve exploring in-group dynamics. As noted earlier, prior research has shown that overweight individuals tended to show much less in-group favoritism and association than ethnic and other minority groups (Rudman et al., 2002; Wang et al., 2004). It may then be prudent to further explore the support that overweight

individuals may lend one another (i.e., shared experience, suggestions for addressing or dealing with weight-related stigma) and the avenues through which this process might occur.

Another area for further research may include exploring both men's and women's previous experiences with men's violence against women and how those experiences may influence sentencing behaviors. As there was a wide range of sentences assigned in the current study, it may be advantageous to further explore how previous familial or personal exposure to men's violence affects perceptions of men's violence against women, and how these factors impact ideas about consequences, punishment, and legal aspects of domestic violence.

In addition to the implications for research from the current study, previous researchers have highlighted in-group and between-group differences related to the perception of weight (Duncan & Robinson, 2004; Latner et al., 2005; Roehling et al., 2007). As the United States continues to become more diverse, it will be important to identify both risk and protective factors regarding the perception and beliefs about weight and body size as they relate to various social identity status variables. For example, perhaps people in collectivist cultures tap into strengths, such as the importance of extended protective kinship networks in handling men's violence against women. (Latner et al., 2005; Roehling et al., 2007).

Additional research with healthcare providers and educators may also be pertinent and warranted. Schwartz et al. (2006) wrote that overweight and obese individuals tend to

internalize negative messages regarding size, including that overweight individuals are lazy, unmotivated, and less intelligent than those individuals of normal weight. As such, negative messages regarding the intersection of weight and ability are often introduced or perpetuated by those with social influence, such as educators and health providers (Huizinga et al., 2009). Further research concentrating upon the social and psychological aspects of negative messages regarding weight may help to mediate the damaging effects of biases and inaccurate information concerning weight.

The field may also benefit from further exploration of peer to peer interactions. Latner et al. (2007) wrote that negative stereotypes regarding overweight individuals tend to begin early in the developmental process. This early categorization affects how overweight children view themselves as well as the way in which children of normal weight view them (Davison & Birch, 2001). With the early years of development including critical milestones, it will be important to further scrutinize the outlets (i.e., social media and familial messages) through which children are learning and internalizing messages regarding weight and size. Moreover, it may also be fruitful to further explore the role of weight in men's violence against women, particularly including those boys and girls bullied as children. As overweight girls and women may be at higher risk to be targets for bullying and men's violence (Brownell et al., 2005; Pearce et al., 2003), it is likely prudent to continue to explore the role of weight in men's violence against women.

Further research regarding protective factors, ethnicity, and country of origin will also be critical. Latner et al. (2005) reported that African American women adopted higher levels of self-esteem and body satisfaction than White and Latina women. Spurgas (2005) reported that Latina women were more comfortable and perceived less body image disturbances when residing in their countries of origin. As such, exploring the cultural and personal protective factors may continue to be fruitful.

In general, continuing to engage in research targeting preventative strengths and strategies will assist in understanding and implementing change on personal, societal, and more global platforms. Additional research exploring experience with men's violence against women may generate critical information that may assist in reforming public policies or further educating others on the dangers and long lasting effects of men's violence against women.

Implications for Theory

Recent theories of weight-based stigma (Latner & Stunkard, 2003; Puhl & Brownell, 2006) suggested that devaluing overweight individuals begins as early as pre-school and negatively influences self-esteem and happiness (Rogge, Greenwald, & Golden, 2004). The findings of the current study are relevant to this theory because participant behavior (i.e., assigning longer sentences due to perceived weight differences), suggested the continued existence of weight-based stigma. The discovery that participants with a higher BMI score assigned longer sentences to the perpetrator may have underpinned an in-group bias toward weight. As uncertainty exists as to

whether this finding underlies a greater sense of disgust with individuals of similar weight, further theoretical exploration of values and beliefs regarding the perception and size of weight for individuals with higher BMI scores will likely foster a deeper understanding of within group, weight-based stigma.

A second explanation may involve the way in which men's violence against women was presented in the study. The depiction of violence was designed to replicate violence as it occurs most often with a man physically striking a woman in their home; however, men's physical violence also includes using size to intimidate as well as tossing/throwing objects to incite a fear-based response (Puhl et al., 2009). As the sentencing behavior of participants shifted with higher BMI scores and a discrepancy in the weight of the perpetrator and victim, further exploration of the perception of what constitutes men's violence, and how size plays a role in differing violent situations, may also help to foster a better understanding of how weight-based stigma may affect the perception of men's violence as well as further illuminate what individuals consider to be violent acts.

Additionally, more research surrounding the notion of civilized oppression suggested by Rogge et al. (2004) may also help to understand weight-based stigma. As the potential for participants' experiencing pity for the overweight women who were physically abused by the perpetrator existed within the study, it is possible that participants of normal weight saw the overweight victim as a subordinate and therefore deserving of protection as evidenced by the discrepancy in sentencing for normal weight

perpetrators and overweight victims (Harvey, 1999). It is possible that this potential for protection and subordination of overweight individuals may create a system based on power that could humiliate or oppress overweight individuals. It may therefore be critical to continue to research weight oppression so that we understand and can eventually dismantle a system that often overwhelms overweight individuals and can leave them feeling powerless.

Implications for Practice

The results of the current study suggest that a number of considerations for practice be explored. As anti-fat biases tend to exist within all levels of the healthcare profession, including helping professions, it is prudent to consider the practical implications that weight stigmatization could have during psychotherapy (Bocquier et al., 2005; Vacek, 2007). Given that disparity was seen in the length of sentencing between those scenarios in which the perpetrator and victim were of different weight and when perpetrators and victims were of the same weight, it is possible that healthcare professionals may view the victims and perpetrators of violence differently dependent on weight status.

In the case of a woman being physically abused, if the healthcare professional is cognizant of a weight discrepancy between the victim and perpetrator, it is possible that healthcare professionals may feel more strongly protective or outraged for the victim. Strong feelings may present as greater empathy for the woman, higher levels of anger toward the woman's abuser, or higher levels of disgust toward the perpetrator when the

woman is overweight. Moreover, as participants with higher BMI scores assigned longer sentences, it is also possible that the weight of the healthcare professional may also play a role in the delivery of medical or mental health services. It may therefore be important to explore the reactions of healthcare professionals with their supervisors or through peer or colleague discussions. Furthermore, and in the case of mental health professionals, exploring weight biases and how such professionals view themselves may also be important when working with women who have experienced the violent acts of men.

It may also be important to explore the ways in which healthcare professionals respond to violent men. As participants assigned longer sentences when men's weight varied from the weight of the women victims, this may affect how mental health providers view men in treatment for violence against women. It may be fruitful to explore the role and significance of weight and size when working with violent men in treatment. In addition, exploring the reactions of mental health practitioners toward violent men likely also warrants attention as practitioner attitudes may be altered depending on the relative weight and size of the victim and perpetrator.

The discrepancy in sentencing behavior in the study highlighted the continued existence of weight-based stigma. In the cases where sentences were shorter in duration for the perpetrators and victims of the same weight, this result suggested that individuals may be more accepting of violence when perpetrators and victims are of similar body shape and size. The potential for folk norm of "picking on someone your own size" as being acceptable may subtly permeate programs and workshops aimed at reducing weight

based stigma. The field would likely benefit from a more extensive exploration of the prevailing systems embedded within the societal fabric.

Beyond the specific results of this study, but based in the literature, there are important additional considerations in terms of therapy and weight stigmatization. One example is the physical layout of a therapy space. Creating a welcoming physical location for therapy can be helpful in creating a warm and accepting environment in which overweight individuals can feel comfortable. Including a wider chair or couch can create a sense of awareness of differences.

Beach et al. (2007) discussed overweight individuals' reticence to receive and seek help from medical and helping professionals. The stigmatization of overweight and obese individuals has been prevalent throughout society leading to negative stereotypes (Puhl, Moss-Racusin et al., 2008). Weight and the biases that obese and overweight individuals experience may be an opportunity for growth during individual or group therapy. While engaging a client or a group regarding weight may not always be appropriate, clinicians may want to consider what having weight-related conversations would entail. Challenging one's own biases, conceptualizations, and experiences with weight-based stigmatization will be important when preparing for an intervention or conversation about weight. Moreover, it is also critical for practitioners to explore one's comfort in discussing weight-based oppression. Consulting literature regarding non-judgmental language and current issues may also be helpful in working with overweight and obese individuals.

The practice of psychotherapy is one way that clinicians and health care providers can assist in reducing weight-based stigmatization. Yet another and potentially personally taxing way to work to reduce weight-based stigmatization is in a clinician's own life. As familial, interpersonal, and work related relationships have all been reported to be areas in which weight-based oppression occurs, challenging the societal messages within these relationships is critical (Blaine & McElroy, 2002; Boyes & Latner, 2009; Puhl, Moss-Racusin et al., 2008). Social justice and challenging those perpetuating oppressive systems are other avenues through which clinicians can act. As this suggestion removes an individual from a professional role, personal choice will be paramount.

Implications for Training

A number of implications for training can be gleaned from the current study. The first implication is working with institutions (i.e., universities, elementary schools) to enact larger social change and understanding regarding weight bias. As sentencing behavior shifted when a discrepancy in weight existed, addressing the preconceived notions individuals hold about size and weight will be critical. The idea that people were more accepting of men's violence against women when the perpetrator and victim were of the same weight highlighted the idea that violence may be more permissible when perpetrators and victims are of a similar weight. Exploring and leading candid conversations with healthcare professionals, administrators, law makers, and students regarding weight and men's violence against women may help to address the difference

in sentencing structure found in the study while raising awareness about weight-based biases.

In the case of the overweight perpetrator and the normal weight victim, it is possible that participants were reacting to the research, which has cited that larger boys tend to bully others more often (Brownell et al., 2005). This finding may aid in training in two ways. First boys - who later become men - may learn to use their size to attain goals or assert their will, and mental health professionals-in-training should be aware of this fact. Second, it may be important to address the role of weight and size in the ways men communicate in their intimate partner relationships.

Many larger systems act to create and maintain systems of oppression. In the case of overweight individuals, such systems negatively affect the self-esteem and interpersonal connections of overweight individuals (Boyes & Latner, 2009; Puhl & Brownell, 2006). It is therefore critical that those committed to social justice and the systematic interruption of oppressive systems intervene at the institutional levels. Outreach programming, discussion groups, and workshops are a number of ways that clinicians and educators can challenge and discuss weight-based stigmatization. Through re-conceptualization and conversations about the harmful nature of weight-based stigmatization, it is hoped that a cultural shift can begin to occur that will allow individuals to begin to question and shift their views and potential stereotypes associated with weight.

Families, friends, educators, and health care providers all also engage in behaviors that perpetuate weight-related biases (Horsburgh-McLeod et al., 2009; Puhl, Moss-Racusin et al., 2008). Similar to engaging in diverse forms of training, individuals can also educate themselves further regarding the intricacies regarding weight-based stigmatization. Activities such as deconstructing jokes with peers, further exploring medical barriers for individuals who are overweight or obese, and participating in diversity seminars and trainings can deepen an understanding of the pervasive and harmful effects of weight-based stigmatization (Puhl & Brownell, 2001). Similarly, interweaving discussions of sizism and weight-related discrimination into curricula and classes could be helpful. Educating students is one way in which training can help to enact change at a more systemic level.

Further training may also assist in helping healthcare providers engage in more productive, understanding conversations regarding weight. As results from the current study suggested that higher BMI score were associated with longer sentences, it is possible that overweight and obese individuals could act as allies for one another once internalized weight stigma is reduced. Input regarding oppressive and stigmatizing experiences could serve as a means through which doctors, nurses, and other healthcare providers can begin to see the barriers that overweight and obese individuals experience in seeking medical services.

Clinical supervision may provide a rich opportunity to address issues related to weight-based stigma. The supervisory relationship serves as a central mode through

which clinicians in training develop appropriate skills and attitudes (Heru, Strong, Price, & Recupero, 2004). As such, the supervisory relationship can aid in reducing weight-based stigmatization in a number of ways. First, supervisors can act as a model for supervisees in openly discussing and challenging their own biases regarding weight and weight-based stigmatization while also encouraging supervisees to explore their own biases and blind spots regarding weight and weight-based stigmatization. In opening the door for fruitful, yet challenging discussions, supervisors may also provide the opportunity for supervisees to consider and explore alternative views and perspectives regarding weight (Johnson, 2007). Furthermore, the supervisory relationship can serve as a place for supervisees to discuss weight-related therapeutic issues so that supervisees will feel more comfortable and act more efficaciously with clients of size. As supervision can be intimidating to supervisees, it will be important to consider the difficulty and importance of addressing multicultural issues such as size and weight-related bias in a safe yet challenging supervisory relationship.

Strengths of the Study

Upon undertaking and creating the study, the researcher was unaware of a similar study that sought to explore the intersection of weight and the potential effects on the perception of men's violence against women. In exploring this area absent in the literature, the researcher sought to fill a gap in the literature while simultaneously exploring how individuals view weight in the context of violence. Through the series of ANOVA's and exploratory regressions, the researcher was able to ascertain individual

perceptions, while scrutinizing these perceptions on a more global level. The results suggested that not only does weight affect sentencing behaviors but that individuals with higher BMI scores tended to assign longer sentences implies that weight may affect the perception of men's violence against women. The aforementioned findings not only highlight socially embedded biases, but support the previously reported data that in-group favoritism may not exist within overweight and obese community circles (Wang et al., 2004). Other strengths include the study's experimental design, including the ability to manipulate variables and conduct reliable statistical analyses. Furthermore, the study contained a large sample size, raising its statistical power.

Limitations of the Study

While the study explored an area that has garnered little attention, limitations existed. As the study was conducted with a university population, participant age range was limited. As a result, global generalizability remains an issue. A second limitation includes a somewhat limited range of BMI scores with a high majority of persons reporting BMI scores within the normal range. This restricted range of BMI scores may have affected sentencing and perception behavior, therefore limiting potential reporting.

Another limitation includes the lack of significance regarding blame scores on the DVBS (Petretic-Jackson et al., 1994). As the DVBS norms were generated on largely Caucasian samples, it is possible that the diversity of participants in the current study had an effect on the overall scores. In addition, the DVBS may not have adequately captured the nuances of blame in the particular scenario.

Conclusion

Though the field of psychology has been active both in research and implementation of individual and group services regarding weight-related biases and men's violence against women, contemplating further steps is critical in lessening human suffering. A combination of future research, interventions aimed at social media, and supportive efforts may offer successful means through which the field of psychology can enact meaningful, long-lasting changes regarding weight stigmatization and men's violence against women.

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Appendix A

Demographics Questionnaire

Demographics Questionnaire

DIRECTIONS: Please complete the following questions.

1. Age: _____

2. Gender: Man: _____

Woman: _____

Transgender: _____

3. What is your race/ethnicity (Please click on the number in the one best describes you):

1. Black/African/African American

2. White/Caucasian/European American

3. Asian/Asian American/Pacific Islander

4. Hispanic/Latino(a)

5. Native American/Alaskan Native

6. Other: _____

4. Height in inches: _____

5. Weight in pounds: _____

6. I see myself as:

1. Underweight: _____

3. Overweight: _____

2. Normal Weight: _____

4. Obese: _____

Appendix B

Vignette Text

VIGNETTE TEXT

DIRECTIONS: Please carefully read the scenario below.

Chance and Mariah had been dating for several years and were recently married two years ago. One evening, they had discussed having a nice, quiet dinner at home. The two went food shopping the previous night in preparation for the meal. Due to Mariah's work schedule, she volunteered to cook the meal, with Chance agreeing to help when he arrived home.

Mariah is a teacher, and on this particular day, was forced to stay later than expected for a staff meeting. Rather than leaving school at 3:30 P.M. as she expected, Mariah departed from the school at 4:30 P.M. and arrived home at 5:00 P.M. Upon arriving home, Mariah sat down for approximately 30 minutes, exhausted from a difficult day. She knew that Chance finished his work day at 4:30 and would be arriving any minute, but wished to rest before hurriedly beginning the preparations for dinner.

After resting, Mariah began preparations for the meal. She was later than she had hoped to be, but began the cooking process when she felt ready. Mariah glanced at the clock and saw that it now read 6:00 P.M. She paused for a brief moment and began to wonder where Chance was. Mariah recognized that traffic patterns varied and continued to prepare their meal.

Chance entered the couple's home at around 6:30 P.M. and greeted Mariah with a hug.

"Hello sweetheart," he said as he embraced her.

"Welcome home," she replied. Chance threw his jacket on a chair in the kitchen and sat down.

"Did you have a good day?" he asked.

"It was hectic, but it's over now," she said.

Chance smiled. "I hear you on that one. Why is dinner so late?"

"Well, I had to stay for a surprise meeting at school. Anyway, why are you late?"

"New client. The boss wanted me to take the client for a brief dinner." The two fell silent for a moment.

"I thought I smelled alcohol when you hugged me," said Mariah.

"I didn't want to be a prude. The client would have felt awkward having a beer alone, you know?" he said.

"I guess so," replied Mariah as she stirred a bowl full of vegetables.

"Here, let me help," said Chance as he took the bowl from her.

"Thank you," said Mariah as she hurried toward the stove. Both Chance and Mariah continued to prepare the meal together in silence until Chance spoke.

"I don't understand why that school is always springing these meetings on you. I mean, a little warning would be nice."

"I agree," stated Mariah. "But what can I do?"

"Speak up or something," said Chance sharply. "Thanks to them, we won't be eating until 7:30."

"Well, your boss is always asking you to do last minute things with your clients too," said Mariah. "I mean, it's the same situation."

"Not it isn't," replied Chance, "These clients are integral to my success. They're important to our success."

"And the kids at my school aren't?"

Mark shook his head. "Mariah, your job is just as important as mine...I was simply saying that letting a client go could be disastrous."

"Not attending a meeting and letting my kids and parents down would be disastrous too."

Both Chance and Mariah's tones began to change, their voices getting louder.

"I'm not saying that," began Chance.

"Then what are you saying Chance?" she questioned.

"That my job is more important!" he asserted. Mariah set down her cooking utensils placed them on the counter, and began to exit the kitchen.

"And here we go," said Chance. "That's it, just walk away." Mariah stopped and turned toward Chance.

"We may as well forget our date night," Mariah said as she stood within the entrance of the kitchen.

"What, why?" Chance asked. Mariah again began to walk out of the kitchen.

"Where do you think you're going?" demanded Chance. He walked toward Mariah and playfully grabbed her shoulder.

"Let me go," she said, her eyes looking away from him.

"Come on, let's not do this," he said.

"Just," began Mariah, "Let's just drop it." Mariah turned again to walk away, and Chance once again reached for her.

"Don't touch me!" she responded gruffly, "Chance, let me go. Now!" Mariah struggled to break free, but Chance did not let go.

Chance screamed, "Shut it, you bitch! You're not going anywhere!"

Mariah yelled back, "Let go of me you bastard! Let go!" Chance reached for her wrist, grabbed her forcefully, and struck her face. Mariah screamed and collapsed on the floor. Mariah remained on the floor for a moment, before each went to separate rooms in the house.

Appendix C
Vignette Images









Appendix D

Domestic Violence Blame Scale

Domestic Violence Blame Scale
Petretic-Jackson, Sandberg, & Jackson, 1994

For this measure, violence is defined as physical assault or violence between partners. For the current survey, Chance will always be the husband, and Mariah will be the wife. Listed below are several statements sometimes used to account for domestic violence. Please indicate your agreement/disagreement with or perception of the frequency of each statements. If you agree with a statement, please indicate the degree to which you agree. If you disagree with a statement, please indicate the degree to which you disagree. There are no right or wrong answers.

Keep the scenario between Chance and Mariah in mind as you respond.

1. The amount of sex and violence in the media today strongly influences the husband to physically assault his wife.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

2. Domestic Violence is a result of wives being regarded as property by our society.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

3. A husband who physically assaults his wife should be locked up for the act.

Almost _____ Almost
Never 0 1 2 3 4 5 Always

4. A husband who physically assaults his wife is “mentally ill” or psychologically disturbed.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

5. Domestic violence can be mainly attributed to peculiarities in the husband’s personality.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

6. It is the wife who provokes the husband to physically assault her.

Almost _____ Almost
Never 0 1 2 3 4 5 Always

7. Domestic Violence is the product of a male-dominated society.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

8. Wives encourage domestic violence by using bad judgment, provoking the husband's anger, and so on.

Almost _____ Almost
Never 0 1 2 3 4 5 Always

9. Wives are physically assaulted by their husbands because they deserve it.

Almost _____ Almost
Never 0 1 2 3 4 5 Always

10. Domestic violence can be avoided by the wife trying harder to please her husband.

Almost _____ Almost
Never 0 1 2 3 4 5 Always

11. Domestic violence is more likely to occur in unstable homes.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

12. Domestic violence is more likely to occur in families with poor interpersonal relationships.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

13. The husband's abuse of alcohol and drugs cause domestic violence.

Almost _____ Almost
Never 0 1 2 3 4 5 Always

14. Domestic violence occurs because society accepts it in marriage.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

15. Domestic violence is more likely to occur in slum or "bad" areas.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

16. As stress on the marriage increases, so does the probability of domestic violence.

Strongly _____ Strongly

Disagree 0 1 2 3 4 5 Agree

17. Domestic violence is more likely to occur in families that are socially isolated from the community.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

18. Husbands who physically assault their wives cannot control their violent behavior.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

19. Husbands who physically assault their wives had dominant, aggressive fathers who also

engaged in domestic violence.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

20. The rise of the “women’s movement” and feminism has increased the occurrence of domestic violence.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

21. Wives exaggerate the physical and psychological effects of domestic violence.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

22. In our society, it is a husband’s prerogative to strike his wife in his own home.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

23. Husbands who physically strike their wives because in our society this is defined as acceptable masculine behavior.

Strongly _____ Strongly
Disagree 0 1 2 3 4 5 Agree

Appendix E

Implicit Person Theory Scale

Implicit Person Theory Scale

Levy & Dweck, 1997

Using the scale below, please indicate the extent to which you agree or disagree with each of the following statements by selecting the number that corresponds to your opinion.

	1. Strongly	2. Mostly	3. Disagree	4. Agree	5. Mostly Agree	6. Strongly Agree
The kind of person someone is, is something very basic about them, and it can't be changed very much.						
People can do things differently, but the important parts of who they are can't really be changed.						
Everyone, no matter who they are, can significantly change their basic characteristics.						
As much as I hate to admit it, you can't teach an old dog new tricks. People can't really change their deepest attributes.						
People can always substantially change the kind of person they are.						
Everyone is a certain kind of person, and there is not much they can really do to change that.						
No matter what kind of person someone is, they can always change very much.						
All people can change even their most basic qualities.						

Appendix F
Sentencing Form

Sentencing Form

DIRECTIONS: Imagine that you are a judge responsible for handing down a sentence to Chance for his actions in the vignette you read. Please indicate the length of sentence (in months or years) from no jail time (0 years) to 99 years (life in prison).

Your Sentence: _____

Appendix G

Consent Form

Informed Consent Form (TWU)

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study:

Principal Investigator: Luke Belsky, Doctoral Student, Department of Counseling Psychology at Texas Woman's University

Purpose of the Study: You are being asked to participate in a research study which seeks to uncover factors that may contribute to men's violence against women. The study is aiming to uncover the intersection of variables pertaining to men's violence against women and the impact this may have in prevention and intervention.

Study Procedures: You will be asked to read a short story and fill out three forms and a demographics questionnaire that will take about thirty to forty-five minutes to complete.

Foreseeable Risks: The potential risks involved in this study are loss of confidentiality and potential discomfort with the material. Attempts to minimize these risks include separating your consent form from your data. In addition, if you should become uncomfortable with the material, fatigued, or wish to withdraw from the study at any time, know this option is available to you without penalty. Finally, you will receive a debriefing form at the end of this study to increase the likelihood that your participation in this research may benefit you. A referral list of counseling resources will also be provided.

Benefits to the Subjects or Others: We expect the project to benefit the field of psychology by learning more about attitudes about men's violence. As men's beliefs regarding women, and others' perceptions of men and women, we hope the results will not only have an impact on the understanding of men's beliefs about women, but will also inspire future research regarding men's attitudes toward women.

Compensation for Participants: You will receive an opportunity to apply to win one of two Amazon.com gift cards worth twenty-five dollars each. Your name will be entered in the drawing, if you so choose, and will be pulled upon completion of the data collection. You will be notified by either e-mail or mail and receive the gift card via the U.S. Postal Service if you are one of the winners.

Procedures for Maintaining Confidentiality of Research Records: The researcher will put forth extra care to ensure that any identifiable information (i.e., consent forms) are kept in a locked room in a locked cabinet where access is limited to the study's researchers. Furthermore, the information obtained through the research measures will be kept in a separate location in locked conditions to ensure that confidentiality is maintained. While there is potential for you to receive a gift card, the researcher will pull your name at random. Winners will receive the gift cards in a plain white envelope. Lastly, the confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, contact Luke Belsky at (940) 898-2303

Review for the Protection of Participants: This research study has been reviewed and approved by the TWU Institutional Review Board (IRB). The TWU IRB can be contacted at (940) 898-3375 with any questions regarding the rights of research subjects.

Research Participants' Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Luke Belsky has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

Printed Name of Participant

Signature of Participant

Date

Informed Consent Form (UNT)

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study:

Principal Investigator:

Key Personnel: Luke Belsky, Doctoral Student, Department of Counseling Psychology at Texas Woman's University.

Purpose of the Study: You are being asked to participate in a research study which seeks to uncover factors that may contribute to men's violence against women. The study is aiming to uncover the intersection of variables pertaining to men's violence against women and the impact this may have in prevention and intervention.

Study Procedures: You will be asked to read a short story and fill out three forms and a demographics questionnaire that will take about thirty to forty-five minutes to complete.

Foreseeable Risks: The potential risks involved in this study are loss of confidentiality and potential discomfort with the material. Attempts to minimize these risks include separating your consent form from your data. In addition, if you should become uncomfortable with the material, fatigued, or wish to withdraw from the study at any time, know this option is available to you without penalty. Finally, you will receive a debriefing form at the end of this study to increase the likelihood that your participation in this research may benefit you. A referral list of counseling resources will also be provided.

Benefits to the Subjects or Others: We expect the project to benefit the field of psychology by learning more about attitudes about men's violence. As men's beliefs regarding women, and others' perceptions of men and women, we hope the results will not only have an impact on the understanding of men's beliefs about women, but will also inspire future research regarding men's attitudes toward women.

Compensation for Participants: You will receive an opportunity to apply to win one of two Amazon.com gift cards worth twenty-five dollars each. Your name will be entered in the drawing, if you so choose, and will be pulled upon completion of the data collection.

You will be notified by either e-mail or mail and receive the gift card via the U.S. Postal Service if you are one of the winners.

Procedures for Maintaining Confidentiality of Research Records: The researcher will put forth extra care to ensure that any identifiable information (i.e., consent forms) are kept in a locked room in a locked cabinet where access is limited to the study's researchers. Furthermore, the information obtained through the research measures will be kept in a separate location in locked conditions to ensure that confidentiality is maintained. While there is potential for you to receive a gift card, the researcher will pull your name at random. Winners will receive the gift cards in a plain white envelope. Lastly, the confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, contact Luke Belsky at (940) 898-2303

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Luke Belsky has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

Printed Name of Participant

Signature of Participant

Date

Appendix H
Debriefing Form

Debriefing Form

Thank you for agreeing to participate and completing the current research study. In an effort to be transparent, I wanted to reveal the true nature of the study. The scales you completed are meant to explore whether or not weight affects the perception of men's violence against women. Both sizism and men's violence against women are social issues that affect thousands of families and individuals. This study was created in order to address the seriousness of these societal and cultural issues.

The nature of this study was not revealed until now in an effort to collect the most unbiased data possible. I feel that it is important to reveal the nature of the study to you as it is important to understand why the study is being conducted. As your peers or friends may also be completing the survey, we ask that you do not share any of this information with them until they have completed the study.

Appendix I

Referral Contact Information

Referral Contact Information

Counseling and Testing Services (University of North Texas)
Chesnut Hall, Suite 311
P.O. Box 310968
Denton, Texas 76203
Phone: (940) 565-2741

Texas Woman's University Counseling Center
West Jones Hall
P.O. Box 425350
Denton, TX 76204-5350
Phone: (940) 898-3801

Denton County Friends of the Family
4845 S I-35 E, Suite 200
Corinth, TX 76210
Phone: (940) 387-5131

Counseling Center of Denton
1512 Scripture Street
Denton, TX 76201
Phone: (940) 382-5328