

Designing a Group Therapy Program for Coping with Childhood Weight Bias

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Research indicates that the negative psychosocial consequences of childhood obesity may reflect the degree of weight bias and mistreatment affecting the child. Even though comprehensive practice models evolve over time, the intense distress of these children calls for more timely intervention. Using a modification of social research and development methodology, a short-term group therapy approach using cognitive and behavioral methods was designed. Questionnaires were developed to assess both the child's and the parents' perceptions of the frequency, circumstances, and responses to being teased. At the end of the program, all of the children and parents showed proficiency in describing and demonstrating the coping strategies in the curriculum. A two-year follow-up found that most of the children reported fewer episodes of teasing. This article demonstrates the use of intervention research methodology to rapidly design and implement a preliminary approach to help children with severe obesity cope with weight-related teasing. Although this program needs further empirical testing and refinement before it can be more widely deployed, it represents an important initiative in responding to the distress of children who are victimized because of obesity.

KEY WORDS: *childhood weight bias; group therapy*

As the pandemic of childhood obesity continues, there is increasing concern regarding the emotional and social functioning of obese youths (Heinberg & Thompson, 2009; Panzer et al., 2012; Rimms, 2004). Many studies have documented that, compared with normal-weight peers, children who are obese are at greater risk for diminished domains of self-esteem (French, Story, & Perry, 1995), impaired quality of life (Pinhas-Hamiel et al., 2006), and, in some instances, psychiatric disorders (Mustillo et al., 2003). However, a more complete understanding of the relationship between obesity and mental health requires consideration of the role of weight bias in the child's distress (Latner & Schwartz, 2005). As an extensive review of this topic observed:

Overall, these findings suggest that the negative psychological outcomes that have at times been connected with heavier body weight may be primarily responsible for the consequence of the negative reactions of others to excess weight. . . . If these negative reactions were substantially limited, then the numerous adverse psychological consequences associated with childhood obesity would be greatly reduced." (Latner & Schwartz, 2005, p. 125)

Weight bias may thus function as an intervening variable between the child's obesity and subsequent psychosocial difficulties. Research has documented widespread victimization among school-age children with excess weight, though prevalence rates are not consistent (Eisenberg, Neumark-Sztainer, & Story, 2003; Hayden-Wade et al., 2005).

There is evidence that teasing and mistreatment is associated with binge eating in children, which contributes to their weight problem (Neumark-Sztainer et al., 2002). Leading obesity organizations have initiated task forces (North American Association for the Study of Obesity, The Obesity Society, 2004) and research programs (Yale Rudd Center for Food Policy & Obesity, 2013) to address this problem. In a position paper regarding childhood obesity, the Centers for Disease Control and Prevention concluded that "the reduction of weight bias is just as important as the reduction of body mass index" (Washington, 2011, p. 3).

A review of the relevant literature finds recurrent suggestions that parents intervene on behalf of their children in response to bias situations (Latner & Schwartz, 2005; Washington, 2011). On a broader scale, experts advocate addressing discriminatory attitudes and behaviors at a policy and program level and monitoring bias in media affecting young

people (Washington, 2011). However, there do not appear to be any clinical programs to help the children themselves cope with mistreatment. Puhl's (2005) chapter on coping with weight stigma reviews a variety of adult-oriented mechanisms and strategies but notes the scarce research in this area and concludes, "It is too early to predict which methods of coping are most appropriate for obese individuals" (p. 281).

This article describes the process of developing and implementing a group therapy approach to teach cognitive, behavioral, and interpersonal coping skills to children who are victimized by weight bias. We believe this is the first clinical program of this kind designed specifically for these children. The Live Light Live Right Pediatric Obesity Program at Brookdale University Hospital serves an inner-city population that has higher rates of pediatric obesity than the national average. The program provides comprehensive medical, nutritional, mental health services, and community-based supervised exercise activity. All patients are repeatedly assessed regarding obesity-related teasing and mistreatment.

MATERIALS AND METHOD

Developing a Practice Model

Traditional practice models, such as cognitive therapy (Beck, 1976) and structural family therapy (Minuchin & Fishman, 1981), evolved over many years and were supported by a substantial number of experimental and quasi-experimental research efforts. However, because the typical time lag between the design and implementation of research-based psychological treatments is 20 years (Hoagwood, 2003), we felt that the compelling nature of weight-related victimization of obese children called for more rapid intervention.

We therefore adopted a modified version of Rothman's (1980) social research and development methodology (social R & D) to formulate and implement a program for coping with childhood weight bias. Social R & D, as a form of intervention research, begins with the designation of a clinical problem and target population. The process continues with the retrieval of relevant consensus findings and generalized principles regarding the problem, as well as possible solutions. These data are then converted into therapeutic guidelines that are operationalized for application and field

tested. (The subsequent phases of social R & D—not part of our effort—involve refining the intervention, choosing an appropriate research design to fully assess the approach, and promoting its adoption in practice.) Model development of this kind needs to be distinguished from evidence-based treatments, which rely heavily on findings from randomized clinical trials as the most scientifically valid data. Other forms of information are considered "less credible and acceptable from a scientific, evidentiary-based standpoint" (Ollendick & King, 2004, p. 4). In contrast, practice models incorporate "whatever sources of information appear relevant to the goal or problem at hand" (Patti, 1981, p. 41). Observational research, accumulated clinical experience, and expert opinion, for example, can provide useful treatment concepts and techniques.

Defining the Problem and Target Population

Weight bias directed toward overweight and obese children includes verbal and physical assaults, attacks over the Internet, and exclusionary behavior (Latner & Schwartz, 2005). Severe or constant abuse may require intervention by school personnel or law enforcement. Weight bias has been documented in experiments with children as young as three years (Cramer & Steinwert, 1988), though studies indicating psychosocial distress as a consequence generally involve older children (Janssen, Craig, Boyce, & Pickett, 2004).

A review of data from our screening instruments and clinical interviews indicated that verbal teasing was the most common form of weight bias. In addition, it was most frequently reported in the 10- to 14-year age group, regardless of degree of obesity. From this population, we selected 10- to 12-year-old patients (who tested positive for weight bias on screening) as our target population and invited these families to participate in a new program. Our initial group consisted of three boys and three girls, with one of the females discontinuing after the orientation. To further define our clinical problem, we met with each child and one parent and ascertained that verbal teasing at school was the primary form of mistreatment. We supplemented this information with parent and child questionnaires that were created specifically for this intervention study. The Parent Weight Bias Survey (PWBS) consists of four items assessing parental perception of (1) the

location of incidents; (2) the frequency of incidents; (3) the child's actual reactions, both observed and told to parent; and (4) parental advice given to the child. The Child Weight Bias Survey (CWBS) consists of seven items: Five items assess the frequency of teasing and exclusionary acts, one lists the child's reactions (seven options), and the other lists perceived parental advice (six options). These measures were not tested for validity or reliability, as they were primarily intended to collect additional details about the clinical problem for the purpose of designing the intervention. On these measures, parents indicated that teasing occurred in several locations (with relatives, in public, at school), with school endorsed by every parent. Four of five checked the frequency of incidents as daily. Their children reacted both passively (that is, crying, feeling sad, ignoring, and walking away) and actively (that is, teasing back, hitting, and telling an adult). Most often, the children tried to ignore their teasers. Parents were very consistent in endorsing ignoring, walking away, and telling an adult as preferred coping strategies. On the CWBS, most of the children indicated the frequency of teasing as very much and three of five noted being socially excluded very much. All of the children responded that they reacted emotionally to being teased (that is, feeling sad or crying), and only one child would tell an adult.

It is important to note that in discussing these responses, the children acknowledged their parents' recurring advice to ignore the bullies but indicated that it does not work. On exploration, their efforts were limited to one attempt to avoid eye contact or not respond to a verbal taunt. When the teasing continued, the children disclosed that they would confront the teaser, which usually escalated the abuse. Parents who were frustrated by the continuing attacks tended to scold their children for not handling the situation as instructed. Clearly, the children (and perhaps their parents) did not understand that ignoring, as a deliberate form of extinction, was a repeated and absolute lack of verbal or physical response.

A third measure, a tool for creating coping skills, was a self-esteem-oriented sentence completion task that was administered to the children. The task consists of 17 items that tap a range of positive traits and abilities. The purpose of this instrument was to develop a personalized list of cognitive antidotes that the child could draw on to counter

negative internal dialogues due to teasing. These specific responses would later form the basis for one of the coping skills being taught.

We now had a much clearer picture of the clinical problem: There was verbal teasing at school on a daily basis, with parents advocating passive responses (primarily ignoring) and the children responding with emotional distress.

Relevant Theory and Concepts

Relevant information to guide the design of the intervention included data from the questionnaires and research and clinical findings about responding to teasing, maintaining self-esteem, and learning social and emotional skills. Contact with nationally recognized experts in weight bias and with group therapists who were providing programs for obese teens was also part of the retrieval process. Coping with the teasing incidents mentioned by our patients appeared to involve two elements: the interpersonal assault and the emotional distress generated by negative self-attributions. Social learning theory (Bandura, 1986) and cognitive theory (McMullin, 1986) provide well-established methods and techniques for countering noxious (peer) behavior and generating cognitive antidotes to reduce upsetting thoughts and feelings. There are also numerous publications for professionals, parents, and youths regarding bullying and bias of all kinds. Freedman's (2002) book, *Easing the Teasing*, offers a full menu of coping methods, with age- and situation-specific guidelines for implementation.

Clinical Guidelines

The various concepts derived from our search were translated into clinical materials and skills to be implemented in a specific format.

Format. Because of its suitability for teaching, universalizing distress, and generating peer support, the small-group format was chosen to facilitate the acquisition of these coping skills (Lieberman, 1979).

The small group is a natural and highly attractive setting for most children and adolescents. . . .

Because of its kinship with the natural peer group, the treatment group more nearly simulates the real world of most clients than does the treatment dyad of a high status adult and a low status child." (Rose & Edleson, 1991, p. 4)

Specific to our concerns, group process better facilitates universalizing the distress of victimized children, promoting mutual support, and role-playing teasing situations by using peers to replicate actual school bias situations. There are no known group interventions for weight bias, as clinical efforts have been directed toward either decreasing weight-related stigmatization in the general (or school) population or providing family or institutional support for victimized individuals (Haines & Neumark-Sztainer, 2009).

Various aspects of group structure were determined by the nature of the problem, the target population, and the objective of the intervention. The literature review and our data indicated that prepubertal boys and girls with obesity were frequently verbally teased by peers at school, regardless of their body mass index, with much consequent emotional distress. There were no restrictions for group membership, other than age and experiences with weight bias. We sought to counter the pernicious effects of teasing by teaching cognitive and behavioral methods to cope with these incidents, and we hypothesized that children this age could be taught and use only a few strategies. To facilitate this, we chose a six-session program that began with a parent-only meeting to review the children's experiences with victimization and to preview the coping skills to be taught. As in traditional family-based behavior modification, the goal was to enable the parents to maintain the intervention after group sessions ended, with as-needed consultation with staff.

Skills. Corresponding to the short-term format, and to facilitate mastery by the children (and effective coaching by the parents), we selected only three coping skills. Two of the techniques—ignoring and positive self-talk—were responses already familiar to the families, but they were not necessarily used effectively. The third, a confrontational method, was novel and appealing. All three responses were considered both developmentally and situationally (school) appropriate.

Presented and modeled by the therapist, ignoring helps the child gain a sense of control, rather than feeling helpless. Children who are obese should be prepared for the possibility that teasing may initially intensify in response to ignoring. Role playing (therapist-child, child-child) supplemented with visualization, the imagery of "tease balloons"

bouncing harmlessly off child, and Styrofoam balls imprinted with tease words were used to detoxify hurtful and degrading comments. (Additional techniques for teaching ignoring are noted in Freedman's [2002] book.)

Positive self-talk as a coping strategy involves two dimensions. First, the child was helped to develop an internal dialogue to assess the validity of the source and content of the negative comments. Second, the child's positive self-attributions—determined by discussion and previously administered sentence completion—were used as a source of cognitive antidotes to self-deprecating thoughts. Parents were encouraged to supply important validating qualities and abilities regarding their child.

Clinicians individualized positive self-talk for each group member, enabling the child to draw on his or her supply as the situation warranted. Discussion, visual cues, and role playing reinforced the child's use of this technique, as well as the natural peer support and validation afforded by the group process. Specific countering phrases, a form of cognitive restructuring (McMullin, 1986), were rehearsed, along with other methods for self-talk.

The "so what" confrontational strategy enables the child who is obese to verbally confront the teaser in an attempt to suppress the satisfaction the teaser gains from belittling others. In this sense, it is a behavioral method similar to ignoring, which also disrupts the reinforcement available to the teaser. Advised to use the phrase only in situations with one adversary, the child acknowledges the offense and responds indifferently, "so what," to the point of futility. The appeal of this technique is that the victim may feel empowered and the teaser may become exasperated, an important therapeutic outcome for both. This strategy is more complex and requires additional instruction and repetition of role play.

Materials. Bibliotherapy has long been used to promote psychoeducational goals. Parents received several handouts about weight bias. In addition, we prepared and distributed a user-friendly summary of the three coping skills. We also presented a video segment from the "Big Hurt" (CWK Network, Inc., 2004), a documentary about the emotional toll of weight-related abuse.

Protocol. The initial session with parents alone gave them an orientation to the purpose of the program and a preview of the six sessions. We discussed

parental perceptions of the children's mistreatment, which was amplified by the film clip. We demonstrated the coping strategies and emphasized the parents' continuing therapeutic role after the end of the program.

The first of four sessions with the children focused on their mistreatment; the therapist elicited the actual teases and obscenities. These were later used in role playing to desensitize the children and to help them develop countering statements. In addition, the self-esteem measure was administered to clarify the child's positive self-attributions; these attributions were used during role playing to neutralize hurtful remarks. A play activity with prizes concluded this session.

Each of the next three sessions was devoted to teaching one coping skill, reviewing the previous week's lesson, and addressing any distressing incidents at school. The fifth session reviewed the coping strategies and facilitated an exchange of contact information to foster support and friendship. The final session, which was for parents only, consisted of reflections about the program, a review of the skills for coping with teasing, and a discussion about any additional concerns regarding their child's obesity. We documented all interventions and outcome data in a specially designated database, and these were approved by the institution's review board. Informed consent was obtained from the parents at the time of the initial evaluation.

RESULTS

At the end of this summer program, children and parents showed proficiency in explaining the coping strategies and role playing appropriate responses to replicated abuse situations.

Two years after the initial intervention, we contacted the five families and administered the PWBS and CWBS. Similar to the data obtained in the pre-intervention PWBS, four of five parents noted that teasing continued to occur in several locations, with school endorsed by all (one parent and child indicated that all teasing had stopped). However, the frequency of incidents had decreased to a few times per week from the daily occurrences that were previously reported. Parents continued to emphasize ignoring, walking away, and telling an adult as preferred responses to teasing. However, they indicated that their children's reactions, whether observed or verbalized, did not include telling an

adult, being emotionally upset, nor being aggressive toward the teaser.

The responses from all five children on the CWBS indicated that the frequency of incidents was now sometimes (one reported no further teasing), and feeling socially excluded was now more variable than the previous "very much." In this regard, the children still reported a lack of invitations to parties, but their involvement in recreational activities had improved, with one child reporting "always" and two reporting "sometimes." A striking postintervention difference was that none of the children indicated emotional distress in response to being teased; instead they endorsed ignoring and, for two children, walking away. These were two of the three strategies that they perceived their parents suggesting, but parental advice "to tell an adult" was not included in any child's responses.

DISCUSSION

This article demonstrated the use of intervention research methodology to develop and implement a therapeutic program to help obese children cope with weight-related verbal abuse. Although society has become increasingly concerned with the victimization of individuals with stigmatizing conditions or features, many of the ameliorative efforts are directed toward modifying the abusive environment rather than enabling the victim to cope with the mistreatment. This program represents, to our knowledge, the first known treatment approach specifically designed to teach obese children how to handle teasing in the school environment. In a six-session group format, children and their parents learned and demonstrated several cognitive and behavioral coping techniques intended to reduce both the frequency of teasing episodes and the child's emotional distress.

Two years after the intervention, the outcome data encourage speculation about the experience of childhood weight victimization and its amelioration. According to both the parents' and children's reports, the frequency of teasing incidents had decreased. Parental advice to ignore, walk away, and tell an adult persisted (and was now supported by the group intervention), but parents viewed their children as not choosing to inform an adult (in most instances, school personnel). This was confirmed by the CWBS; none of the children endorsed telling an adult. This finding raises the possibility

that, as obese children mature socially, they tolerate incidents of weight bias because they perceive that being a "snitch" or "rat" is fundamentally more alienating. This is consistent with stigma research that posits that perceived controllability of the problematic trait is associated with greater rejection and negative responses (Crocker, Major, & Steele, 1998). Another concern based on this observation would be that obese children may have had negative experiences when they requested help from teachers and other school personnel and do not view them as a source of support, despite parental urging (Neumark-Sztainer, Story, & Harris, 1999).

The emotional distress (crying, getting angry, sadness) that was reported prior to the intervention by parents and children was no longer mentioned. We consider the possibilities that the persistence of teasing, albeit decreased, had desensitized the victims and that the reduced frequency of the teasing had made the aversive incidents more tolerable. The positive self-talk, which was personalized for each group member, might have been an effective antidote for the teasers' hurtful remarks and the victims' negative ruminations.

It is also worth noting that the maturation of the children might have been reflected in less overt expressions of emotional pain.

Overall, these findings suggest that this group program did not result in any negative consequences for the participants and may have contributed to the positive outcomes of reduced emotional distress and fewer episodes of teasing. Consistent with the social R & D model, this preliminary intervention needs to be refined and tested with a more formal experimental or quasi-experimental design.

Limitations

There are important methodological issues that limit the generalizability of the findings. Even for intervention research of this kind, a larger sample would be more valuable. In addition, the PWBS and the CWBS were not research-validated instruments. As a preintervention test, both measures were essential in guiding the development of the group intervention; but when they are used as outcome measures, the results are confounded by several concerns. First, the parents may have reported a reduction in teasing to signal their effectiveness in helping their children cope, as well as to validate the intervention. Second, the children may have

reported reductions in teasing and emotional distress, increased social acceptance, and the endorsement of ignoring abusers, according to their perceptions of both parental and clinician expectations. These are significant considerations, but the passing of two years (with no clinical contact during that period) until follow-up may have mitigated the parents' and children's need for approval.

Conclusion

Intervention research methodology can provide viable clinical strategies for addressing novel problems in distressed populations. Practitioners interested in this problem require an understanding of childhood obesity, weight bias, group process, and cognitive-behavioral techniques. Clinicians also need to be aware that group methods still require an individualized approach to each child's distress and coping efforts.

Given the emotional suffering of children with obesity, we responded to Kinscherff's (1999) challenge titled "Empirically Supported Treatments: What to Do until Data Arrive (or Now that They Have)?" by developing this preliminary model. The program needs to be replicated, field tested, and evaluated to clarify its value. We hope that it will spur further practice and research activity. **SW**

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Original manuscript received April 30, 2013

Final revision received July 12, 2013

Accepted July 22, 2013

Advance Access Publication April 4, 2014