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# The Sexual Behaviors and Practices of People with Obesity: A Pilot Study

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# THE SEXUAL BEHAVIORS AND PRACTICES OF PEOPLE WITH OBESITY: A PILOT STUDY

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**ADAM D. AKERS, Psy.M.**

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I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **ADAM D. AKERS** ENTITLED **THE SEXUAL BEHAVIORS AND PRACTICES OF PEOPLE WITH OBESITY: A PILOT STUDY** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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**Abstract**

The study was designed as a pilot of an online survey intended to assess the amount and type of sexual behaviors in which members of the obese community engage. Further, the study examined how this population may differ from individuals of typical weight with regard to sexual behaviors and practices, including risky sexual practices and self-esteem. As a pilot study, feedback from members of the population of interest was elicited in a fashion consistent with the principles of Participatory Action Research. The feedback provided by the participants was used to make improvements to the survey for the purpose of future replications (i.e., relationship status, religious views on sexual behaviors). The results of the study indicated that there is a positive correlation between being classified as obese and concerns regarding one's sexual performance due to weight.

## Table of Contents

**The Sexual Behaviors and Practices of People with Obesity**

## Chapter 1

Over the past several decades, the number of overweight and obese persons in the United States has risen steadily (Center for Disease Control, 2007). Even with the increasing number of obese people, there has not been a reduction in the stigma and discrimination that accompanies being classified as obese or overweight. Further, people with obesity, unlike other minority groups (i.e. racial minorities, people with disabilities), have not come together to form a supportive community (Millman, 1980; Goode & Vail, 2008).

The distinction between the terms overweight and obese is based upon structured weight classifications which are determined by using a formula that yields a Body Mass Index, commonly referred to as BMI. The BMI formula is based on a person's weight and height. A BMI is not a direct measure of body fat or obesity. However, it provides an estimate of body fatness, and is used by major health organizations like the Center for Disease Control (CDC) and the World Health Organization (WHO) to indicate body fatness (CDC, 2007; WHO, 2006).

Interacting with medical professionals is a certainty for the vast majority of Americans. When people with obesity interact with medical professionals they are often given less time than average weight patients. Additionally, the majority of the time spent with health professionals is spent discussing the patient's weight and obesity related

co-morbidities (i.e., Hypertension, Type II Diabetes). Thus, many of the other aspects of the obese patient's health and well-being are overlooked or neglected, including sexual behavior and sexual health (Bess, 1997). The current study was intended to pilot a survey designed to examine the sexual health and behaviors of people who are overweight and obese. As a pilot study, the intention was intended primarily to elicit feedback from the participants for future data collection. Elements of Participatory Action Research were employed as evident by the inclusion of the population of interest in the survey development process. The feedback provided by the participants was used to make improvements to the survey for future replications. The participants were recruited by online postings on various websites devoted to issues of sexual health and obesity. The participants (N=39) initiated the online survey. However, 11 participants did not complete the entire survey and were not included in the analysis, leaving a final sample of 28 (N=28). Participants ranged in age from 25 to 66 years of age. With regard to gender, the sample included 10 males and 18 females. All of the participants were of European American descent. The BMI's of the sample ranged from 22.1 (normal range) to 52.1 (obese), with six of the participants in the normal weight range, five in the overweight range, and 17 in the obese range. With regard to sexual orientation/ preference, the sample included three participants who identified as homosexual, 23 participants who identified as heterosexual, one participant who identified as heterosexual and also identified as "bi-curious," and one who identified as bisexual. The most clinically relevant results of the study indicated that there appears to be a positive correlation between being classified as obese and concerns regarding one's sexual performance due to weight (+.49) significant at .05. Additionally, based on the feedback

provided, several changes were made to the survey for future data collection. Further, attempts will be made to procure a more diverse sample with regard to ethnicity and sexual orientation/preference. Specific changes will be indicated in the document.

# Chapter 2

## Literature Review

### Purpose

This literature review includes the current available research on obesity, sexual behaviors of people of varying weight, and societal beliefs about weight (i.e., stigma and discrimination). Additionally, the literature review examines the utility of conducting research using the internet and how using elements of Participatory Action Research (PAR) can ensure that the research is conducted in a manner that supports and affirms the population of interest. The review was completed to inform the research team of the multifaceted issues faced by individuals who are overweight and obese in terms of sexual behavior and sexual health. This information will allow the researchers to create suggested guidelines for medical and mental health professionals to utilize when treating individuals who are overweight or obese.

### Obesity

The number of people in the U.S. alone who are classified as overweight or obese has reached a new all-time high. Recent reports indicate that approximately 65% of the adult population in the United States meets the criteria to be classified as either overweight or obese (Center for Disease Control, 2007). Men were found to be classified as overweight more often than women (67.2% vs. 61.9%); however, women in the U.S. are more likely to meet the criteria for obesity than men (33.4% vs. 27.5%) (Must, et al.,

1999). Further, the rates of childhood obesity have been steadily rising over the past forty years (Flegal, Carroll, Ogden, & Johnson, 2002; Center for Disease Control, 2007).

The distinction between the terms overweight and obese is based upon structured weight classifications which are determined by using a formula that yields a Body Mass Index, commonly referred to as BMI. The BMI formula is based on a person's weight and height. A BMI is not a direct measure of body fat or obesity. However, it provides an estimate of body fatness, and is used by major health organizations like the Center for Disease Control (CDC) and the World Health Organization (WHO) to indicate body fatness and risk for other weight related health problems (CDC, 2007; WHO, 2006). To calculate a person's BMI using standard units of measure (i.e. inches and pounds), one begins by multiplying the person's weight in pounds (lbs.) by a conversion factor of 703 and dividing by his or her height in inches (in.) squared (CDC, 2009). For example, a person who is 6 feet 2 inches tall (74 inches) and weighs 250 pounds would have a BMI of 32.09 ($BMI= 250*703/74^2$).

BMI has historically been divided into four categories or weight classes: underweight- a BMI of 18.5 or less, normal or ideal weight- a BMI ranging between 18.5 and 24.9, overweight- a BMI ranging between 25.0 and 29.9, and obese with BMIs being 30 or greater. However, as the population continues to increase in weight, a more detailed understanding of obesity levels has become necessary to ensure thorough and appropriate treatment of obese patients. Current medical information indicates that the category of obese has been divided into three subcategories or levels. A BMI between 30.0 and 35.0 is classified as obese level I, BMI's ranging from 35.0 and 40.0 are now classified as

obese level II or morbid obesity, and BMI's of 40.0 and greater are classified as obese level III, or severe obesity (Cleveland Clinic, 2009).

When a person gains excess weight, he or she has an increased risk for weight related medical and psychological problems (Kolotkin, Crosby, Koloski, & Williams, 2001; Field et al., 2001; Schafer & Ferraro, 2011). The most common co-occurring medical conditions, typically referred to as co-morbidities, include hypertension, hypothyroidism, high cholesterol, joint and muscle pain, sleep apnea, gall bladder disease, and some forms of cancer (Patterson, Frank, Kristal, & White, 2004). Further, people with obesity are at risk for several weight-related psychological and emotional problems including depression and anxiety (Palinkas, Wingard, & Barrett-Connor, 1996; Carpenter, Hasin, Allison, & Faith, 2000; Rivenes, Harvey, & Mykletun, 2009; Schafer & Ferraro, 2011**).** Additionally, people who are overweight or obese are at risk for developing and maintaining negative self-images and self-concepts (Palinkas, Wingard & Barrett-Connor, 1996; Kolotkin, Meter, & Williams, 2001; Stunkard, Faith, & Allison, 2003). The psychological impact of having a negative self-image and self-concept has the potential to create maladaptive thoughts and lead to inhibited social interactions in individuals with obesity. The internalization of these negative self-image results from several potential factors including social isolation, negative stereotypes, and the reinforcement of negative thoughts and beliefs regarding being overweight or obese (Chen & Brown, 2004; Oliver, 2006; Goode & Vail, 2008; Schafer & Ferraro, 2011).

**Obesity Stigma and Discrimination**

"Fat people are lazy, smelly, and dumb." "If they wanted to, they could just lose the weight." "They choose to be fat." "They are a burden on others, and an

embarrassment to be seen with." These are just a few of the statements and thoughts that the overwhelming majority of our society holds to be true about individuals who are obese (Schafer & Ferraro, 2011). Obese and overweight individuals are subjected to these types of comments and societal beliefs from an early age. This saturation of negative beliefs about being overweight predisposes obese and overweight individuals to forming negative self-beliefs (Carr & Friedman, 2005; Schafer & Ferraro, 2011). Research has indicated that many parents treat their overweight children more negatively and offer less support both emotionally and financially to their overweight children; especially their overweight daughters (Crandall, 1995). Additionally, family and friends of overweight people often wrongly believe that by continually discussing the size of their overweight loved one, or ridiculing him or her, they are encouraging him or her to lose weight, when in actuality the opposite is true (Bess, 1997; Puhl & Brownell, 2003; Goode & Vail, 2008). The constant focus on the obese, or overweight, person's weight typically serves to reinforce the negative thoughts and feelings with which the obese or overweight person is already struggling.

When leaving their families to enter school, overweight children and adolescents experience higher rates of teasing and ridicule than any other group of children. They are less accepted by peers, and on the occasions they are accepted, they are made the "loveable mascot" of the group (Bess, 1997; Neumark-Sztainer, Falkner, Story, Perry, Hannan, & Mulert, 2002). Furthermore, overweight students are graded more harshly by teachers and given less encouragement to apply for higher education (Canning, 1966; Crandall, 1991; Latner, Stunkard, & Wilson, 2005). For those overweight individuals

who do apply to college, their acceptance rates are significantly lower than their average weight peers (Canning 1966, Oliver, 2006).

Fat bias and discrimination has been observed in the professional workforce as well. Obese persons have experienced greater difficulties finding employment for positions for which they are qualified and often are forced to accept jobs for which they are overqualified (Register & Williams, 1990; Rothblum, Brand, Miller, & Oetjen, 1990; Paul & Townsend, 1995). Further, once in a job, they are often denied reasonable accommodations (i.e. larger chairs or cubicles) for them to complete their work. Additionally, overweight workers are more often rated poorly and promoted less frequently than average weight employees. Overweight workers are labeled as slow, lazy, and disheveled in appearance more often by supervisors than are thinner employees (Rothblum, Brand, Miller, & Oetjen, 1990; Oliver, 2006).

Obesity stigma and fat bias are also observed in the medical and mental health world. Medical providers have been found to spend less time with obese or overweight patients and often focus on weight loss rather than the specified reason for treatment (Teachman & Brownell, 1992; Schafer & Ferraro, 2011). Furthermore, and perhaps most damaging, the obese or overweight individual is not seen as a complete person and many of the medical or psychological needs go unmet due to the provider's focus on the patient's weight. This is especially true with regard to sexuality and sexual health (Bess, 1997).

Being overweight, or obese, has been shown to serve as a barrier to many aspects of an individual's life; including leisure activities (Lewis & Van Puymbroeck, 2008), employment (Paul & Townsend, 1995), receiving medical and mental health services

(Bess, 1997; Gott, Galena, Hinchliff, & Elford, 2004; Brown, 2005), purchasing reasonably priced clothing, and many other areas (Greenberg, Eastin, Hofschire, & Brownell, 2003).

In a recent study by Latner et al. (2008), participants were asked to rate their negative beliefs and report their likelihood to engage in acts of discrimination against three separate minority groups; "gays," "Muslims," and "overweight people." The results of this study indicated that individuals have more negative beliefs about overweight people than any of the other groups, and or more likely to engage in discrimination against overweight people than the other two groups. The results of this study indicated that it is more socially acceptable to discriminate against overweight individuals.

One of the greatest barriers faced by overweight and obese people is attempting to initiate and form personal relationships with others (Chen and Brown, 2004). There are several studies that have looked at the damaging effect obesity stigma and discrimination has had upon obese people. The work of Chen and colleagues (2004) illustrates the depth to which obesity stigma can reach.

**Obesity and Sexual Stigma**

Chen and Brown (2004) conducted an experiment examining the impact of obesity stigma on the sexual relationships of obese people. The researchers adapted and replicated the seminal work of Richardson et al. (1961). Chen and Brown had participants rank six drawings of people from the gender to which the participant was sexually attracted (i.e., straight males were asked to rank females; homosexual males were asked to rank males). The drawings were identical except for the physical characteristic he or

she was assigned. Below each drawing there was a description of the person's physical characteristics, stating the following: healthy, missing right arm, uses a wheelchair, obese, history of mental illness, history of curable STDs. The participants were asked to rank (in order from 1 to 6 with 6 being the most desirable) the characteristics they would most prefer to have in a sexual partner.

The participants in this study ranked the obese person lowest the majority of the time, with males ranking obesity as least desirable more often than females. This study clearly illustrated obesity stigma and discrimination are present in our society. Obese people face increased rejection and other obstacles (i.e. anxiety surrounding social status and interactions) when attempting to initiate intimate sexual relationships with others; including other overweight and obese persons (Chen & Brown, 2004).

**Obesity Bias Turned Inward: Internalized Oppression**

The pervasive and widespread negative view of fatness has had a damaging effect on overweight and obese people. While all minority groups experience varying levels of internalized oppression, many minority groups have cultivated a sense of pride and atmosphere of support and fellowship (i.e. African American groups, Women's rights groups). To a lesser degree, the members of the disability community have begun to develop pride around disability, and support one another like minority groups in recent years. These groups work collectively in their battle for acceptance and equality. They serve to affirm and strengthen members of their particular community. This is not the case for the overwhelming majority of obese people. Obese people are more likely to believe the negative stereotypes about obesity and harshly judge and criticize other overweight individuals and themselves (Millman, 1980; Goode & Vail, 2008). This

inward fat bias incites greater levels of social isolation and negative self-thoughts for the overweight or obese person (Bess, 1997). Louderback (1970) wrote, the social climate has become "so completely permeated with anti-fat prejudice that the fat themselves have been infected by it. They hate other fat people; [they] hate themselves…" (as cited in Goode & Vail 2008). The language of Louderback, while dated and derogatory towards obese people by today's standards, does not diminish or invalidate the truth of the message. These statements reflect the overwhelming lack of cohesion and support within the largely absent obese community. Additionally, the increased problems with negative body image among overweight and obese people are constantly reinforced by society at large (Thompson, 1996; Schafer & Ferraro, 2011).

It should be noted that in recent years there has been some progress in the forming of obese and overweight affirming groups. Groups of overweight and obese people are coming together for support and to celebrate their "fatness," as a part of their identities, not a condition to be cured or to receive support or encouragement for their efforts to lose weight (Saguy & Ward, 2011).

**Body Image and Obesity**

The media of western society strongly influences how the average person feels about his or her body (Rand, 1979; Bess, 1997). People, including the overweight and obese, compare themselves to others. The most common comparison group is the people in the media; including those seen on television, in movies, and in advertisements. However, overweight and obese people are drastically underrepresented in all forms of media and those that are depicted are portrayed as people to be laughed at or pitied (Greenberg, Eastin, Hofschire, Lachlan, & Brownell, 2003). Regardless of the

differences between themselves and what society and media call the "ideal" body, overweight and obese persons still compare themselves to the unattainable "ideal" standard (Reinitz, Wright, & Loftus, 1989; Martin & Kennedy, 1993; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; Trampe, Stapel, & Siero, 2007). Typically, after failing to measure up to the unrealistic "ideal," the overweight or obese person is left with negative thoughts about himself or herself, his or her physical appearance, and his or her ability to attract potential intimate partners (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; Trampe, Stapel, & Siero, 2007). Over time these negative thoughts about self and appearance become a salient negative body image which begins to affect every aspect of the overweight or obese person's life; especially his or her romantic or sexual interactions with others (Chen & Brown, 2004).

**Negative Body Image and Sexual Interactions**

Obesity and negative body image has been shown to have a significant impact on a person's sexual life. Research has illustrated that obese persons report higher rates of sexual dysfunction, less satisfaction with his or her sex life, and experience greater amounts of anxiety due to weight and appearance when engaging in sexual activities with others; both within committed relationships and casual encounters (Bess, 1997; Moskowitz & Seal, 2010).

Bess (1997) reported in her article *Obesity and Human Sexuality,* that overweight and obese women often are fearful of competing for the interest of others. This fear and anxiety manifests itself in activities such as dressing or behaving in sexual or erotic manners, engaging in conversations with unknown potential romantic or sexual partners, reporting that they feel as if they are unable to attract anyone, and fearing that others will

find their body grotesque and unattractive. Additionally, Bess stated that many obese women suffer from negative body image and "may refuse to initiate interpersonal encounters with others." Conversely, obese women often enthusiastically enter into relationships with others who appear to be accepting of them, leaving these women vulnerable to unhealthy or exploitive relationships.

Researchers have found that women who have lost large amounts of weight vary in relationship satisfaction and status. Those women who were involved in healthy and supportive relationships reported that after minor adjustments to their new lifestyles, their relationships deepened and became more satisfying. However, women who were involved in unhealthy and unsupportive relationships reported more relationship instability and less satisfaction with their partners and relationships. Further, many reported ending those relationships to seek healthier and more fulfilling relationships (Schweitzer & Chipperfield, 1986; Applegate & Friedman, 2008).

Further, Bess (1997) also reported that obese males have difficulties in sexual interactions due to anxiety about their weight and appearance, as well as face actual rejection by potential sexual partners. Additionally, for many obese males the fear of rejection leads to reduced number of sexual encounters with others which in turn leads to higher rates of autoerotic sexual activity including self-stimulation and masturbation.

Recently, there have been two published studies that focused on risky sexual behaviors; specifically unsafe anal intercourse (UAI) in homosexual males (Kraft, Robinson, Nordstrom, Bockting, & Rosser, 2006; Allensworth-Davies, Welles, Hellerstedt, & Ross, 2008). Both studies examined whether or not obesity and body image played a role in the frequency of engaging in UAI. Both Kraft et al. (2006) and

Allensworth-Davies et al. (2008) found that homosexual males who had BMIs that were in the underweight classification were less likely to engage in UAI. Additionally, males who were in the normal weight range reported higher rates of UAI. Further, men who were either overweight or obese reported less instances of UAI. However, the overweight and obese males reported less anal intercourse in general when compared to the other two groups. In both studies researchers believe this is due to a higher number of underweight males in the gay community, and that being underweight is seen as the ideal body type for this population; thus, the underweight males would likely have the highest body satisfaction of the three groups. The authors also go on to indicate that the overweight and obese group may prefer mutual masturbation due to anxiety over exposure of their bodies to sexual partners.

The authors of both studies indicate that the higher rates of risky sexual behavior in the form of unsafe anal intercourse among the normal weight group likely results from issues with body image and fear of losing the sexual partner by insisting on or suggesting the use of condoms.

A similar study was conducted by Wingood and colleagues (2002). In this study, the researchers focused on adolescent African-American females. The participants filled out surveys to assess body image and then completed face to face interviews with the researcher to assess sexual behaviors. The results of the study indicated that African-American women who have a negative body image are more likely to engage in risky sexual behaviors. The results also indicated many of the women in the study who were dissatisfied with their bodies had a significant level of anxiety about the loss of their

sexual partner if they attempted to negotiate condom use. Additionally, this group of women believed they had fewer quality options for sexual partners.

**Obesity as the Object of Sexual Attraction**

There are those who make overweight and obese individuals the object of fetish behaviors (Swami & Tovee, 2009). Additionally, there is a growing subsection of specialized pornography and erotica devoted to what is termed Big Beautiful Women (BBW) (Blank, 2000; Kulick, 2005) and "Bears" (overweight Gay males) (Gouch & Flanders, 2009).

Individuals who participate in the fetish behavior of engaging in sexual activity with only overweight and obese women are referred to as "Fat Admirers" (FA) (Swami & Tovee, 2009). While many have argued this is a place where obese can find acceptance, harm may come when obese individuals are unaware of the nature of this relationship. Specifically, that they are being used as sexual objects and not viewed as a complete person is exploitive behavior. If it is the case, that both parties in a sexual relationship are aware and accepting of the nature of the relationship, free of any coercion, it is a mutually beneficial relationship. However, if the person with obesity is unaware of the basis of the relationship the possibility of emotional damage from exploitation can be significant (Blank, 2000; Kulick, 2005).

The men who engage in sexual activity with Bears are referred to as cubs (Gouch & Flanders, 2009). In these sexual relationships, the individual's weight and excess fat as well hair and physical strength are incorporated into the sexual activities.

It is important to make the distinction between sexual objectification of people with obesity or who are overweight, and simple attraction to larger body types. Sexual objectification occurs when you reduce a person to one aspect of who he or she is, for example, only seeing a person with obesity as fat. That person has many more aspects to his or her identity that would be considered if entering into a physical or emotional relationship.

**Sexual Quality of Life for Obese People**

Past research has found support for obese people experiencing increased anxiety with regard to sexual interactions and relationships (Bess, 1997). Additionally, support has been found for increased rates of sexual dysfunction in obese people (Jagstaidt, Golay, & Pasini, 1997; Andersen, Heitman, & Wagner, 2008). Kolotkin and colleagues (2006) examined the sexual quality of life for obese people. The results of the study indicated that obesity was associated with greater impairments in sexual quality of life. Impairments included lack of enjoyment in sexual activities, lack of sexual desire, and difficulties with sexual performance. Further, the results indicated that obese females reported lower sexual quality of life than obese males, and that those individuals that lost weight reported an increase in his or her sexual quality of life. Women reported societal pressures to be thin and aspects of sexisms as reasons for low sexual quality of life.

**Sex and Obesity**

The research on obesity and sex is increasing; however, the majority of the work focuses on two main areas. The first major area of focus is sexual dysfunction and how weight loss will improve sexual functioning and sexual satisfaction (Jagstaidt, Golay, &

Pasini, 1997; Adolfsson, Elofsson, Rossner, & Unden, 2004; Andersen, Heitman, & Wagner, 2008). The second major area of focus in the current body of research is the increased level of anxiety obese individuals experience with regard to issues related to body image and body dissatisfaction during sexual activity and intimate relationships (Bees, 1997; Chen & Brown, 2005). However, the literature relating to sexual satisfaction and risky sexual behaviors is limited at best. This study is intended to begin to fill this gap in the research by developing a survey to begin examining both the level of sexual satisfaction and rates of risky sexual behaviors in overweight and obese people. This crucial aspect of the sexual experience of overweight individuals is missing in the current research. Obese people are viewed only in terms of their sexual dysfunction and not as whole complete sexual beings.

To examine the level of sexual satisfaction an obese individual experiences, it is crucial that the participant's level of comfort with his or her body and satisfaction with body image is quantified. Additionally, it is crucial to gauge the level of satisfaction the individual has with regard to the amount, quality, and type of sexual activities in which he or she engages.

It is hypothesized that obese people are more likely to have higher rates of body dissatisfaction and hold more negative beliefs about their body than overweight and typical weight persons. Additionally, it is hypothesized that obese and overweight persons will report less satisfaction in the amount and type of sexual activity. Finally, it is hypothesized that engagement in risky sexual behaviors will increase as BMI increases--however, will peak in individuals who are classified as overweight and then begin to

decline in those people classified as obese, due to a lack of overall sexual encounters with others.

**Clinical Relevance**

The stigma of being overweight or obese runs deep in our society. Past research has shown that many in the helping professions also hold the belief that obese people are less important than their typical weighted counterparts (Gott, Galena, Hinchliff, & Elford, 2004; Brown, 2005). Thus, when an obese or overweight person utilizes medical or mental health services, their provider may spend less time with the obese or overweight patient and give that patient's case less thought or attention. What typically occurs is that the obese or overweight person's provider sees only the person's surplus weight and then attempts to focus on weight reduction efforts and does not treat or appropriately address the presenting issues (Teachman & Brownell, 1992; Brown, 2005). Furthermore, the obese or overweight person is not seen as a complete person. The patient's physical, emotional, psychological, and sexual needs are overlooked because many helping professionals and people in general think that the only important aspect of an obese person's life is weight reduction. This weight loss focus leaves little to no time for discussion about sexuality and sexual health between helping professionals and overweight or obese patients (Teachman & Brownell, 1992; Brown, 2005).

In the field of clinical psychology, it is important for practicing psychologists to understand their own prejudices towards different groups of people. However, obesity stigma, or sizeism, is given very little attention in most doctoral level psychology training programs. Further, even less attention is given to the sexual behaviors of the overweight

and obese population. By not looking at this area in the lives of overweight and obese patients, clinical psychology is doing a disservice to this population.

The literature on obesity and sexuality often deals with sexual dysfunction or sexual quality of life. There is currently very few published works examining the level to which overweight and obese people are engaging in risky sexual behaviors. Additionally, there are even fewer studies examining the possible contributing factors and outcomes to engaging in risky sexual behaviors in the overweight and obese population. This gap in the literature indicates a need to examine the topic of the sexual practices of overweight and obese persons with a focus on risky sexual behaviors. Further, the lack of research on the sexual experiences of overweight and obese individuals reflects the bias against these people and is evidence for the stereotype of persons in these populations as non-sexual beings (Teachman & Brownwell 2001; Chen & Brownwell, 2005).

The purpose of the current study is to gather information from people with varying BMI's about the types of sexual activities in which they are currently or have previously engaged, including amount of sexual activity and number of partners at different points in the lives of the participants. The goal of collecting this information is to develop a survey to better understand the sexual practices, especially rates of engagement in risky sexual behaviors by overweight and obese people. It is hoped that this survey can be developed and used to illuminate the pervasive impacts of fat bias in the lives of overweight and obese people. Finally, it is hoped that the revised survey can ultimately be used to collect data that will inform mental health and medical professionals in their treatment and understanding of obese patients.

# Chapter 3

# Method

## Participants

The participants (N= 39) were recruited from various websites that focus on issues related to obesity and/or sexual health such as: www.obesity.org, www.dailystrengh.org, and www.obesityaction.org (for a complete list see Appendix C). The primary investigator contacted the various sites and posted a link to the online pilot survey (including informed consent and debriefing information, survey feedback form, and information about the current study). The participants were not compensated in any way. Of the 39 participants, 11 did not complete the survey. Thus, their information was not included in the analysis, making the final number of participants 28 (N=28). Participants ranged in age from 25 to 66 years of age. With regard to gender, the sample included 10 males and 18 females. All of the participants were of European American descent. The BMI's of the sample ranged from 22.1 (normal range) to 52.1 (obese), with six participants falling in the normal weight range, five in the overweight range, and 17 in the obese range. No participants were in the underweight range. With regard to sexual orientation/preference, the sample included three participants who identified as homosexual, 23 participants who identified as heterosexual, one participant who identified as heterosexual and also "bi-curious," and one who identified as bisexual or omnisexual.

**Materials**

This study was an online pilot measure with an open ended feedback form (see Appendices A and B). The study was submitted to the Wright State University Institutional Review Board and was approved. The survey was posted on an online survey website, www.Zoomerang.com. For the purpose of this study, the measure was developed in order to assess the participant's BMI, level of concern over his or her weight and appearance during interpersonal and sexual situations, body satisfaction, sexual satisfaction, and engagement in risky sexual behaviors. The measure contains 22 questions on which the participant was asked to rate a statement from 1 (Never True) to 5 (Always True), and two open-ended questions which asked the participant to describe his or her feelings regarding weight and sex life. Respondents were also asked to submit demographic information including height and weight which were used to establish BMI. Additionally, respondents were asked to report the number of sexual partners he or she has had at different periods of time (the past 6 months, 1 year, 5 years, and lifetime). Further, participants were asked to report their satisfaction with number of sexual partners for the specified time periods. The survey feedback form asked the participants to offer suggestions for improvements (i.e., wording of questions, inclusion of aspects of sexual behaviors that were not addressed, and any other information the participant believed to be important) to the survey for future use. All of the participants' responses were kept confidential and no identifying information was collected. Survey results were only available to be viewed by the researchers and were secured on an encrypted server.

The decision to design a measure for the study was made following a search of the current literature. No sufficient measures were found that allowed for the examination

of the areas of interest in the current study. Specific questions were generated from themes found in the literature. During the literature review, multiple studies focused on sexual dysfunction (Jagstaidt, Golay, & Pasini, 1997; Adolfsson, Elofsson, Rossner, & Unden, 2004; Andersen, Heitman, & Wagner, 2008), higher rates of "risky" sexual behaviors (i.e., lower rates of condom use, higher rates of remaining in abusive and/or unhealthy relationships) (Wingood, Diclemente, Harrington, & Davies, 2002; Moskowitz, & Seal, 2010), and fewer sexual/romantic relationships (Bees, 1997; Schafer, & Ferraro, 2011) when comparing overweight and obese individuals to average weight peers. However, no studies were found that examined the complete sexual experience of obese and overweight individuals. Thus, it was decided to create a measure and complete a pilot study.

**Procedures**

The participant completed an online informed consent prior to beginning the survey. By navigating to the survey page from the informed consent page the participant indicated he or she fully understood the purpose of the research and gave his or her consent to freely participate. The participant was then instructed to carefully read all directions and to answer each question as honestly as possible. Following the completion of the survey, the participant was asked to provide open ended feedback about the survey.

**Participatory Action Research**

In an effort to develop an adequate survey, elements from Participatory Action Research was utilized. Over the past several decades, a growing number of researchers and persons with disabilities have begun to emphasize the need for consumers from the population of study to become intricately involved at all levels of empirical studies

including research development, implementation, and dissemination of studies examining the group to which they belong (Balcazar, Keys, Kaplan & Suarez-Balcazar, 1998). This process is referred to as participatory action research (PAR) (Balcazar, Keys, Kaplan & Suarez-Balcazar, 1998). PAR helps to ensure that the research team is being authentic in their attempts to improve the lives of the population of interest and inform others of the issues facing the population of study. Further, by having members of the population of interest on the research team, it helps to ensure that the researchers ask questions using non-offensive and appropriate language, and that the questions asked are the most vital for the population of interest. Additionally, PAR serves to empower the group of interest and allows members of that particular group to play an integral role in the telling of their own story. While there are drawbacks to PAR, which often include increased cost and time, the benefits of including consumers from the group of interest far outweigh any of the pragmatic drawbacks.

The current study incorporated elements of PAR in the following ways: the primary researcher is a member of the population of interest; members of the population of interest were asked to provide feedback on the focus of the study and the questions of the survey following the initial pilot phase of data collection.

**Conducting Research Using the Internet**

People of all ages from all over the world are utilizing the internet for a variety of reasons; from keeping in contact with friends and family, to paying bills and dating (Internet World Statistics [IWS], 2006). Over the past ten years, medical and psychological services and research are increasingly being conducted via the internet (Whitehead, 2007). Using the internet to recruit participants increases the likelihood of a

achieving a geographically diverse sample (Kraut et al., 2004; Whitehead, 2007). However, using the internet for research can result in sampling bias and increases the difficulty of obtaining proper informed consent and ensuring confidentiality (Kraut et al., 2004). Researchers should attempt to find participants from several different sources and keep all material with identifying information separate from research data in order to ensure a pure sampling process and maintain confidentiality for all participants (Kraut et al., 2004; Whitehead, 2007). With regard to consent, it can be stated that by submitting the completed survey, a participant is consenting to participate in the research; much the same way returning a paper survey implies consent using a mail-in format (Whitehead, 2007). Thus, as long as researchers use caution and discretion, internet research can be a valid and beneficial tool.

**Analysis**

The current study includes analysis of qualitative and quantitative data. Participants were asked to provide open-ended feedback as to the questions asked and not asked. The goal of the initial analyses is to determine the relevance of the research questions to members of the targeted group consistent with elements of PAR. Eliciting feedback on the pilot survey from the initial respondents helps to ensure that the research team is being authentic in their attempts to improve the lives of the population of interest and inform others of the issues facing the population of study. Further, receiving feedback on the pilot survey helps to ensure that the researchers asked questions using non-offensive and appropriate language and that the questions asked are the most vital for the population of interest. Following obtaining feedback, the necessary and appropriate changes were made to the survey and included in the results of this initial pilot. It is the

intent of the researchers to use this pilot project to collect further data in order to obtain a detailed and accurate understanding of the sexual practices and behaviors of overweight and obese people. This will include conducting a second round of data collection using the revised survey with a larger and more diverse sample.

# Chapter 4

# Results

## Qualitative Data

As a part of the survey used in this study, the participants were asked to respond to eight open-ended questions. The questions focused on several areas including why the participant was not satisfied with the number of sexual partners in the past six months, one year, five years, and over their lifetime, attempts to lose weight, detail times when the participant's weight was significantly greater or less than it is at the current time, and satisfaction with the participant's current weight. Each of the questions revealed several themes. However, no themes were identified that were specific to a given weight class (Typical, Overweight, or Obese). The most common sample wide themes will be detailed further in the discussion section.

## Quantitative Data

It was hypothesized that obese people would be more likely to have higher rates of body dissatisfaction and hold more negative beliefs about their body than overweight and typical weight persons. However, results indicated no correlations to support this hypothesis. The lack of support for this hypothesis may be due the sample size of the pilot group. Additionally, it was hypothesized that obese and overweight persons will report less satisfaction in the amount and type of sexual activity. Results indicated that there is a negative correlation between weight classification and number of sexual

partners had in the last one year, $r = -.469$, $p < .05$, five years, $r = -.381$, $p < .05$, and lifetime, $r = -.458$, $p < .05$ (see table 1).

The results also indicated a positive correlation between increased weight and increased concerns about sexual performance due to weight, $r = .49$, $p < .05$ (see table 2). Finally, it was hypothesized that engagement in risky sexual behaviors would increase as BMI increased; however-- would peak in individuals who are classified as overweight and then begin to decline in those people classified as obese, due to a lack of overall sexual encounters with others. Again, no support for this hypothesis was found. The lack of support for this hypothesis may be due the sample size of the pilot group.

**PAR Information**

Upon the completion of the measure, the participants were asked to provide feedback regarding the survey questions and the study topic in general. This was included in this pilot study in order to ensure that it adequately examined all the pertinent issues related to the sexual behaviors and practices of people with obesity and people who are overweight. By including this optional feedback it will allow the research team to make the appropriate changes to the survey for future studies.

After reviewing the feedback comments made by twenty of the participants, two major themes were identified. The first theme related to question phrasing and scaling errors and concerns. The second theme related to relationship status.

The most common feedback given was the addition of a not applicable option for the sexual behaviors questions that asked for the participant to indicate their enjoyment of a specific sexual activity, for example “I think it would have been helpful to have a "not applicable" option on some of the questions”, “The questions seemed completely

acceptable, no improper phrasing. I would suggest more options for the scaled answer options, such as not applicable." As the survey was written for this pilot study, participants were forced to choose never true even if they had never engaged in the specific sexual activity. The addition of a not applicable option would allow future participants to indicate they had never engaged in the activity and thus could not indicate their level of enjoyment. Additionally, participants indicated that some questions needed to have a different scale then the five point rating scale. For example, "Look at the question about having a one night stand. Make the answer choices clearer because I wasn't sure how to respond. I had one "one-night-stand" encounter in my life but wasn't sure how to communicate that using the answer choices."

The second most common theme was the need to inquire if the participant was in a committed relationship. Several participants indicated that there should be questions that inquire about relationship status (single, married, committed relationship), and if the person's partner is overweight or obese. Many of the participants indicated that their sexual behaviors and practices varied based on their relationship status, for example "I thought it was odd that at no point was I asked if I am in a committed relationship. Were I single (instead of married) I would probably have a very different social life, and therefore a different sex life". Due the comments made by many participants the revised survey will include the options to discuss how the participants have altered their sexual behaviors based on their relationship status.

# Chapter 5

# Discussion

## Overview of Findings

The current study was a pilot study in order to develop a survey to examine the sexual behaviors and practices of people who are classified as overweight or obese. Further, it was intended to solicit feedback on the survey in order to ensure that the survey was assessing all the areas that may be important to the sexual lives of the participants. The majority of the analyses conducted revealed no significance. This may be due to the small sample size of this pilot study. Also, the homogeneity of the sample with regard to ethnic background and sexual orientation/preference may have contributed to the lack of significance of the results of the study. However, some interesting results were found to be significant.

The results indicated that there was a positive correlation between increased weight classifications and increased concerns regarding sexual performance due to weight. These findings are in line with the results of Bess (1997). This indicate s that those people who were classified as overweight or obese were more likely to report concerns about their sexual performance because of their weight. These findings are to be expected considering the majority of persons classified as normal or healthy weight would not have increased concerns about their weight since he or she does not likely have

excess weight to cause concerns. Additionally, it is likely that a portion of the anxiety felt by these participants is related to internalized stigma of being overweight.

A significant negative correlation was observed between weight and satisfaction with number of partners in the past one year, five years, and over a lifetime. As weight increased, the reported satisfaction with number of sexual partners at these three time periods decreased. This theme branched off in two distinct patterns. First, a large portion of participants indicated that they regretted sexual encounters due to lowered self-esteem. This is commonly found in overweight and obese women who enter into unhealthy relationships due to lower self-esteem and the belief that they cannot find more appropriate partners (Bees, 1997; Applegate, & Friedman, 2008). The other pattern of responses reflected dissatisfaction with a low number of or "missed" sexual encounters due to one's increased weight. This group of participants indicated issues with wanting sex more often than they were engaging in it and being unable to find suitable partners. These findings are similar to those of Bess (1997) which indicated that overweight males often reported a reduced number of sexual encounters due to anxiety related to initiating romantic and sexual relationships with others.

When examining the qualitative data provided by this study, no clear and significant themes were identified with regard to the various weight classifications. However, there were several common themes with regard to satisfaction with the number of sexual partners at various time periods (discussed above), satisfaction with weight and attempts to manage weight, and satisfaction with current sex life.

Further review of the qualitative responses offered by the participants regarding their satisfaction with the number of sexual partners in the past six months, one year, five

years, and over a lifetime revealed a theme of several participants indicating that they regretted the number of sexual partners they have had. Some participants indicated regretting having too many partners. Some responses by participants that indicate this include: “I regret not waiting for my wife. I was too casual when I was young”, and “I had a lot of self-esteem issues when I was younger and made a lot of stupid mistakes” Conversely, several participants reported regret about having too few sexual partners. Some responses that reflect this theme include: “Not enough.”, “I should have been chasing more hot women.” and “Maybe I haven't had enough experience.”

With regard to the themes of level of satisfaction with current weight and attempts to manage weight across the sample the most common theme was a reported desire to improve personal health and fitness among the participants. There were several participants in the overweight and obese category that indicated they were happy with their weight and others that indicated they were not happy with their weight. Thus, no clear major theme was observed.

With regard to satisfaction with current sex life, the most common theme observed across the entire sample was that the participants indicated he or she enjoyed his or her sex life and he or she considered it to be “healthy.” However, a significant portion of these people also indicated that while they enjoyed their sex lives they would like to be engaging in more sexual activity (i.e., “I am married and my wife and I enjoy sex together. I would like it more often. But when we have sex it is good”, “It is somewhat limited. With children, work and other obligations, we are either too tired to have sex or have lost the time”, and “I am pleased with my sex life within my marriage. I do wish my

sex drive were higher because it is an area of dischord [sic] between my husband and me."

**Clinical Relevance**

The stigma of being overweight or obese runs deep in our society (Schafer, & Ferraro, 2011; Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008). Past research has shown that many in the helping professions also hold the belief that obese people are less important than their typical weighted counterparts (Gott, Galena, Hinchliff, & Elford, 2004; Brown, 2005). Thus, when an obese or overweight person utilizes medical or mental health services, their provider may spend less time with the obese or overweight patient and give that patient's case less thought or attention. What typically occurs is the obese or overweight person's provider sees only the person's surplus weight and then attempts to focus on weight reduction efforts and does not treat or appropriately address the presenting issues (Teachman, & Brownell, 1992; Brown, 2005). Furthermore, the obese or overweight person is not seen as a complete person. The patient's physical, emotional, psychological, and sexual needs are overlooked because many helping professionals and people in general, think that the only important aspect of an obese person's life is weight reduction. This weight loss focus leaves little to no time for discussion about sexuality and sexual health between helping professionals and overweight or obese patients (Teachman, & Brownell, 1992; Brown, 2005).

The purpose of the current study was to gather information from people with varying BMI's about the types of sexual activities in which they are currently or have previously engaged, including amount of sexual activity and number of partners at different points in the lives of the participants. The goal of collecting this information

was to develop a survey to better understand the sexual practices, especially rates of engagement in risky sexual behaviors of overweight and obese people. It is hoped that this survey can be developed and used to illuminate the pervasive impacts of fat bias in the lives of overweight and obese people. Finally, it is hoped that the revised survey can ultimately be used to collect data that will inform mental health and medical professionals in their treatment and understanding of their obese patients.

In the field of clinical psychology, it is important for practicing psychologists to understand their own prejudices towards different groups of people. However, obesity stigma, or sizeism, is given very little attention in most doctoral level psychology training programs. Further, even less attention is given to the sexual behaviors of the overweight and obese population. By not looking at this area in the lives of overweight and obese patients, clinical psychology is doing a disservice to this population.

In an attempt to address the disservice to the overweight and obese population by medical and mental health professionals the researchers offer the following suggestions. First, providers should examine their own personal beliefs regarding weight. If the individual provider finds that he or she holds bias or prejudices regarding overweight or obese people he or she should confront and challenge those personally held beliefs. This may include a course of psychotherapy to aid him or her in the process. Next providers should remember to view all of their patients as complete individuals and not focus solely on a single aspect of the patient's identity. When working with individuals from the overweight community providers should avoid focusing treatment only on weight and health concerns related to weight. During the initial phase of treatment with overweight or individuals with obesity providers should initiate frank and open discussions focusing

on how the patient thinks and feels about his or her weight and develop a shared paradigm of how to address the patient's care. It is also crucial to assess the patient's knowledge of sexual health and provide any information needed to fell any gaps in knowledge. Additionally, providers should assess the patient's feelings regarding sexual activity and how their weight impacts those feelings. The most crucial aspect of working with any patient including individuals from the overweight and obese community is to conceptualize the patients as a complete individual and unique individual and not to make assumptions based on research or clinic work with other individuals with similar diversity variables.

**Strengths and Limitations**

This study has several strengths and limitations that may have diminished the usefulness of the obtained results. The strengths of the study include the inclusion of members of the population of interest on the research team as well as giving the participants of the study the opportunity to provide suggestions and feedback regarding how to improve the focus of the study and the questions contained in the survey. Further, the study is attempting to examine an area that rarely gets any consideration in practice and/or in research; the sexual experiences of overweight and obese people. The study also has several limitations and logistical issues that hampered the usefulness of the survey, including the diversity of the sample and the phrasing of several of the questions that comprised the measure.

By incorporating elements of PAR, the research team makes the best effort to ensure that they are examining the issues with greatest sensitively and respect for the population of interest. As stated earlier, the primary investigator is a member of the

overweight and obese community. This allows the research team to have access to the thoughts and ideas of a member of the community at all points in the research process. Further, the feedback solicited from the participants provided several different viewpoints that will be included in future studies, which will be discussed in the following section.

The major limitation of the study was the lack of diversity of the sample and overall size of the sample. The total sample was of European American descent. Because of the sample being of the same racial category, it is impossible to generalize the findings to other racial groups. Further, the overwhelming majority of the sample identified themselves as heterosexual (n=25). Thus, it is not possible to examine any differences or similarities based on sexual orientation due to the low number of participants who self-identified as homosexual, bisexual, or other sexual identity variables. Ways to counteract these limitations will be discussed in the next section.

An area that needs to be corrected prior to replicating this survey is that the religious and/or moral views regarding sexual behaviors of the participants should be included in future versions of the survey. Many parents reported their sexual behaviors and attitudes about sex changed based on their level of participation in religious activities. For example, on participant reported "When I was younger I had sex with different people, but I am active in my church and I regret those activities I wish I had waited for marriage to have sex."

Another limitation of this pilot survey was that it did not allow the participants to disclose any physical conditions including sexual dysfunction and reduced libido or sex drive that may be inferring with their sexual activity. Multiple participants suggested adding this to the survey in their comments about the pilot. Examples of such included:

"because of developing Multiple Sclerosis and being overweight, my husband and I do not have a healthy sex life together. We love each other dearly, but he is older too and has ED (sic), so we just don't make sex the main part of our relationship", "My current sex life is not very active. I would like it to be, but I find that my sexual drive is low. This is distressing to my spouse, which in turn distresses me" and "My sex life could be healthier, but my overall health is struggling at the moment. Anti-depressants have taken their toll on my libido."

**Recommendations for Improvement and Future Study**

The current study was designed as a pilot study for future replication. Based on the information gleaned from participant feedback and issues identified by the research team, the following recommendations for improvement to future studies are made: the research team should make changes to the questions asked on the survey, survey a more diverse sample, and include an area where participants who choose not to complete the survey can indicate the reason(s) for their choice. The specific changes needed for the survey questions are discussed in the PAR subsections of the results section. A more diverse and larger survey sample may be accomplished by posting links for the online survey on websites that are designed specifically for other racial groups (i.e., African American, Latino) or on sites that focus on homosexual and/or bisexual concerns. To increase the sample size in future studies it may beneficial to remove the on-line element and use traditional face-to- face methods. Possibly, conducting multiple focus group sessions with participants from established groups, such as support groups for overweight individuals (i.e., weight watchers, Overeaters anonymous) or surveying groups at

established events like health fairs, gay pride events, and e National Association to Advance Fat Acceptance conventions.

Finally, to improve future versions the researchers should include an area where participants who choose not to complete the survey to indicate the reason(s) for their choice to not continue the survey, could possibly allow the research team to make adjustments to the survey in an attempt to retain more participants.

## Appendix A

**Demographic Information**

Age _____

Height_____

Weight_____

Gender

Female___

Male___

Transgendered Male to Female____

Transgendered Female to Male____

Not Listed_____

Sexual Orientation and/or Preferences

Homosexual____

Heterosexual___

Bi or Omnisexual____

Not Listed_____

Ethnicity

African American____

Euro-American____

Asian___ specify_____

Pacific Islander___ specify_____

Aboriginal people___ specify_____

Latino/Latina ___specify_____

Not Listed_____

Number of sexual partners in the last 6 months ___

I am satisfied with this number Y N

If No Why? _____

Number of sexual partners in the last year___

I am satisfied with this number Y N

If No Why? _____

Number of sexual partners in the 5 years ___

I am satisfied with this number Y N

If No Why? _____

Number of sexual partners over a lifetime____

I am satisfied with this number Y N

If No Why? _____

How do you feel about your weight?

How would you describe your sex life?

**Please rank the following items using this scale**

**1- Never true**

**2- Sometimes true**

**3- True half the time**

**4- Mostly true**

**5- Always true**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | I am not self-conscious. | 1 | 2 | 3 | 4 | 5 |
| 2. | My self-esteem is as good as it could be. | 1 | 2 | 3 | 4 | 5 |
| 3. | I like myself . | 1 | 2 | 3 | 4 | 5 |
| 4. | I initiate social interactions. | 1 | 2 | 3 | 4 | 5 |
| 5. | I am afraid that others will not like me. | 1 | 2 | 3 | 4 | 5 |
| 6. | I avoid looking at pictures of myself. | 1 | 2 | 3 | 4 | 5 |
| 7. | I enjoy vaginal intercourse. | 1 | 2 | 3 | 4 | 5 |
| 8. | I enjoy anal intercourse. | 1 | 2 | 3 | 4 | 5 |
| 9. | I enjoy giving oral sex. | 1 | 2 | 3 | 4 | 5 |
| 10. | I enjoy receiving oral sex. | 1 | 2 | 3 | 4 | 5 |
| 11. | I use birth control or ensure my partner does. | 1 | 2 | 3 | 4 | 5 |
| 12. | I use condoms or other measures to protect against STD/STIs. | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 13. I only have sex within a committed relationship. | 1 | 2 | 3 | 4 | 5 |
| 14. I feel comfortable discussing my sexual desires/preferences with partners. | 1 | 2 | 3 | 4 | 5 |
| 15. I feel comfortable when I am naked with others. | 1 | 2 | 3 | 4 | 5 |
| 16. I am distracted by concerns about my body during sex. | 1 | 2 | 3 | 4 | 5 |
| 17. a- I have engaged in group sex because I chose to. | 1 | 2 | 3 | 4 | 5 |
| b- I have engaged in group sex because my partner asked me to. | 1 | 2 | 3 | 4 | 5 |
| 18. I have had at least one "one night stand." | 1 | 2 | 3 | 4 | 5 |
| 19. I have concerns about my sexual performance because of my weight. | 1 | 2 | 3 | 4 | 5 |
| 20. I have anxiety about meeting new sexual partners. | 1 | 2 | 3 | 4 | 5 |
| 21. I am satisfied with the amount of sexual activity I engage in. | 1 | 2 | 3 | 4 | 5 |

22. I have engaged in risky sexual behaviors because I was afraid my partner would leave me if I refused. 1 2 3 4 5

## Appendix B

**Respondent feedback on pilot survey questions**

Please indicate your opinion on the questions asked of you in this survey. Please include any comments on question content, phrasing, and relevance. Additionally, please offer any areas that were not present in the current version of the study that you feel are appropriate and pertinent to the area of research. Thank you for your participation in the survey and in this analysis of the initial version.

## Appendix C

*Obesity Websites*

www.obesity.org

www.obesityaction.org

www.obesityhelp.org

http://obesity1.tempdomainname.com/

http://www.dailystrength.org/c/Obesity/support-group

http://www.healthcentral.com/obesity/

http://health.groups.yahoo.com/group/OSSG/

http://www.experienceproject.com/groups/Have-Obesity/98951

http://groups.google.com/group/alt.support.obesity/topics

## Appendix D

Hello,

My name is Adam D. Akers. I am a graduate student at Wright State University, School of Professional Psychology (SOPP) in Dayton, OH. I am currently working on my doctoral dissertation under the advisement of Dr. Julie Williams. My research is examining the sexual behaviors and practices of persons who are classified as overweight or obese. The study is an online survey that you may preview at the following link http://www.zoomerang.com/Survey/WEB22A5FZP5RPX/Preview.

This first version includes an area to provide feedback regarding the survey and the research in general. It is my intention to integrate the feedback provided by the respondents in this initial pilot study in order to improve the survey and replicate the study for publication at a later date. I would like permission to send an email about my research study via any and all list services you may have access to, in an attempt to illicit participants for my research.

Thank you for your time and consideration.

Adam D. Akers, Psy.M.

## Appendix E

Hello all,

My name is Adam Akers. I am a graduate student in clinical psychology and I am a member of the obese community. I am conducting a survey to examine sexual behaviors and practices of persons with obesity or who are overweight. It is my intention to help members of these communities receive better services from their medical and mental health providers in order to better meet their sexual needs. I would really appreciate it if you would consider taking my survey. Average or typical weight persons are welcome as well; I need a comparison group. Here is a link to the survey http://www.zoomerang.com/Survey/WEB22A5FZP5RPX. Once at the site you will be given more information regarding the research and the process.

Thanks

Adam

## Appendix F

**Demographic Information**

Age _____

Height_____

Weight_____

Gender

Female___

Male___

Transgendered Male to Female____

Transgendered Female to Male____

Not Listed_____

Sexual Orientation and/or Preferences

Homosexual____

Heterosexual___

Bi or Omnisexual____

Not Listed_____

Relationship Status

Single_____

Committed Relationship_____ Length of relationship_____

Ethnicity

African American____

Euro-American____

Asian___ specify_____

Pacific Islander____ specify_____

Aboriginal people____ specify_____

Latino/Latina ____specify_____

Not Listed_____

Number of sexual partners in the last 6 months___

I am satisfied with this number Y N

If No Why? _____

Number of sexual partners in the last year_____

I am satisfied with this number Y N

If No Why? _____

Number of sexual partners in the 5 years _____

I am satisfied with this number Y N

If No Why? _____

Number of sexual partners over a lifetime_____

I am satisfied with this number Y N

If No Why? _____

Have you ever engaged in a “one night stand”?

Yes____ (How many? _____ ) No____

How do you feel about your weight?

How would you describe your sex life?

Please describe how your religious/spiritual or moral beliefs impact your thoughts about sexual behavior and the amount and type of sexual activities you participate in.

**Please rank the following items using this scale**

**1- Never true**

**2- Sometimes true**

**3- True half the time**

**4- Mostly true**

**5- Always true**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | I am not self-conscious. | 1 | 2 | 3 | 4 | 5 |
| 2. | My self-esteem is as good as it could be. | 1 | 2 | 3 | 4 | 5 |
| 3. | I like myself . | 1 | 2 | 3 | 4 | 5 |
| 4. | I initiate social interactions. | 1 | 2 | 3 | 4 | 5 |
| 5. | I am afraid that others will not like me. | 1 | 2 | 3 | 4 | 5 |
| 6. | I avoid looking at pictures of myself. | 1 | 2 | 3 | 4 | 5 |
| 7. | I enjoy vaginal intercourse. | 1 | 2 | 3 | 4 | 5 |
| 8. | I enjoy anal intercourse. | 1 | 2 | 3 | 4 | 5 |
| 9. | I enjoy giving oral sex. | 1 | 2 | 3 | 4 | 5 |
| 10. | I enjoy receiving oral sex. | 1 | 2 | 3 | 4 | 5 |
| 11. | I use birth control or ensure my partner does. | 1 | 2 | 3 | 4 | 5 |
| 12. | I use condoms or other measures to protect against STD/STIs. | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 13. I only have sex within a committed relationship. | 1 | 2 | 3 | 4 | 5 |
| 14. I feel comfortable discussing my sexual desires/preferences with partners. | 1 | 2 | 3 | 4 | 5 |
| 15. I feel comfortable when I am naked with others. | 1 | 2 | 3 | 4 | 5 |
| 16. I am distracted by concerns about my body during sex. | 1 | 2 | 3 | 4 | 5 |
| 17. a- I have engaged in group sex because I chose to. | 1 | 2 | 3 | 4 | 5 |
| b- I have engaged in group sex because my partner asked me to. | 1 | 2 | 3 | 4 | 5 |
| 18. I have concerns about my sexual performance because of my weight. | 1 | 2 | 3 | 4 | 5 |
| 19. I have anxiety about meeting new sexual partners. | 1 | 2 | 3 | 4 | 5 |
| 20. I am satisfied with the amount of sexual activity I engage in. | 1 | 2 | 3 | 4 | 5 |

21. I have engaged in risky sexual behaviors because I was afraid my partner would leave me if I refused. 1 2 3 4 5

## Appendix G

## Participant Narrative Responses

**Question 8: I am satisfied with the number of sexual partners over the past 6 months.**

“Well, it's nice to have sex with someone other than myself once so often...You can only mastrubate for so long.”

“I'm married”

“Not enough.”

“I would prefer 1 (one).”

“I love hot women but my wife is not hot anymore.”

**Question 10: I am satisfied with number of sexual partners over the past year.**

“b/c I'm married”

“Not enough”

“I would prefer 1 (one).”

“See #8**”**

**Question 12: I am satisfied with the number of sexual partners over the past 5 years.**

“Not enough”

“had multiple affairs on wife that ended badly”

“I would prefer 1 (one).”

“See #8”

**Question 14: I am satisfied with the number of sexual partners over a lifetime.**

“I regret the first one”

“I regret not waiting for my wife. I was too casual when I was young.”

“I had a lot of self-esteem issues when I was younger and made a lot of stupid mistakes.”

“promiscuous during college years; not happy with the people I slept with. They had no meaning.”

“Not enough”

“When I was younger I had sex with different people, but I am active in my church and I regret those activities I wish I had waited for marriage to have sex.”

“I wish I had waited for marriage and only had my spouse as my lifetime sexual partner.”

“I would have prefered 1 (one).”

“I should have been chaseing more hot women”

“Maybe I haven't had enough experience.”

**Question 15: Please describe your feelings about your sex life**

“I am married and my wife and I enjoy sex together. I would like it more often. But when we have sex it is good.”

“It is somewhat limited. With children, work and other obligations, we are either too tired to have sex or have lost the time.”

“I love sex! I am a very happy fat person and love sex with the fat person I am in a relationship with.”

“The first thing that comes to mind is: it would be nice to have sex life. At the moment, I feel I would like to have more than zero sexual partners (referencing question #8).”

“because of developing Multiple Sclerosis and being overweight, my husband and I do not have a healthy sex life together. We love each other dearly, but he is older too and has ED, so we just don't make sex the main part of our relationship”

“I am pleased with my sex life within my marriage. I do wish my sex drive were higher because it is an area of dischord between my husband and me.”

“I have a small child and a husband who travels. It is virtually non-existent, but great when it happens.”

“erratic and non extistent at times”

“I've been in a monogomous relationship for the past 13 years, and am very happy with our sex life”

“I am very satisfied. Sex is good and is getting better now that I am losing weight. The biggest problem is finding enough time to unwind and destress beforehand.”

“I am extremely happy to be with one person who can fulfill my every need and who will be my one and only partner for the rest of my life. One night stands are useless and degrading and I'm glad those days are long behind me.”

“My sex life was great in college when I was working out regularly and playing intramural sports. But since then I've gained some weight and it's much harder for me to hookup for casual sex with attractive women. Mostly I've just been going back to previous girlfriends for sex”

“My sex life could be healthier, but my overall health is struggling at the moment. Anti-depressants have taken their toll on my libido.”

“i need poon”

“my sex life is good, i used to struggle about self esteem issues regarding my weight, funny enough, i am way more self confident now than i was 50 lbs ago”

“I have a good sex life considering I have three small children that keep me busy. We make time for eachother and are faithful to eachother. I enjoy my partner and he fulfills me in the sack! :)”

“Overall unsatisfactory...only 3 long-term relationships between 1 year and 3 years in duration.”

“Active as can be expected”

“i think it is good”

“Its okay. I wish I had sex more often and on a regular basis.”

“I am currently not having any. I recently got divorced from my husband of 19 years”

“My current sex life is not very active. I would like it to be, but I find that my sexual drive is low. This is distressing to my spouse, which in turn distresses me.”

“I have been married for 40 years”

**Question 16: Please describe any and significant or formal attempts to alter your weight.**

“every weight program under the sun”

“Laxatives, binging and purging, starvation, exercise.”

“exercise more, monitor food intake, diet pills”

“I don't think this space would be big enough! The latest was low carb. I've been attempting to take a "healthier choice" approach to food but sometimes I just want something that tastes good.”

“I suffered from eating disorder in late teens and early 20s and used to attempt to lose weight through not eating enough or purging. For the past 5 years or so, my weight has been stable and I have not tried to change it.”

“None”

“weight watchers on numerous occasions throughout junior high and high school, a significant diet in my junior year of college when I was eating healthy and working out 4 times a week, and most recently a significant diet after the birth of my last child in which I was eating healthy”

“weight watchers”

“I've dieted, exercised, and taking otc meds to try to reduce my weight...nothing has worked.”

“11 Protein diet - lost 100 pounds in 2000 and gained 70 of it back. Bariatric surgery (gastric sleeve)in 2009 - have lost 101 pounds so far and am down 135 pounds from my highest weight of 305.”

“I have been a pretty skinny person my whole life, until I had a baby. Now, I'm a lot larger than I want to be. But, after trying to diet several times over the past 3 years, I have decided that I am ok with who I am now and that it's ok to be a little plump.”

“My weight was fine during college when I was working out obsessively and playing sports. But my body type requires that continually which I haven't kept up”

“In the last 2 years I have been working towards losing some, and I have achieved it mostly through time, but also through changes in diet and activity.”

“weight training”

“nothing significant, i have lost weight via working out and eating right”

“diet and exercise after having three children in a row.”

“NA”

“Attempted fad diets, personal trainer for a short time, exercise programs with WII and others”

“Dieting, exercise”

“none really. every now and again i try to eat better and exercise, but it never really sticks.”

“I lost about 85 when I moved for work in 2005 by working out and eating very little. I have since put the weight back on”

“I have been on many diets starting at the age of 12, including Weight Watchers, Nutri-System, Slim Fast, Atkins, and general calorie counting.”

“I lost weight by riding an exercise bike”

“Continuous struggle with dieting attempts and up and down weights, too numerous to count.”

“2 years ago regularly attended gum. Lost almost 20 pounds.”

**Question 17: Please list any periods in your life, following being classified as overweight when your weight was significantly different, 30lbs or more, heavier or lighter than you are currently starting from age 15.**

“age 25 I lost 50lbs when I was on a medical weight lost program.”

“At 16 lost 85 pounds, eating disorder At 21: had gone up about 30 pounds At 24: had baby, kept about 20 pounds At 28: Had second baby, kept about 50 pounds At 35: lost 35 pounds”

“age 15-20 overweight, age 20-23 average weight, age 24+ overweight”

“My first weight loss attempt was 4 years ago. I lost 70 pounds in 7 months and slowly put most of it on over the last 4 years.”

“Have never been overweight.”

“None”

“during my first pregnancy, I gained 89 lbs.”

“I have steadily gained weight throughout the years. However, fast, significant weight differences happened in high school during one particular run with weight watchers in which I lost 40 lbs, the diet during my junior year of college yeilded a 30 lbs weight loss, and the birth of my last child, coupled with the diet that followed equaled a 35 lbs weight loss. Significant periods of weight gain include my freshman year in college during which I gained 20 lbs, the first few years I was with my husband I gained approx. 30lbs, and throughout the course of the marriage a total gain (it fluxuated of course) of about 35 lbs.”

“Before I became pregnant for the first time I was about 45 lbs lighter. I never lost the weight I gained during pregnancy”

“20's”

“I was thin until becoming pregnant with my first child at the age of 26. After that, I've been in a constant battle with my weight.”

“Age 21 to 35 I weighed 305 pounds. I lost 100 pounds in 2000. I gained 70 pounds back over the period of 2008/2009 due to a car accident which prevented me from exercising. In 2009 I had bariatric surgery (gastric sleeve) and have lost 101 pounds since June 2009. I was never considered overweight until about 3 years ago - around age 28 or so. Even now, I'm only about 30 pounds more than where I "should" be.”

“In 2008 I experienced rapid weight gain as a side-effect of medication. At the onset, I weighed 130-135. In less than a month I had gained at least 40 pounds, went up multiple jean-sizes as well as cup sizes.”

“none”

“i gained 30 lbs after the death of my father at age 22”

“Only when I was pregnant.”

“NA”

“Gained significant weight upon entering college over freshman year of 40 pounds but did not lose...also gained significant weight with each pregnancy 2”

“when i was 16 i hit a growth spurt, so i gained a bit of weight, but it has been mostly a slow gain of weight over the years.”

“I have been fat all my life.”

“In high school, I was about 170. In my early 20's, I got up to 270. In my later 20's I got down to”

“In  my early 30's, I went up to 230. And now, in my late 30's, I am back up near 270 again.”

“got heavier after the birth of my kids”

“Age 15: 105#, Age 26: 165#, Age 27: 112#, Age 30: 160#, Age 31: 104#, Age 42: 195#, Age 43: 140#, Age 48: 200#, Age 54: 165#, Age 55: 195#, Age 56: 255#, Age 56: 220#, Age 57: 232#. (These are approximate as well as can be remembered.)”

“Age 30 199 pounds.”

**Question 18: How do you feel about your weight?**

“I hate being fat.”

“Where I am right now, I am more concerned about my health than weight. I have been exercising regularly and have stopped restricting my diet.”

“it's too high”

“Sometimes happy and sexy-feeling, sometimes I feel disgusted with myself.”

“I did not get on the scale for the past year or so but feel pretty good about fitting in my old jeans.”

“Slightly overweight but within normal bounds for my age, height & gender.”

“i don't like it”

“I do not like being overweight and have dreamed for the better part of my life about being thin. However, currently, I'm not depressed about the state of my body or looks. The things that get to me the most about my weight is the lack of energy and the bad example I'm setting for my children. Whenever I think about losing weight, I immediately dismiss it because I love food too much. I just don't have the desire to give up the fattening food that I love... I feel guilty about that.”

“Eh - sometimes it bothers me, but not to a great extent.”

“am unhappy, but do not have the motivation to change it.”

“I feel uncomfortable and unattractive most of the time.”

“Very good now. I felt horrible when I weighed 272.”

“I'm over it. I feel happier now than I have ever been in my life.”

“I currently feel that my weight is ok, I look proportionate with my height, I don't have a lot of excess flab, just bigger breasts and thighs. Before my major weight gain, my weight

had remained in the same range (130-135 pounds) for close to 10 years, through later adolescence, high school, and college."

"comfy"

"i do not feel like i am in shape, i get frustrated by not being able to do the physical things i used to do with the same ease"

"I am happy that I am almost back to my pre pregnancy shape and am back to my pre pregnancy weight. I feel healthy and try to eat in moderation."

"I am overweight and even marked as obese"

"Wish I weighed less. (goal weight of about 160)"

"wish i was a little thinner, but overall am satisfied"

"I want to be thinner"

"I wish I was more fit."

"I hate it."

"I am happy being me"

"Unhealthy."

"I am ok with it but I would like to loose 70 pounds."

**Question 43: Please indicate your opinion on the questions asked of you in this survey. Please include any comments on question content, phrasing, and relevance. Additionally, please offer any areas that were not present in the current version of the study that you feel are appropriate and pertinent to the area of research. Thank you for your participation in the survey and in this analysis of the initial version.**

"Some questions were difficult to anwser, lik on the second page about weight loss and question 17 during the second portion of the survey."

“I do believe that it would be beneficial to include a married/single question and how long.”

“question 23 has "mostly true" listed twice, question 39 has "always true" listed twice There's a mistake on the scale on question 39. FYI. AWESOME that you're doing this research. Fat people are marginalized, ridiculed and are made the butt of jokes regarding intimacy. I was a little put off by this survey's use of the word "obese" instead of "fat." The fat acceptance movement rejects the use of the medically derived "obese" because it sometimes serves as justification for prejudice.”

“Check question 23. "Mostly true" is used twice.”

“Why the group / anal sex questions?”

“this survey is more written to the single individual.”

“Q23 "Very True" twice”

“I thought it was odd that at no point was I asked if I am in a committed relationship. Were I single (instead of married) I would probably have a very different social life, and therefore a different sex life.”

“I don't have any comments.”

“Look at the question about having a one night stand. Make the answer choices clearer because I wasn't sure how to respond. I had one "one-night-stand" encounter in my life but wasn't sure how to communicate that using the answer choices.”

“I think it would have been helpful to have a "not applicable" option on some of the questions. Also "performed" is not spelled correctly on one of the questions (can't remember which one, but it was spelled preformed.) -- Hope this helps!”

“The questions seemed completely acceptable, no improper phrasing.. I would suggest more options for the scaled answer options, such as not applicable. I would also include questions concerning your partner: the other person's comments, what is communication like, is your partner overweight or obese, etc.”

“n/a”

“I am a thinner person, but have insecurities probably as significant as others who are overweight...interesting to note how weight is only one factor in determining self-consiousness or self-image.”

“Questions were well written and specific to the detail trying to be received.... Relationship and Reproduction status may be helpful (i.e., if I am married my recent sexual history may be different than a non-married individual - if I am trying to concieve, my use of protection may be different than when I was not trying to concieve, etc.) should be a "N/A" catagory for some questions. for example, i have never engaged in anal intercourse, so i can't answer whether i enjoy it or not. should also be a relationship status question, because i am not anxious about meeting sexual partners now (because i don't need to), but 5 years ago that may have been different... and so on.”

“questions fine”

“I was confused by some of the questions”

“Some of the "Never true/ Sometimes true..." questions were not relevant to me now, but were in the past. I was a little unsure about how to answer them. I chose to answer the questions with the frame of how true they were when that experience was relevant.”

“no comment”

“Since I haven't been sexually active in the past 5 years, the answers to the last set of questions pertained to my lifetime of sexual activity.”

“All questions were pertinent to survey.”

“Survey was fine”

## Appendix H

## Tables

Table H1

*Correlation between weight and satisfaction with the number of sexual partners*

| measure | one year | five years | life time |
|---|---|---|---|
| weight | -.469* | -.381* | -.458* |

*Note.* *= significant at .05.

Table H2

*Correlation between weight and anxiety about sexual performance due to weight*

| measure | anxiety |
|---|---|
| weight | .49* |

*Note.**= significant at .05.

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