

GERRINGER, BRITTANY PUTNAM, Ph.D. Training Competent Counselors for EveryBODY: The Impact of a Health at Every Size Training on Weight Bias and Its Relationship to Multicultural Competence. (2022).

Directed by Dr. Kelly Wester. 154 pp.

Weight discrimination, the maltreatment of individuals perceived to have larger sized bodies driven by both implicit and explicit biases about weight, is a growing issue in society with deleterious effects for individuals of size (Andreyeva et al., 2008; Hatzenbuehler et al., 2009; Puhl & King, 2013; Swift et al., 2013; Tomiyama, 2014). Despite having training in multicultural competence which provides ways for counselors to gain awareness of biases and skills to work with clients who differ from them, unfortunately, counselors are not immune to weight biases impacting their counseling work, with counselors demonstrating comparable (and unfortunately high) amounts of weight bias as other professionals (Akoury et al., 2019; Puhl et al., 2014). Strong weight bias is also evident in counselors-in-training (CITs), who tend to characterize higher weight clients as having significantly more negative characteristics and significantly lower work efficacy than lower weight clients (Pascal, 2011), and ascribe a poorer prognosis to clients of size (Adams, 2008). Therefore a critical time to address weight stigma is in the training of new counselors and mental health professionals, before harm can be perpetuated in their work.

The Health at Every Size (HAES) paradigm presents a paradigm shift from the historical view that higher body weight is a disease to be treated, by instead positing that all bodies are good bodies deserving of care and respect regardless of size, that weight loss is not inherently a means to increasing health, and advocates to decrease weight discrimination instead of perpetuating it (*ASDAH: Trademark Guidelines*, 2003). While there have been studies on the efficacy of non-HAES aligned weight stigma trainings to decrease implicit and explicit biases in mental health trainees (Cravens et al., 2016; Pratt et al., 2016) and some studies in the efficacy of

HAES-aligned weight stigma trainings in college students and dietetics students (Brown, 2009; Humphrey et al., 2015; Rosalez et al., 2015), to date, there have not been studies on how a HAES-aligned weight-stigma training tailored for CITs impacts implicit and explicit weight bias. The present study utilized a quantitative two-group crossover quasi experimental design to examine how a HAES-informed training on weight stigma will impact CITs' implicit and explicit weight bias, and HAES competence, and how multicultural competence is related to change in both implicit and explicit weight bias. A total of 55 counselors in training participated in the study, 32 in the treatment group and 23 in the delayed intervention group. The data was analyzed using repeated measures ANOVAs to explore the changes in pre-post bias scores and a correlation analysis to explore the relationship between multicultural competence on bias change. Results of the study indicated small but not statistically significant changes in implicit bias and significant decrease in explicit bias, though due to a high amount of missing data concrete interpretation is cautioned. The results also indicated a significant increase in HAES competence after the training and a nonsignificant relationship between multicultural competence and bias change. This study provides an important next step in moving the counseling field forward in terms of better preparing counselors to provide a space of healing and support for all clients, regardless of their body size.

TRAINING COMPETENT COUNSELORS FOR EVERYBODY: THE IMPACT OF A
HEALTH AT EVERY SIZE TRAINING ON WEIGHT BIAS AND ITS
RELATIONSHIP TO MULTICULTURAL COMPETENCE

by

Brittany Putnam Gerring

A Dissertation

Submitted to

The Faculty of the Graduate School at

The University of North Carolina at Greensboro

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Greensboro

2022

Approved by

Dr. Kelly Wester

Committee Chair

DEDICATION

To my Aunt Desiree, whose life story was the spark that started this journey; your unseen struggles were not in vain.

“For from Him and through Him and to Him are all things. To Him be the glory forever. Amen.”

Romans 11:36

APPROVAL PAGE

This dissertation written by Brittany Putnam Gerringe has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair

Dr. Kelly Wester

Committee Members

Dr. Connie Jones

Dr. Amanda Tanner

Dr. L. DiAnne Borders

May 11, 2022

Date of Acceptance by Committee

May 11, 2022

Date of Final Oral Examination

ACKNOWLEDGEMENTS

I have had a wonderful community of support which has made this process possible. I thank God and every person in my life who has supported me along my journey. I know that I will never be able to fully capture the gratitude I feel in my heart, but I will try my best here!

I first want to thank my committee chair, Dr. Wester for her tireless support, her research expertise, and her sticking with me through analyzing the complicated statistics in this dissertation study. I always knew that you believed in me and would push me to produce a dissertation that was of excellent quality and for that I am forever grateful. I would also like to thank Dr. Jones for her encouragement, wisdom, and confidence in me. From day one as a Master's student at UNCG, you were a mentor and one of my biggest supporters, and I know that I would not have achieved the successes I have achieved today without your encouragement; you are my hero and role model. Thank you Dr. Tanner for your expertise in Public Health and always pushing me to think outside of the box and to continually acknowledge intersectionality in my work. Thank you Dr. Borders for your wisdom and passion for teaching and clinical supervision. So much of what I learned from you as a professor and as a supervisor informed the intervention training in my dissertation. I truly had the best committee a doctoral student could ask for and I appreciate you all so much!

It is also fitting that I thank the students of UNCG CED department. From the Master's counseling students who provided so much wonderful insight as they participated in my study, to my wonderfully supportive supervisees, to my CED 610 students who provided feedback for my pilot study, to my CED 310 students who gave me such lovely encouragement: thank you all so much! This dissertation would have been impossible without your participation! I also want to

acknowledge and thank my cohort members Caroline, Jaimie, Kervins, and Lindsey—I feel so good for us (FSGFU) as we are all finishing up our doctoral studies!

I would be amiss to not take this opportunity to also thank my wonderful family. To my amazing husband, Seth, thank you for always being there for me, ready with a hug, encouraging words, and (maybe) a glass of wine. Thank you for being patient with me in this process and always pushing me to pursue my dreams. To my wonderful mama, thank you for a multitude of prayers, late nights at the kitchen table inputting data into SPSS with me, and a lifetime of love and encouragement. And, thank you for sharing your story with me—the healing journey you started 27 years ago continues to ripple out and touch other lives. To my wise dad (aka Toastee), thank you for instilling in me a love of science, a curiosity for the world, and the daring to face the impossible head on—I certainly did that here! To my fantastic brother, Ben, thank you for always keeping me humble and making me laugh in a way that only a little brother can do. To my sweet Pecan, our greyhound who passed away halfway through the program, thank you for your lovely gentle soul and being my constant writing companion. To my silly boy Loki, our newly adopted greyhound, thank you for your goofiness and never-wavering love—you were also a wonderful writing companion and a reminder to not take life so seriously. To my extended family, my friends, and my coworkers at Three Birds Counseling, thank you for your encouragement, prayers, love, and support. It is truly staggering for me to think about how loved I am and how much I love you all!

I lastly want to thank my counseling clients I have seen over the years. Your stories and experiences provided me with invaluable insight and a passion for helping make the counseling room, and ultimately the world, a better place for all bodies.

TABLE OF CONTENTS

LIST OF TABLES.....	x
LIST OF FIGURES.....	xi
CHAPTER I: INTRODUCTION.....	1
The Harms of Weight Discrimination.....	1
Weight Discrimination in Mental Health Practice and Training.....	3
Approaches to Body Size in Counseling.....	4
Multicultural Competence in Counseling.....	7
Sizeism in Multicultural Counseling Training.....	8
Need for the Present Study.....	9
Purpose of the Present Study.....	12
Significance of the Present Study.....	12
Research Questions.....	13
Operational Definitions.....	14
CHAPTER II: REVIEW OF THE LITERATURE.....	16
Introduction: Dieting or Disease?.....	16
Implicit & Explicit Weight Bias: Drivers of Weight Discrimination.....	17
Where Does Weight Stigma Happen? Who Perpetuates It?.....	21
Media & Pop Culture.....	21
Medicine.....	22
Education & the Workforce.....	24
Personal Relationships with Others & the Self.....	25
Weight Bias in Counselors & Counselors in Training.....	26

Factors that Contribute to & Influence Weight Bias.....	30
Other Identities.....	30
Sociocultural Factors.....	31
Institutions.....	33
Environmental Factors.....	34
Interpersonal Factors.....	34
A Paradigm Shift: History & Tenets of HAES.....	35
HAES Application in Practice.....	40
Pros & Cons of HAES in Counseling.....	42
HAES & Weight Stigma Trainings for Mental Health Practitioners.....	44
Multicultural Competence.....	48
Weight Bias & Multicultural Competence in Counselor Education.....	51
Putting the Pieces Together.....	53
CHAPTER III: METHODOLOGY.....	56
Research Questions and Hypotheses.....	56
Methodology.....	57
Participants.....	58
Intervention.....	58
Instruments.....	59
Procedures.....	64
Planned Statistical Analyses.....	66
Pilot Study.....	67
Participants.....	67

Intervention.....	68
Instruments.....	68
Procedures.....	69
Data Analysis.....	70
Results of Pilot Study.....	70
Implications of Pilot Study.....	71
CHAPTER IV: RESULTS.....	74
Sample.....	74
Testing of Hypotheses.....	77
Impact of HAES-Aligned Weight Stigma Training.....	82
Comparison of Treatment vs Delayed Intervention.....	84
The Relationship Between Multicultural Competence & Weight Bias.....	87
Exploratory Post-hoc Analyses.....	88
CHAPTER V: DISCUSSION.....	90
Summary of Study Findings & Connection to Prior Research.....	90
Implicit Weight Bias.....	91
Explicit Weight Bias.....	94
HAES & Multicultural Competence.....	98
Limitations.....	100
Implications for Counselor Education & Supervision.....	103
Areas for Future Research.....	108
Concluding Thoughts.....	110
REFERENCES.....	112

APPENDIX A: CURRICULUM LEARNING OBJECTIVES.....	140
APPENDIX B: OUTLINE OF THE HAES-INFORMED WEIGHT STIGMA TRAINING INTERVENTION.....	142
APPENDIX C: WEIGHT ATTITUDES IMPLICIT ASSOCIATION TEST.....	144
APPENDIX D: ANTIFAT ATTITUDES QUESTIONNAIRE-REVISED.....	146
APPENDIX E: DEMOGRAPHIC VARIABLE QUESTIONS.....	148
APPENDIX F: INTERVENTIONS & MEASURES SCHEDULE.....	150
APPENDIX G: SAMPLE WORDING CHANGES TO THE MCI.....	151
APPENDIX H: FEEDBACK QUESTIONS FOR MCI WORDING CHANGE.....	152
APPENDIX I: FEEDBACK QUESTIONS ON TRAINING INTERVENTION.....	153
APPENDIX J: ENLARGED VIEW OF TABLE II.....	154

LIST OF TABLES

Table I. Sample Demographics by Treatment Group.....	74
Table II. Means for Each Measure by Group & Time.....	81
Table III. Intervention & Measures Schedule	81
Table IV. Means for IAT Pre & Post by Group.....	82
Table V. Means for AFA Pre and Post by Group.....	83
Table VI. Means for IAT Times 1 & 2 by Group.....	84
Table VII. Means for AFA Times 1 & 2 by Group.....	85
Table VIII. Means for HAES by Group.....	87

LIST OF FIGURES

Figure I: Missing Data AFA Time 1.....	79
Figure II: Missing Data AFA Time 2.....	79
Figure III: Missing Data AFA Time 3.....	80

CHAPTER I: INTRODUCTION

A variety of body shapes and sizes exist in our world today. Currently, the number of individuals in the United States who have larger bodies, often described in the stigmatizing medical terms “overweight” and/or “obese,” is on the rise, with research from the Centers for Disease delayed intervention and Prevention (CDC) indicating that from the 1999 to 2018, the prevalence of “obesity” in the United States has increased from 30.5% of adults to 42.4% of adults (CDC, 2020). Further, recent data from the CDC (2020) indicates that 72% of US adults over the age of 20 fall into the category of “overweight and/or obese.” Weight increase has been further exacerbated by the recent COVID-19 pandemic, with 42% of individuals reporting an average weight increase of 29 pounds since the start of the pandemic in early 2020 (APA, 2021). Despite the increasing visibility of fat bodies in society, it is still considered generally unacceptable and problematic to move through the world in a larger body.

The Harms of Weight Discrimination

Weight discrimination, the unequal treatment of people perceived to be overweight, is alarmingly on the rise in recent years (Andreyeva et al., 2008; Phelan et al., 2014). It has been well-documented in the attitudes of health care professionals (Phelan et al., 2015; Puhl et al., 2014, 2016; Swift et al., 2013), as a detriment to success in education (Puhl & King, 2013), influence workforce hiring practices (Carels et al., 2015), and in the social relationships of individuals with large bodies (Brewis, Hruschka, et al., 2011). Discriminatory actions are driven by biases, both implicit and explicit. Implicit biases are defined as “actions or judgments that are under the delayed intervention of automatically activated evaluation, without the performer’s awareness of that causation” (Greenwald, McGhee, & Schwartz, 1998, p. 1464). In the context of weight, implicit weight bias refers to unconscious actions or judgements about people based on

their perceived larger body size (Phelan et al., 2014). Explicit biases are those actions, beliefs, or judgements that occur on a conscious and overt level (Phelan et al., 2014). These negative beliefs about individuals with a larger body size then serve as the catalyst for individuals to engage in weight discrimination behaviors.

Experiences of weight discrimination take a toll on folks with larger sized bodies. The physical health detriments that result from experiences of weight discrimination include but are not limited to, higher blood pressure, increased stress as measured by sustained heightened cortisol levels, and sexual dysfunction (Himmelstein et al., 2015, 2019; Nutter et al., 2016; Phelan, Burgess, Puhl, et al., 2015). Weight discrimination in a medical context can lead fat patients to delay or avoid care for fear of discrimination (Drury & Louis, 2002; Olson et al., 1994). Medical professionals report having less respect for fat patients and endorse beliefs that they are unmotivated, lazy, and unlikely to follow treatment recommendations (Phelan et al., 2015; Puhl et al., 2016). Due to these negative beliefs, medical providers spend less time with fat patients, engage in less patient-centered communication and rapport-building, and are less likely to do certain screenings or discuss healthcare strategies other than weight loss, which all result in poorer health outcomes and treatment prognosis for fat patients (Phelan et al., 2015; Puhl et al., 2014, 2016). Mental health professionals are not immune to weight bias. They demonstrate similar amounts of weight bias as other medical professionals, which often results in a compromised quality of care and early dropout from treatment (Akoury et al., 2019; Puhl et al., 2014). Clearly, weight discrimination has a tremendous detrimental impact on physical health.

The psychological ramifications of weight discrimination are also numerous. Individuals who experience weight discrimination are at risk for increased disordered eating (particularly binge-eating behavior), depression, loneliness, social isolation, suicidality, and anxiety (Nutter et

al., 2016; Phelan et al., 2015). Weight discrimination is also linked to increased vulnerability to developing a substance use disorder and psychiatric comorbidity, being diagnosed with more than one mental health disorder (Hatzenbuehler et al., 2009). In order to cope with the stress of weight stigma, higher weight individuals must exert large amounts of cognitive effort to regulate the negative emotions, intrusive thoughts, and interpersonal anxieties they experience in response to discrimination (Hunger et al., 2015). These negative emotions can include both heightened stress-related emotions (e.g., nervous, overwhelmed, worried) and self-conscious emotions (e.g., guilty, disgusted with self, ashamed) (Blodorn et al., 2016; Major et al., 2012). Weight stigma has also been shown to decrease self-regulation and executive functioning cognitive abilities, particularly after discrete discrimination events, possibly related to the aforementioned intense negative emotions it invokes (Blodorn et al., 2016).

Weight Discrimination in Mental Health Practice and Training

Unfortunately, for fat folks seeking psychological support to cope with these stressors, the counseling room often is a space of harm instead of healing. Mental health professionals are certainly not immune to weight bias, and appear to exhibit comparable levels of weight bias as other health professionals (Puhl et al., 2014). In the counseling room, when counselors engage in weight discrimination behaviors driven by biases, this can lead to decreased client comfort, trust, client disclosures, and an increased likelihood of dropping out of treatment for clients of size (Akoury et al., 2019). Relatedly, counselors with high implicit weight bias also tend to diagnose clients of size with more severe mental health disorders, assign lower levels of global functioning, and view them in a more negative light (Davis-Coelho et al., 2000; Warchal & West, 2013; Young & Powell, 1985). Therapists also rate fat clients as being more unattractive and embarrassed than their smaller bodied clients (Agell & Rothblum, 1991).

Strong weight bias is also evident in mental health practitioners in training. Counselors-in-training (CITs) tend to characterize higher weight clients as having significantly more negative characteristics and significantly lower work efficacy than lower weight clients (Pascal, 2011), and ascribe a poorer prognosis to clients of size (Adams, 2008), all revealing the presence of implicit weight bias. In research on marriage and family therapy trainees, Pratt et al. (2014), documented high levels of explicit weight bias and low levels of efficacy in working with fat clients. Therefore a critical time to address weight stigma is in the training of new counselors and mental health professionals, before harm can be perpetuated in their work.

Approaches to Body Size in Counseling

Currently, larger body size is generally viewed in one of two opposing ways in counseling practice (Kinavey & Cool, 2019). The first approach is one of discrimination and eradication: the fat body is something that must be changed. This leads clinicians to encourage weight loss strategies ranging from restrictive dieting to behavioral modification strategies such as avoiding certain situations where off-limits foods will be readily available (Williamson & Perrin, 1996). It is also common for mental health professionals to provide readiness assessment, as well as pre- and post-operative counseling, for bariatric surgery patients, an extreme form of weight delayed intervention in which parts of the stomach are removed to decrease the patient's ability to eat (Lier et al., 2012; Wadden & Sarwer, 2006). One of the primary clinical theoretical orientations in our field, Cognitive Behavioral Therapy (CBT), is often touted as the gold standard of encouraging weight loss in clients, with many clinicians offering treatment for weight loss (Castelnuovo et al., 2017; Cooney et al., 2018; Grilo & Masheb, 2005). Often, higher weight is conceptualized as a sign of mental health concerns and issues with lacking self-delayed intervention and positive coping, with the belief that if one can learn to delayed intervention

one's weight this will address the co-occurring mental health concerns (Hassel et al., 2001; Pascal & Kurpius, 2012; Young & Powell, 1985). This approach actively posits that a larger sized body is bad and should be pathologized, thus communicating to clients with larger sized bodies that they are unacceptable as they are; put simply, this is weight discrimination.

The second approach to weight in counseling is through a lens of Health at Every Size (HAES) practice. HAES is a set of tenets compiled by the Association for Size Diversity and Health (ASDAH) and is the culmination of decades of research and advocacy work from members of the fat acceptance movement (Altman-Bruno, 2013). Typically in the application of HAES, mental health professionals work with clients on how to increase their body acceptance, how to cope with stressors, and to increase skills such as mindfulness which are key to engaging in intuitive eating/exercising (Bacon, 2010). In the counseling literature, there has been conceptual use of HAES, encouraging counselors to conceptualize clients from a HAES lens (viewing larger body size as an oppressed identity) and to work with clients on body acceptance (Kinavey & Cool, 2019; Warchal & West, 2013). In stark contrast to the view of weight as a problem to be solved, HAES is used in mental health practice to encourage providers to lean into a social justice approach by examining their own biases related to body size and advocating for changes in society to end weight discrimination while also working with clients to be able to do the same (Erickson Cornish et al., 2010). The HAES approach has 5 principles:

1. Weight Inclusivity
2. Health Enhancement
3. Respectful Care
4. Eating for Wellbeing
5. Life-Enhancing Movement

This theoretical approach will be discussed more in depth in the literature review, however, it is important to note tenets 1 and 3 here. The first principle of weight inclusivity refers to accepting and respecting body size diversity and rejecting the idealization or pathologization of certain weights or body types. The HAES perspective posits a stance of body acceptance which refers to (a) holding favorable opinions of one's own body and the bodies of others (regardless of actual physical appearance), (b) acceptance of one's own body and the bodies of others in spite of weight, body shape, and imperfections, (c) respect of one's own body by attending to its needs and engaging in healthy behaviors, and (d) protection of one's own body and the bodies of others by rejecting unrealistic body images portrayed in the media (Avalos et al., 2005). Put succinctly, HAES encourages providers to uphold the belief that all bodies are good bodies--a stark departure from the biased traditional view that only certain smaller bodies are good bodies, a bias that drives weight discrimination.

The HAES movement's principle three, respectful care, is also essential to note here, as this is the tenet which most directly addresses the issues of weight bias and discrimination. This principle states that individuals who work from a HAES approach must acknowledge their personal biases, and work to end weight discrimination, weight stigma, and weight bias. In doing this, providers must provide information and services from an understanding that socioeconomic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities (*ASDAH: Trademark Guidelines*, 2003). HAES, therefore, has a focus on the intersectional nature of multicultural competence as well as a call to social justice advocacy in the realm of weight oppression. The issue of weight discrimination, HAES posits, can be answered by adopting a stance of body acceptance, of the self and of others, and by having multicultural competence to engage in social justice work.

Multicultural Competence in Counseling

The field of counseling has a strong focus on multicultural competence. Multicultural competence has been a growing focus in the counseling profession since the 1980's and is now considered one of the primary pillars of our profession (Arredondo et al., 1996; Ratts, 2009; Ratts et al., 2016; Sue et al., 1992). Multicultural competence is described as possessing the necessary skills to work effectively with clients from various cultural and/or ethnic backgrounds (Holcomb-McCoy & Myers, 1999). This is codified in the Multicultural and Social Justice Counseling Competencies (MSJCC) as well as the American Counseling Association's (ACA) Code of Ethics. The MSJCC, built on Sue and Sue's (2008) model, divides multicultural competence into three areas: (a) attitudes and beliefs—awareness of one's own assumptions, values, and biases; (b) knowledge—understanding the worldview of culturally diverse clients; and (c) skills—developing appropriate intervention strategies and techniques, and (d) action—actively utilizing knowledge and skills in their work (Ratts et al., 2016). Relatedly, within the MSJCC, two of the specific knowledge competencies expected of counselors are (a) being able to define various forms of bias and (b) knowing the ways that bias can affect counselors' work (Arredondo et al., 1996; Ratts et al., 2016). A high degree of multicultural competence is associated with many positive therapeutic outcomes including increased satisfaction and disclosures for clients with marginalized identities in counseling, decreased early termination of the counseling relationship, and better treatment outcomes (Constantine, 2007; Hook et al., 2013; Kim et al., 2019; Owen et al., 2011). Given its many benefits and alignment with professional ethics, multicultural competence is also a vital component of counselor education. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards explicitly require that the counselor education curriculum include training

on social and cultural diversity, the impact of attitudes and beliefs, power, and privilege impact clients from diverse identities and how to work with clients of differing cultural identities (Section 2, F.2.a-h). It is important to note that Sue and Sue's (2008) original model was developed to as a means to address race and ethnicity in counseling, however MSJCC has been expanded upon to broaden the definition of culture to include the intersections of different privileged and marginalized identities (e.g., gender, sexuality, ability status, etc.) (Ratts et al., 2016). As previously discussed, HAES advocates argue that larger body size is a marginalized identity, particularly given the rampant negative effects of weight discrimination (Brown & Saltus, 2015). Since the counseling profession places great importance on multicultural competence, including the awareness of one's biases and the impact they may have on clients, particularly those with marginalized identities, teaching counseling students about the impact of sizeism feels like a natural and necessary component of counselor education.

Sizeism in Multicultural Counseling Training

There have been several calls for inclusion of sizeism in multicultural counseling training and anecdotal use of sizeism training for students studying to be mental health practitioners (Bergen & Mollen, 2019; McHugh & Chrisler, 2019; Rothblum & Gartrell, 2019). These strategies include: teaching weight stigma from a HAES perspective, by incorporating discussions of the lived experiences of fat people, advocating for social justice for fat rights, and providing information about the detrimental impact of diet culture, which educators report has been successful in fomenting conversation and anti-weight stigma growth in trainees (Bergen & Mollen, 2019; McHugh & Chrisler, 2019; Rothblum & Gartrell, 2019). However, on the whole, sizeism has been documented as being woefully underrepresented in multicultural counseling textbooks (Kasardo, 2018). Not only are discussions of sizeism missing from textbooks, but also,

they are lacking in mental health training in general. Research conducted by Pratt et al. (2014) demonstrated that Licensed Marriage and Family Therapists (LMFTs) and trainees reported feeling that they had received inadequate training to work with clients of size, and in a follow up study found that MFT trainees reported high levels of explicit weight bias despite taking multicultural coursework (Pratt et al., 2016). Given that sizeism is often considered one of the last acceptable prejudices, it unfortunately is unsurprising that it is an under-discussed topic even in multicultural classrooms (Kavic, 2001). It is time for a HAES-aligned anti-weight stigma training to be explored in counselor education to further the fight against weight discrimination.

Need for the Present Study

There have been only a few attempts to incorporate sizeism, from a non-HAES-aligned perspective, into mental health training programs (Cravens et al., 2016; Lawrence et al., 2012). Lawrence and Cravens (2014) developed a training program for marriage and family therapy trainees that was comprised of five experiential activities which exposed trainees to diverse issues related to working with overweight clients: (1) privilege and oppression narratives, (2) dominant themes in the media, (3) the application of biological, psychological, and social considerations to a clinical vignette, (4) understanding weight bias, and (5) clinical setting considerations. In addition to the experiential activities, a Weight Bias Questionnaire (adapted from Puhl & Brownell 2007) was included to help trainees evaluate their own biases on issues of body size and weight. It is important to note that this training, while it did address issues related to the oppression of fat bodies and gaining awareness of how weight bias impacts clinical care, was not grounded in the HAES philosophy of body acceptance, as an important component of the training was to teach students how to support clients in losing weight and making weight loss the focus of therapy. Because of the lack of this important component of a HAES-informed

training, this training is still perpetuating the harmful idea that fat bodies are inherently bad and should be changed. After Lawrence and Cravens' (2014) training, MFT trainees reported that they felt they had increased their awareness of their weight bias and that they thought a training like this was important to include in their training sequence; however, the purpose of collecting data from this training was to better understand students' reactions to a weight bias training and their thoughts on whether it should be incorporated as part of their course sequence. This training has not been tested for practical efficacy or statistical significance, or used to examine changes to implicit and explicit weight bias, so further research is needed to test if the training actually decreases different types of weight bias and/or increases efficacy when working with clients of size. An earlier set of training recommendations created by Lawrence et al. (2012) was created for master's of social work (MSW) trainees which covered content such as health, stigma, and cultural competence and specific examples of how this content can be integrated into their training sequence (e.g., videos of the impact the media's focus on thinness on weight bias). Another important component of this training is to increase trainees' awareness of their own weight biases while also teaching them how to work with clients to lose weight (Lawrence et al., 2012). It is important to note, however, that this training has not been empirically tested to see if it actually increases efficacy at working with clients of size or in decreasing weight bias in trainees. Also, both of these trainings are not designed from a HAES perspective, as evidenced by their inclusion of strategies to work with clients to lose weight, which, unfortunately, serves to perpetuate the view that "obesity" is a problem to be solved in therapy and that it is acceptable for clinicians to recommend weight loss as a treatment option.

To date, there is no HAES-aligned weight stigma training published that is specifically for mental health professionals. The Association for Size Diversity and Health (ASDAH) has

compiled a curriculum comprised of three PowerPoints to utilize in teaching college students and healthcare professionals about a weight neutral approach to health which includes a discussion of impact of weight stigma and the importance of reckoning with one's personal weight biases (*HAES® Curriculum*, n.d.). This training is certainly HAES-aligned and, in a study of dietitians-in-training, has demonstrated the ability to decrease explicit antifat attitudes after attending all three of the roughly three hour long lectures (Rosalez, 2014), however, this training is not specific to mental health professionals. An extended adaptation of the ASDAH HAES-grounded curriculum has been documented in promising initial findings in college students enrolled in a health class which utilized a semester-long HAES curriculum (Humphrey et al., 2015). Lastly, utilizing a shorter adaptation of the HAES training has been shown to help increase efficacy and comfortability using a weight-neutral approach to dietetic practice (Brown, 2009). There have yet to be any studies on if or how this (or an adapted version of this) HAES training is effective with mental health trainees or practitioners. Just as the ASDAH HAES curriculum has been adapted to meet the needs of dieticians (Rosalez, 2014) and the general population of college students (Humphrey et al., 2015), it is important to have a HAES training that incorporates some specifics to mental health practitioners such as utilizing counseling skills such as broaching to initiate discussions of body size, to discuss how body size can be utilized in case conceptualizations, and how the concept of body acceptance can be integrated into the treatment of eating disorders. It is time to put the pieces together and test how a HAES-aligned weight stigma training (and not merely a generic weight stigma training as previously conducted) impacts CITs' weight biases.

Purpose of the Present Study

The purpose of this study is to examine how a HAES-informed training on sizeism will impact counseling trainees' levels of implicit and explicit weight bias, and how multicultural competence is related to change in both implicit and explicit weight bias. This study seeks to address a critical next step in decreasing weight discrimination within the counseling profession: does training counseling trainees about weight bias from a HAES perspective actually help to decrease both implicit and explicit weight bias and create more culturally competent counselors? Stated differently--is it useful to have a HAES-aligned sizeism training as a component of the counselor education curriculum?

Significance of the Present Study

The present study is an important step in addressing weight discrimination in the counseling profession by using teachable skills. While there has yet to be a study which examines the impact of a HAES anti-weight stigma training on both explicit and implicit weight biases, there are promising initial findings that HAES trainings do help to decrease explicit weight bias (Rosalez, 2014). Relatedly, research on college students (Breithaupt et al., 2020) and obstetric medical professionals (Burke, 2019) suggests that explicit weight bias has been shown to significantly decrease after weight stigma training, although implicit weight bias appears to not decrease as a result of these discrete training incidences. The lack of change in implicit bias may be due to the trainings not aligning with the HAES movement. While implicit biases are slow to change, individuals can be better taught to recognize and manage these biases, which is much of the focus of multicultural competence training (Gonzalez et al., 2018; Holcomb-McCoy & Myers, 1999; Vuletich & Payne, 2019) and of the HAES movement. Given that multicultural competence involves counselors using self-awareness, knowledge, skills, and action to address

privilege, oppression, and discrimination within counseling (Ratts et al., 2016; Sue & Sue, 2015), it follows that combining these same skills with a training grounded in the HAES perspective, can help to decrease explicit bias, to help to manage implicit bias, and to enable counselors to work with fat clients who experience marginalization due to their body size. The proposed study is a vital step in helping to fight against weight discrimination in our profession and to make the counseling room a space of safety and healing for all bodies.

Research Questions

The present study seeks to answer the following questions:

Research Question I: What is the impact of participation in a HAES-aligned weight stigma training on implicit weight bias from pre to post-test among Master’s counseling students?

Hypothesis I: Participation in the training will result in a significant decrease in implicit weight bias.

Research Question II: What is the impact of participation in a HAES-aligned weight stigma training on explicit weight bias from pre to post test among Master’s counseling students?

Hypothesis II: Participation in the training will result in significant decrease in explicit weight bias.

Research Question III: How does HAES-aligned training impact the change in implicit weight bias from pre to post-test compared to participants in the delayed intervention group?

Hypothesis III: Participants in the HAES-aligned training intervention group will have a decrease in implicit weight bias above and beyond that of the delayed intervention group.

Research Question IV: How does HAES-aligned training impact the change in explicit weight bias from pre to post-test compared to participants in the delayed intervention group?

Hypothesis IV: Participants in the intervention group will have a decrease in explicit weight bias above and beyond that of the delayed intervention group.

Research Question V: How does HAES-aligned training impact HAES competency?

Hypothesis V: Participation in the training will increase HAES practice competency.

Research Question VI: What is the impact of multicultural competence on change in implicit and explicit weight bias?

Operational Definitions

- **Weight discrimination:** The maltreatment of individuals perceived to have larger sized bodies; this can range from systemic discrimination (e.g. the insurance system in our society is less likely to provide coverage for individuals with a higher BMI), to the discrimination of the individual (e.g. an individual experiencing verbal harassment because of their weight).
- **Sizeism:** prejudice towards people perceived to be “overweight” or “obese” that is fueled by stigma and possesses damaging consequences to its targets (Erickson Cornish et al., 2010)
- **Weight stigma:** negative attitudes and beliefs about people based on their perceived larger body size which drives discriminatory behaviors
- **Implicit weight bias:** negative evaluations and/or judgements about people based on their perceived larger body size; these are mostly subconscious but can also influence conscious thoughts
- **Explicit weight bias:** directly expressed negative attitudes and beliefs about people based on their perceived larger body size that occur entirely on a conscious level

- **Fat/fat bodies:** Within the HAES and Fat Acceptance movements, the once derogatory term is being reclaimed by individuals with larger bodies and used in academic writing (Akoury et al., 2019; Saguy & Ward, 2011). There is still much disagreement over accepted terminology to use to refer to individuals with larger sized bodies, so this researcher, who identifies as having a smaller body, seeks to acknowledge her own privileged identity in writing about individuals with larger bodies, and therefore will use a variety of terms including: fat, fat bodies, clients of size, people with larger bodies, higher weight clients, and will refrain from utilizing the stigmatizing language of “BMI,” “overweight,” and “obese” unless directly quoting previous research.
- **Multicultural competence:** a combination of awareness of one’s own attitudes/biases around different identities, knowledge of different cultural identities, and skills to adapt treatment to be inclusive of a client’s cultural/social identities (Sue et al., 1992).

CHAPTER II: REVIEW OF THE LITERATURE

Introduction: Dieting or Disease?

Roughly 9% of the U.S. population, or 28.8 million Americans, will have an eating disorder at some point in their lifetime (Deloitte Access Economics, 2020). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) characterizes an eating disorders as “a persistent disturbance of eating or eating-related behavior that results in altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning” (pg. 329). Eating disorders are some of the deadliest mental disorders due to increased risk of completing suicide as well as the medical complications that are associated with extreme food restriction (Arcleus et al., 2011). In contrast, approximately 50% of the U.S. population is on a diet, seeking to lose weight via some form of dietary restriction, with weight loss and dieting generally viewed as a means to increase health (Martin & Ogden, 2018). And yet, up to 95% of diets “fail,” that is, after 5 years post-diet, roughly 95% of people regain the weight they had initially lost (Tomiyama et al., 2013). In addition to diets being ineffective long-term, they also cause individuals to feel out of delayed intervention around restricted foods, experience increased incidences of binge eating, experience increased incidences of secretive eating, experience increased feelings of shame around food, engage in social withdrawal, to have a slowed metabolism, and to have increased irritable or depressed moods (Amigo & Fernández, 2007; Hagan et al., 2000; Tribole & Resch, 2012). Dieting also increases one’s risk for developing an eating disorder (Fairburn et al., 2005; Rohde et al., 2015). So why then is dieting so commonly accepted and even celebrated when it has so many negative consequences and overlaps with eating disorders? Put simply, it is the belief that being fat is a condition to be avoided at all costs. One of the strongest held and socially sanctioned biases is the bias against

fat people (Latner et al., 2008). In the most recent update of the DSM-5, “obesity” was heavily considered as a mental health disorder characterized by an “addiction” to food to be remedied with substance use therapy and weight loss, although thankfully there was not enough evidence to support its inclusion (Allison et al., 2008; Marcus & Wildes, 2012). Weight stigma, the negative beliefs about individuals perceived to have larger sized bodies, is an insidious force in our culture and in the field of mental health.

Implicit & Explicit Weight Bias: Drivers of Weight Discrimination

Weight discrimination, the unequal treatment of people perceived to have larger sized bodies, is driven by implicit and explicit biases. Implicit biases are defined as “actions or judgments that are under the delayed intervention of automatically activated evaluation, without the performer’s awareness of that causation” (Greenwald, McGhee, & Schwartz, 1998, p. 1464). These implicit biases can be aligned or in stark contrast to one’s espoused values and beliefs (Daumeier et al., 2019). Implicit biases can have a direct influence on discriminatory behaviors (De Houwer, 2019). Some of the most prominent examples of this are studies of police and college students who are more likely to shoot Black individuals than a white individuals due to their bias that they are more likely to have a gun in a simulation game (Correll et al., 2007; Eberhardt et al., 2004). In the context of weight, implicit weight bias refers to actions or judgements about people based on their perceived larger body size (e.g., the automatic assumption that a fat person is lazy) (Phelan et al., 2014).

Explicit biases, in contrast, include one’s preferences, beliefs, and attitudes that one is readily aware of and can communicate to others (Dovidio & Gaertner, 2010). An example of explicit weight bias would be a person who consciously endorses and communicates the idea that fat people are lazy. Explicit weight bias can be seen in individuals as young as three years old, as

demonstrated in Cramer and Steinwert's (1998) study of preschool children in which children were consistently more likely to endorse a thin character as the "nice" character in a story and the fat character as the "mean" character in a story. Implicit and explicit bias are only modestly related and can each individually predict discriminatory behaviors (Greenwald et al., 1998; Hofmann et al., 2005). These negative beliefs about individuals with a larger body size, either conscious, unconscious, or both, then serve as the catalyst for individuals to engage in weight discrimination behaviors.

Experiences of weight discrimination have a profoundly negative impact on both the physical and mental health of higher weight individuals. The physical health detriments that result from experiences of weight discrimination include but are not limited to, higher blood pressure, increased stress as measured by sustained heightened cortisol levels, and sexual dysfunction (Himmelstein et al., 2015, 2019; Nutter et al., 2016; Phelan et al., 2015). While it is widely believed that "obesity" is a disease as well as a cause of many other health conditions including diabetes, heart disease, and some cancers (Mokdad et al., 2003), there is growing evidence that suggests the experiences of weight stigma rather than weight itself can be the cause of these health concerns. In one of the larger studies of weight discrimination's impact on health, Schafer and Ferraro (2011) utilized data from the Midlife in the United States Study MIDUS, a 10-year longitudinal study with over 1,856 participants, and found that a decline in functional mobility initially attributed solely to "obesity's" impact on joint health, was actually more severe for higher weight individuals who had reported experiencing weight-based discrimination than for higher weight individuals who did not report experiencing weight-based discrimination. This suggests that weight discrimination can be an important factor in negative health outcomes for higher weight individuals. This finding is further corroborated by research from Sutin et al.

(2014) who found that systemic inflammation, a known risk factor cardiovascular disease and diabetes, was significantly increased by experiences of weight discrimination. Most troublingly, in a subsequent study Sutin et al. (2015) found that, even when delayed intervention for risk factors such as BMI, depressive symptoms, self-reported health, smoking, and physical activity level, individuals who had experiences of weight-based discrimination had a nearly 60% increased mortality risk than individuals who had not experienced weight discrimination. Weight discrimination, it appears, can be deadly.

The harmful impact of weight discrimination on physical health is also evident in medical treatment. During the ongoing COVID-19 pandemic, experiences of weight discrimination have been associated with increased risk of complications and death from coronavirus as well as an increased likelihood of being unvaccinated due to concerns of experiencing weight stigma from medical providers (Townsend et al., 2021). Weight discrimination in a medical context can lead fat patients to delay or avoid care for fear of discrimination (Drury & Louis, 2002; Olson et al., 1994). Thus, in trying to avoid discriminatory experiences, fat folks are also put at risk for poorer health outcomes. Weight discrimination also is evident in the clinical care fat patients receive once they do seek medical assistance. Medical professionals demonstrate both implicit and explicit biases by consistently documenting that they have less respect for fat patients and endorse the beliefs that they are unmotivated, lazy, and unlikely to follow treatment recommendations (Phelan et al., 2015; Puhl et al., 2016). Due to these implicit and explicit biases, medical providers spend less time with fat patients, engage in less patient-centered communication and rapport-building, and are less likely to do certain screenings or discuss healthcare strategies other than weight loss, which all result in poorer health outcomes and treatment prognosis for fat patients (Phelan et al., 2015; Puhl et al., 2014, 2016). In the treatment

of higher weight pregnant individuals, implicit and explicit weight bias is associated with obstetric professionals' endorsement of the stereotypical belief that these individuals will not engage in appropriate pre-birth behaviors (e.g. attending medical appointments, eating a balanced diet for fetal health, etc.) and expression of negative attitudes towards working with higher weight individuals who are expecting (Mulherin et al., 2013). These biased beliefs and decreased desire to work with individuals of a larger size compromises the quality of clinical care and thus negatively affects physical health.

Unsurprisingly, the negative psychological impact of weight discrimination is also staggering. Individuals who experience weight discrimination are at risk for increased disordered eating (particularly binge-eating behavior), depression, loneliness, social isolation, suicidality, and anxiety (Nutter et al., 2016; Phelan et al., 2015). Weight discrimination is also linked to an increased likelihood of developing a substance use disorder and comorbid mental health disorder (Hatzenbuehler et al., 2009). While the COVID-19 pandemic has had a negative impact on mental health globally, it appears to also have disproportionately impacted higher weight individuals. Individuals who have experienced weight discrimination report significantly higher depressive symptoms, stress, eating as a coping strategy, and increased binge eating than individuals who have not faced weight discrimination and at higher than their typical level of these symptoms pre-pandemic (Puhl et al., 2020). Weight stigma messages about losing the “quarantine-15” and “getting back to a pre-pandemic body” have been evident in advertising and on social media which have a negative impact on higher weight individuals (Pearl & Schulte, 2021). In order to cope with the stress of weight stigma, higher weight individuals must exert large amounts of cognitive effort to regulate the negative emotions, intrusive thoughts, and interpersonal anxieties they experience in response to discrimination (Hunger et al., 2015). These

negative emotions can include both heightened stress-related emotions (e.g., nervous, overwhelmed, worried) and self-conscious emotions (e.g., guilty, disgusted with self, ashamed) (Blodorn et al., 2016; Major et al., 2012). Weight stigma has also been shown to decrease self-regulation and executive functioning cognitive abilities, particularly after discrete discrimination events, possibly related to the aforementioned intense negative emotions it invokes (Blodorn et al., 2016). Thus, higher weight individuals carry around the psychological weight of discrimination that has been compounded during the pandemic.

Where Does Weight Stigma Happen? Who Perpetuates It?

Media & Pop Culture

Weight stigma is everywhere. Although it has most frequently been thought of and studied as a Western cultural phenomenon that idealizes thin and muscular bodies while disparaging fat bodies, recent evidence suggests that weight stigma is now present even in traditionally fat-positive cultures (Brewis, et al., 2011). Weight stigma is perhaps most widely visible in media and pop culture. From “thinspiration” posts on social media, to magazine covers celebrating the thin bodies of celebrities, a very clear cultural message is being sent that thin bodies are highly desirable. Weight bias is perpetuated in the media by two primary pathways (Ata & Thompson, 2010; Greenberg et al., 2003; Himes & Thompson, 2007). The first pathway is the idealization of slender bodies, with female bodies having to be thin and male bodies having to be muscular (Himes & Thompson, 2007). The second pathway is the underrepresentation of fat bodies. While the majority of the US population can be considered as “overweight and/or obese” according to medical standards (roughly 51% of females and 59% of males), only 13% of females and 24% of males portrayed on television could be considered “overweight and/or obese” according to medical standards (Greenberg et al., 2003). When they are visible on screen,

fat characters are most commonly treated as the butt of fatphobic jokes or presented as being unattractive, unintelligent, and/or undesirable (Robinson et al., 2008). The other primary presentation of fat people occurs through reality television shows, which in theory, are supposed to provide a realistic representation of the struggles of fat individuals. However, shows such as *My 600lb Life* or *The Biggest Loser* often portray fat individuals in a pitiable and stereotypical fashion. In fact, watching the weight loss show *The Biggest Loser* has been associated with increases in both implicit and explicit weight bias (Karsay & Schmuck, 2019), suggesting that these shows further exacerbate weight stigma as opposed to decreasing it. One promising study conducted by Smirles and Lin (2018) found that when presented with images of plus-sized models, women had decreased explicit weight bias as compared to the delayed intervention group of women who viewed images of thin models. Therefore, increasing positive representation of higher weight individuals could help to mitigate some of the harms caused by current portrayals of fat folks in the media, yet much more research is needed in this area.

Medicine

Weight stigma is also highly apparent in the field of medicine. The medical field has traditionally viewed higher weight as a pathological concern and that weight loss is an attainable and acceptable treatment course for the “disease of overweight and/or obesity” (Wadden & Bray, 2018). Given the pathologized view of fat bodies that is commonly accepted in this field, it is unfortunately unsurprising that weight bias is common among medical professionals. In a large scale comparison study of the implicit and explicit weight bias of medical doctors (MDs) as compared to the general population, Sabin et al (2012) found a comparably high level of implicit weight bias and a slightly elevated level of explicit weight bias among MDs. It also appears that weight bias can be increased due to current medical training standards. In a large scale study of

medical students in the US, Phelan et al. (2014) found that 74% of medical students surveyed exhibited implicit weight bias and 67% exhibited explicit weight bias (as evidenced by a moderate score or higher on the Weight Attitudes Implicit Attitudes Test (IAT) and the Antifat Attitudes Questionnaire, respectively). For context, the implicit weight bias score was comparable to the level of implicit bias against racial minorities and the amount of explicit weight bias was more negative toward higher weight individuals than toward racial minorities, LGBTQ individuals, and impoverished individuals (Phelan et al., 2014). In a followup study a significant increase occurred among students in medical school in both implicit and explicit weight bias as students advanced in their training from year 1 to year 4 (Phelan et al., 2015). These increases in bias were heightened if the students had faculty who modeled weight discriminatory behaviors (e.g. comments about how “obese” patients are the worst patients to treat), but were buffered if students had positive contacts with fat patients (e.g. encountered patients who did not play into the negative stereotypes about fat patients) (Phelan, Puhl, Burke, et al., 2015). Troublingly, when it comes to obesity specialists, medical professionals who primarily work with higher weight individuals, they also endorse high levels of implicit and explicit weight bias (Schwartz et al., 2003). However, more recent research conducted on obesity professionals by Tomiyama et al (2015) suggests that, while levels of implicit and explicit weight bias remain high, overall implicit weight bias in this population has decreased whereas explicit weight bias has remained the same. These findings suggest that, while on the whole the medical field is still distinctly biased against fat individuals, there are still opportunities to decrease bias in the future.

Education & the Workforce

The education and the workforce is another location of weight bias. It has been well documented that the higher a person's weight, the less likely they are to be hired, even if they have outstanding credentials (Carels et al., 2015; Flint et al., 2016; Roehling, 2002; Sims, 2018). Once hired, these individuals experience lower regard and inclusion from their colleagues, are viewed as less intelligent, less productive, and are more likely to be fired than their thin counterparts (Finkelstein et al., 2007; R. M. Puhl & Heuer, 2009). It also appears that higher weight individuals experience a wage gap as compared to their thin colleagues, which is further exacerbated for higher weight women in particular (Baum & Ford, 2004; Pagán & Dávila, 1997). This stigmatization can also be seen earlier in education. Teachers describe higher weight students as untidy, more emotional, less likely to succeed at work, and more likely to have family problems (Neumark-Sztainer et al., 1999). Higher weight adolescents have reported that the school is the most common place for weight-based teasing to occur from their peers and report experiencing bullying more frequently than their smaller sized peers (R. M. Puhl et al., 2011; R. M. Puhl & King, 2013). While 71% of higher weight students reported at least one instance of weight-based teasing in the year sampled, up to 92% of students, regardless of size, reported having witnessed a weight-based bullying incident in the year sampled, indicating that weight-based bullying is the norm in a school setting (Puhl et al., 2013). These instances create a hostile environment which then negatively impacts higher weight students' ability to learn. While there has been less research of weight bias in graduate school, Burmeister et al. in their 2013 study of weight bias in graduate psychology program admissions, applicants with a higher BMI received significantly fewer post-interview offers of admission into psychology graduate programs, particularly if they were also female. Weight bias is seen at every stage of one's

professional career, from kindergarten to even graduate school, which suggests its attention for counselors.

Personal Relationships with Others & the Self

Weight stigma also occurs in the personal relationships of higher weight individuals. Fat people are seen as undesirable as romantic partners, with individuals indicating that they would prefer being in a romantic relationship with a person in recovery for substance use, a person with a mental illness, or a person with an STD over being in a romantic relationship with a fat person (Chen & Brown, 2005; Sitton & Blanchard, 1995). The impact of weight stigma on romantic relationships appears to disproportionately impact women. Fat women tend to report lower quality romantic relationships overall and that they tend to engage in relationships with less desirable men (Boyes & Latner, 2009). Relatedly, male partners of higher weight females rated their female partners as lower in attractiveness and being less than their ideal level of attractiveness in a desired partner, yet interestingly male body size had no impact on the quality of the relationship (Boyes & Latner, 2009). However, it is important to note that these findings are from a highly heteronormative perspective and thus do not capture weight stigma within non-heteronormative romantic relationships.

It would be amiss to discuss locations of weight stigma, without discussing how weight bias can be internalized, that is, fat people can perpetuate bias against themselves. Weight bias internalization is when the individual takes in and believes the negative stereotypes about fat people, applying them to themselves, whether or not it matches their actual experience/identity. For example an individual with internalized weight bias might believe that they are lazy, sick, and undesirable. Internalized weight bias is associated with a number of negative psychological outcomes including depression, anxiety, disordered eating, and decreased motivation (Carels et

al., 2015; Schwartz et al., 2006). Conversely, when fat individuals have higher levels of body appreciation (they believe that their body is good and deserving of care no matter its size) it can serve as a buffering effect against internal and external weight stigma, allowing them to experience higher self-esteem, lower rates of mental illness including disordered eating, improved sexual functioning and pleasure, and are more likely to pursue positive health behaviors such as intuitive eating and exercising (Bacon et al., 2005; Cox et al., 2019; Kim et al., 2019; Satinsky et al., 2012; Schwartz et al., 2006). Body acceptance is also directly associated with decreased incidences of weight discrimination and weight bias internalization (Murakami & Latner, 2015). Weight bias occurs across contexts and is supported by many complex factors.

Weight Bias in Counselors & Counselors in Training

Historically, mental health practitioners have approached body size similarly to medical practitioners: the fat body pathologized (Kinavey & Cool, 2019), which could help to explain why rates of weight bias in mental health practitioners are comparable to medical professionals (Puhl et al., 2014). Weight bias is highly visible in the diagnosis and prognosis of fat clients. In one of the seminal studies of weight bias in psychotherapy, Young and Powell (1985) digitally altered a photograph of one woman to represent either a “best weight model,” “an overweight model,” or “an obese model” and provided the case background of the client describing her history and presenting concerns to a sample of mental health professionals and asked them about their prognosis for the client and the level of severity of her symptoms. The mental health professionals, while hopeful about the treatment prognosis for the client across all three body size depictions, rated the “obese” client as having significantly more symptoms (e.g. addiction, hypochondriasis, resistance to change) and an increased severity of symptoms as compared to the “best weight” and “overweight” conditions, thus demonstrating how weight bias impacts the

diagnostic process of therapy (Young & Powell, 1985). Building off of the work of Young and Powell (1985), Davis-Coelho et al. (2000) sent images of a fat vs a thin client with a writeup of their history and presenting concerns to a sample of psychotherapists and asked them for provisional diagnoses. The researchers again replicated findings that fat clients are more likely to be assigned a more severe diagnosis than thin clients (Davis-Coelho et al., 2000). In follow-up analyses of how therapist identity impacts weight bias, Davis-Coelho et al. (2000) found that younger and female therapists were more likely to exhibit bias in their diagnosis of fat clients than older and male therapists. A similar design was utilized by Hassel et al. (2001) to explore if therapist religious orientation (Christian vs non-Christian) impacted weight bias in diagnosis, and found that religious identity had no impact on weight bias and that weight bias was evident in diagnosis for both Christian and non-Christian therapists in comparably elevated amounts. These studies reveal that the pathological medical mindset of higher weight and use the stigmatizing language of “overweight/obese” has been and continues to be present among mental health professionals. This stigmatizing approach and view of weight is common in the field of mental health (Kinavey & Cool, 2019).

Weight bias also is present in the course of treatment and interventions or goals chosen as the focus of therapeutic work. As discussed previously, body size can be viewed as a sign of mental health concerns such as a ‘food addiction’ or as a mental illness by its own right (Marcus & Wildes, 2012). Recently, the American Psychological Association (APA), has endorsed an “obesity” treatment protocol to use with children that utilizes a behavioral approach to encourage weight loss (Pitt, 2018). This view of body size then invites clinicians to make the pursuit of weight loss a goal of therapy, often via strategies ranging from restrictive dieting to behavioral modification strategies such as avoiding certain situations where off-limits foods will be readily

available (Williamson & Perrin, 1996; Pitt, 2018). One of the primary clinical theoretical orientations in the counseling field, Cognitive Behavioral Therapy (CBT), is often touted as the gold standard of encouraging weight loss in clients, and is endorsed by professional organizations such as the APA for use to pursue weight loss goals with clients (Castelnuovo et al., 2017; Cooney et al., 2018; Grilo & Masheb, 2005). On the more extreme end of the spectrum, when behavioral modification interventions alone are not enough to achieve weight loss, surgical body modifications such as full or partial stomach amputations which decrease the patient's ability to eat are considered an acceptable form of weight loss treatment (Lier et al., 2012; Wadden & Sarwer, 2006). To support this treatment, some mental health professionals provide readiness assessment, as well as pre- and post-operative counseling, for bariatric surgery patients (Lier et al., 2012; Wadden & Sarwer, 2006). It is important that while all of the aforementioned approaches to weight delayed intervention (i.e. "treating obesity") are successful in the short term, that they ultimately are unsuccessful in the long-term and often have negative impacts on the wellbeing of clients (Chu et al., 2019; Hagan et al., 2000; Rohde et al., 2015).

While the detrimental impact of weight bias is well documented across contexts, particularly its negative impact on mental health, there is scant research on the lived experiences of clients of size in counseling. To date, only one study conducted by Akoury et al. (2019) has examined how weight bias is experienced in the counseling room by fat clients. These researchers, in their qualitative inquiry of fat women's experiences in counseling, found that fat women discussed being less likely to open up in counseling or to be more likely to skip sessions or end treatment early if they perceived their counselor as being biased against their weight (Akoury et al., 2019). Relatedly, these clients also expressed pain and frustration at therapists who made weight loss the focus of the counseling work and they advocated for therapists to

follow the client's lead on discussing weight in the counseling room (i.e. not assuming a fat client is coming to therapy for weight loss) (Akoury et al., 2019). This study has several important implications in that it begins to provide evidence to demonstrate that weight bias negatively impacts the counseling relationship and therapeutic experience for fat clients and that the study centers the perspective of higher weight individuals. It is also important to note the one study to date which explores the other side of this dynamic: how weight bias impacts fat therapists. In their 2019 study on how college students rated the efficacy and credibility of therapists with the same credentials and experience with body size as the only differing factor, Moller and Tischner (2019) found that these students consistently rated fat therapists as being less qualified to be therapists, and, in some cases being "unfit" to be therapists due to the assumed pathology of weight. When clients do not see their therapist as fit to be a therapist or have diminished faith in their qualifications, this could lead to lack of utilization of services or premature termination of services. The detrimental effects of weight stigma in the counseling relationship is not only a seasoned clinician issue, but also appears in trainees.

Weight bias is present even in mental health trainees. In a replication of earlier studies of weight bias in mental health professionals (e.g., Young & Powell, 1985; Davis-Coelho et al, 2000) Adams (2008) found that mental health trainees also exhibited weight bias as demonstrated by assigning fat clients more severe diagnoses than thin clients. Expanding upon this finding, Pascal (2011) utilized the same design, but added a variable of client career into the vignettes (e.g. assigned a lower status or higher status career to clients). Pascal (2011) found that CITs again assigned a more severe diagnosis to fat clients than to thin clients, but also found that a lower perceived job status (e.g. a bookkeeper vs a physician) when combined with higher weight resulted in the most severe diagnoses. These findings suggest that for fat clients with

other marginalized identities, weight bias can be exacerbated. Pratt et al. (2016) utilized a descriptive design to examine explicit weight bias in Marriage and Family Therapy (MFT) trainees by utilizing Crandall's (1994) Antifat Attitudes Scale, and found that, on average, trainees exhibited explicit weight bias. Further, they also found that Master's level trainees had higher amounts of explicit weight bias than doctoral level trainees, and that White trainees, particularly White female trainees endorsed the highest amounts of explicit weight bias (Pratt et al., 2016). This finding is important because it was the first measurement of explicit weight bias in trainees and exploration of how other identity factors (e.g. race, gender) are related to the amount of explicit weight bias.. Forristal et al. (2021) found that CITs demonstrated explicit weight bias as measured by the short form version of the Fat Phobia Scale (Bacon et al., 2001) and that this bias then impacted how they diagnosed a fat versus a thin client using the same study design as previous studies (e.g., Young & Powell, 1985). This most recent study, the researchers put all of the pieces together in that they assessed explicit bias as well as implicit bias via clinical decision making, suggesting that both implicit and explicit bias are implicated in weight-biased behaviors. However, to date, there has not been use of a direct measurement of implicit bias (e.g. the IAT) to measure the amount of implicit weight bias in trainees and how this relates to explicit bias.

Factors that Contribute to & Influence Weight Bias

Other Identities

While weight discrimination is enacted across contexts, it is also important to consider the disparities in experiences of weight stigma based on differing and intersecting identities. Greater likelihood of experienced weight stigma is present among younger individuals, and individuals with lower income (Himmelstein et al., 2017; Puhl et al., 2008). Weight

discrimination of Latinas and women in the lowest household income group is significantly greater relative to White women and women with higher household income, suggesting that social status has a buffering effect of weight stigma on psychological wellbeing (Himmelstein et al., 2017; Panza et al., 2020; Reece, 2019). Women who identify as having a sexual minority identity (e.g. identifying as lesbian, bisexual, etc.) also report frequent incidences of weight discrimination, particularly discrimination that intersects with their marginalized sexual identity(ies) (Panza et al., 2020). Across the board, women appear to receive higher rates of weight discrimination than men (Puhl & Brownell, 2001; Puhl et al., 2008; Sikorski et al., 2011). However, men still do experience weight stigma, though it is a complicated picture. Latino and Black men experience less internalized weight stigma than White men, but report no differences in explicit experiences of weight discrimination (Himmelstein et al., 2018). In terms of Black women and weight discrimination, the idea of additive intersectionality, that multiple oppressed identities will result in more experiences of discrimination, does appear to apply (Reece, 2019; Smith, 2019). Compared to Black men and White men and women, Black women endorse the least amounts of internalized weight bias and do not report experiencing as many incidences of weight discrimination as White women (Himmelstein et al., 2017; Reece, 2019; Smith, 2019). Clearly, the experiences of weight stigma are highly dependent on a multitude of identities, and providers should always consider this when treating fat patients.

Sociocultural Factors

It is also important to consider the factors supporting weight discrimination that are much broader than individual identity characteristics. The most distal of factors supporting weight stigma is the sociocultural context. Currently in the United States, there is a strong cultural bias towards thinness and diet culture, which is most visible in the media's portrayal and celebration

of thin bodies (Bacon, 2010; Bordo, 2004). This leads to the primacy of dieting, controlling and limiting one's caloric consumption, in order to achieve the thin ideal body shape. If an individual does not conform to the thin ideal, they must either suffer the consequences of weight stigma, go on a diet, or in some extreme cases, pursue bariatric surgery to shrink their stomach so that they may fit into the cultural ideal (Bacon, 2010; Bacon & Aphramor, 2011). If an individual has a fat body, this is viewed as a moral failure, that they simply did not work hard enough. This idea that one must be disciplined, temperate, and delayed interventioned in their behaviors is rooted in Protestant religious values which still have an important influence on the sociocultural context of American society today (Gerber, 2012). These Protestant values include the belief that gluttony, eating exorbitant amounts of food, is considered a sin and that fasting (refraining from food) is a pathway to religious enlightenment (Griffith, 2004). Therefore, fat bodies are seen as visual 'proof' that an individual has been eating gluttonously and therefore they do not have self-delayed intervention, self-discipline, or temperance. Antifat attitudes have also been linked to high endorsement of conservative political values (Crandall, 1994; Quinn & Crocker, 1999). Conservative political values tend to emphasize how individual actions impact outcomes (i.e. a "pull yourself up by your bootstraps" mentality) which then gets translated to fatness: one is fat because of their own personal failings (Crandall, 1994; Quinn & Crocker, 1999). In recent years, weight discrimination's roots in racial delayed intervention have also been explored, positing that, when attempts to define race by skin color became complicated due to the increasing rates of biracial individuals, eating habits and thus body size were used as the next form of racial delayed intervention or separation (Strings, 2019). Basically, the racist view that Black people were less restrained in their eating (i.e. gluttonous) and were fat because of this led to the linking of body size and eating habits with being considered as taking a lower status in society, and that

then being fat was something to vehemently be avoided, particularly for White women. This cultural context provides the frame which drives more proximal factors of weight discrimination.

Institutions

The next layer of weight discrimination is the institutions and structures in society that enable and encourage weight discrimination to flourish. The first of these is the medical system. Western medicine views fat as a disease epidemic to be fought at all costs and equates fatness with lack of health (Bombak, 2013; Pearl, 2018). Medical students are indoctrinated, via medical school curricula, into the idea that fat is bad and into the many stigmatizing stereotypes of fat patients (e.g. they are “noncompliant”) (Pantenburg et al., 2012; Phelan et al., 2014). There are numerous campaigns to fight the “War on Obesity,” and multiple policies that work to eradicate fatness in our country (CDC, 2020; O’Hara & Gregg, 2006). Another component of the medical system that entrenches weight stigma is the insurance system. “Obesity” screenings and weight management counseling are covered and encouraged under the Patient Protection and Affordable Care Act alongside incentive programs that reward or penalize based on Body Mass Index (BMI) (Wilson et al., 2017). There are even calls for individuals with larger sized bodies to be forced to pay more for insurance and/or to not receive insurance coverage (Bernard et al., 2019). Another structural component that supports weight discrimination is the lack of legislative protection for fat folks. Currently, the state of Michigan is the only state with legal code prohibiting discrimination due to weight, although there are some cities interspersed throughout the United States that have local laws prohibiting discrimination on the basis of weight including: Binghamton, NY; Madison, WI; Urbana, IL; San Francisco, CA; Santa Cruz, CA; and the District of Columbia (Suh et al., 2014). Currently, a large focus for fat activists is advocacy for the addition of “weight” as a protected characteristic (similar to race or sex) in both state and

federal law with an ultimate goal of being added to the protection of the Civil Rights Act of 1964 (Pearl, 2018; Pomeranz & Puhl, 2013; Suh et al., 2014). However, unless the individual is within one of the few areas in the US with laws prohibiting weight discrimination, they currently have no legal protection or recourse from weight discrimination. Put succinctly, weight discrimination is still a legal form of oppression.

Environmental Factors

The next most proximal factors contributing to weight stigma are environmental factors, particularly in the built environment. Buildings, public and private transportation, and furniture are not built for fat bodies. This is particularly true in medical environments where patients cannot fit into waiting room chairs with arms, examination gowns, and blood pressure cuffs (Pearl, 2018; Porter & Catenacci, 2011). Often public transport does not have armless seating to accommodate fat bodies or has seats that are too small, often, as in cases of air travel, causing fat folks to have to buy multiple seat tickets in order to travel somewhat comfortably (Pitter, 2015). Many pieces of furniture have low weight limits, thus severely restricting the availability of furniture that fat individuals can buy and comfortably and safely use both in their homes and in commercial spaces (Williams, 2008). The built environment itself signals to fat bodies that they are not wanted or welcome.

Interpersonal Factors

Moving closer to the individual components of weight discrimination is the interpersonal component. In this layer, social identities (e.g. race, class) and context (e.g. doctor's office, workplace) intersect to produce experiences of weight discrimination. These are incidents such as a doctor refusing to perform certain tests on fat patients because they assume weight is the cause of their health concern or a manager of a fashion boutique refusing to hire a fat woman to

work a customer service job. A deeper discussion of the various interpersonal situations in which weight bias shows up has already been provided in the above section on implicit and explicit weight biases. As discussed previously, these interpersonal weight discrimination incidences are a result of all of the previous factors (sociopolitical, structural, and environmental) alongside personally held biases and stereotypes about fat people. Thankfully, there is a new movement that could provide the answer to the issue of weight oppression in our society.

A Paradigm Shift: History & Tenets of HAES

While the traditional approach to weight and health has been to view fat as inherently unhealthy and bad, a recent movement called the Health at Every Size (HAES) approach radically challenges this notion. The HAES movement is composed of a set of five principles compiled by the Association for Size Diversity and Health (ASDAH) and rooted in a social justice perspective from decades of research and advocacy work from members of the fat acceptance movement (Altman Bruno, 2013). The HAES tenets were born out of the Fat Acceptance movement pioneered by the National Association to Aid Fat Americans (NAAFA) starting in the early 1960's as a reaction to growing concerns about the "obesity epidemic" in the United States and the rise of diet culture (Altman Bruno, 2013). It was a grassroots movement rooted in the lived experiences of fat people and their desire to end weight discrimination in society. In late 1967, an article entitled "More People Should Be Fat!" appeared in *The Saturday Evening Post* and argued the following principles (Louderback, 1967):

1. "Thin fat people" suffer physically and emotionally from having dieted to below their natural body weight.
2. Forced changes in weight are not only likely to be temporary, but also to cause physical and emotional damage.

3. Dieting seems to unleash destructive and emotional tendencies.
4. Eating without dieting allowed Louderback and his wife to relax and feel better while maintaining the same weight.

This set off a flurry of scholarship and research around these principles. A diverse array of individuals including medical professionals, dieticians, mental health practitioners, social workers, lawyers, writers, exercise specialists, artists rallied to create the Association for Size Diversity and Health (ASDAH), a subgroup of NAAFA in 2003, dedicated to studying and promoting HAES tenets (Altman Bruno, 2013). In 2008 Lindo Bacon published the first book, aptly titled *Health at Every Size*, outlining the HAES tenets as they are currently known.

HAES's five tenets are as follows:

1. Weight Inclusivity
2. Health Enhancement
3. Respectful Care
4. Eating for Wellbeing
5. Life-Enhancing Movement.

The first principle of weight inclusivity refers to accepting and respecting body size diversity and rejecting the idealization or pathologization of certain weights or body types. This can also be referred to as body acceptance or appreciation. Put simply, this tenet posits that all bodies are good bodies, deserving of respect and care. The individual benefits of body appreciation are well documented, with individuals with higher body acceptance having higher self-esteem, lower rates of mental illness including disordered eating, improved sexual functioning and pleasure, and are more likely to pursue positive health behaviors such as intuitive eating and exercising (Bacon et al., 2005; Cox et al., 2019; Kim et al., 2019; Satinsky et

al., 2012; Schwartz et al., 2006). Experiences of weight discrimination are decreased when individuals have higher levels of body acceptance, and when practiced by individuals with larger bodies, leads to significantly less stigmatization, and is associated with better perceived self-esteem and mental health (Murakami & Latner, 2015). Body appreciation/acceptance is the foundation upon which the rest of the theory is built.

The second HAES principle, health enhancement, posits that individuals who work from this approach strive to support health policy that promotes equitable access to information, services, and personal practices that improve overall human wellbeing. Rather than viewing health as the absence of physical or mental disease, as it has been traditionally defined by the medical community (Pantenburg et al., 2012), HAES defines health from a holistic perspective and posits that health exists on a continuum that varies with time and circumstance for each individual (Bacon, 2010). Within a HAES framework, health encompasses pleasurable physical activity, flexible and enjoyable nutrition, social support, restful sleep, access to quality medical care, meaningful work, physical safety, a clean environment, social justice, and freedom from stigma (*ASDAH: Trademark Guidelines*, 2003). This is in line with the field of counseling's view of wellness as a holistic concept, encompassing a way of life in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community (Myers et al., 2000). It is also important to note that HAES views wellness and wellbeing through the same holistic view defining it as having one's individual physical, economic, social, spiritual, emotional, and other needs met (Bombak, 2013). Health in the context of HAES is not viewed as a moral imperative and argues that health status and body weight should never be used to judge, oppress, or determine the value of an individual, which is highly related to the third principle.

The third tenet of HAES is respectful care, which is the tenet that explicitly introduces the theory's commitment to social justice and focuses on recognizing and challenging implicit and explicit biases related to body size. This tenet states that individuals who work from this approach must acknowledge their personal biases, and work to end weight discrimination, weight stigma, and weight bias (*ASDAH: Trademark Guidelines*, 2003). Recognizing and challenging personal implicit and explicit weight biases is seen as an essential component of HAES practice. To further provide competent care from a HAES perspectives, clinicians must provide information and services from an understanding that socioeconomic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities, thus challenging clinicians to take an intersectional approach to addressing weight bias. HAES challenges the medicalized view of overweight/obese people as “sick” and “inherently wrong” to view all bodies as good bodies who are deserving of care that increases holistic health, not that merely decreases disease prevalence (Bacon, 2010; Gaesser, 2006). Instead of viewing fat bodies as a disease, HAES views them as an oppressed identity. Given its grounding in social justice, the utilization of HAES also calls individuals to conduct research and to practice counseling in a way that actively works to dismantle weight discrimination.

Tenet four, Eating for Wellbeing, promotes flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on controlling weight (i.e. dieting) (Tribole & Resch, 2012). The fundamental tenets of Intuitive Eating include: eating when hungry, stopping eating when comfortably full, and not placing restrictions on foods unless it is because of medical constraints (e.g. an individual with Celiac Disease, an allergy to gluten, would not eat foods with gluten) (Van Dyke & Drinkwater,

2014). Put simply, Intuitive Eating allows all foods (no foods are “good” or “bad,” rather all foods have value) and the choice to eat is internally guided as opposed to externally delayed interventioned (e.g. by a diet plan). When one’s food choices and eating schedule are regulated by external forces, this leads to a disconnection with one’s internal body cues which then leads to greater instances of eating when not hungry (e.g. emotional eating) as well as feeling out of delayed intervention around food when there are not external rules to guide eating behaviors (Tribole & Resch, 2012). Intuitive Eating, has been associated with numerous health benefits including lower rates of disordered eating, increased eating satisfaction, and improved blood pressure and cholesterol levels (Bacon et al., 2005; Van Dyke & Drinkwater, 2014). In young adults, eating intuitively is associated with lower incidences of disordered eating and increased body trust (Denny et al., 2013). This mindful and gentle approach to eating is also connected with the final principle.

The fifth and final tenet, Life-Enhancing Movement, also known as intuitive movement, encourages physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose (*ASDAH: Trademark Guidelines*, 2003). As it is now conceptualized, intuitive exercise and dysfunctional exercise are opposite ends of the same continuum (Calogero & Pedrotty-Stump, 2010; Hartman McGilley, 2014). It has been well-documented that dysfunctional or compulsive exercising has detrimental impacts on physical and mental health and is a common behavior for individuals with eating disorders (Calogero & Pedrotty-Stump, 2010; Meyer & Taranis, 2011; Naylor et al., 2011). Dysfunctional exercising has four qualities: driven quality of the exercise (e.g. exercising regardless of injury), the exercise occurs in a ritualized and/or rigid fashion (e.g. exercising at the same time and in the same way everyday), with the main reason for exercising being to delayed intervention body

weight and/or shape, and the function of the exercise is to avoid or soothe dysregulated emotion (e.g. exercising to avoid feeling guilty for not exercising) (Hartman McGilley, 2014). On the other end of the spectrum, intuitive exercise then is a flexible (e.g. if one is injured one chooses to rest instead of exercise, exercise can occur on a variable schedule) practice that is pursued for health and enjoyment reasons (e.g. dancing because it is fun, practicing yoga because of its mental and physical health benefits) rather than to delayed intervention body size or to avoid negative emotions.

The literature on intuitive movement or exercise, is a relatively new area of scholarship, but preliminary studies suggest that this type of movement is essential for eating disorder recovery and an increased connection to one's body (Reel & Miyairi, 2012; Reel et al., 2016). This represents a radical shift of exercising for external reasons (e.g. to control weight, to follow an exercise program) and relocates it to internal motivations or simply exercising because it feels good to move one's body in certain ways.

HAES Application in Practice

Given HAES's broad tenets, it is able to be applied in a variety of settings. HAES is an interdisciplinary theory at its core, as it was created from the input and work of nutrition, medical, fitness, and mental health professionals, as well as fat folks themselves (Altman Bruno, 2013). The intuitive eating and movement components of HAES have been applied in dietetic practice, primarily in group settings teaching clients the HAES tenets and how to engage in intuitive eating/exercising along with body acceptance (Bacon et al., 2002; Bacon et al., 2005). Results of this work have been positive, with clients who learn to practice intuitive eating/movement engaging in less cognitive restraint related to eating (restricted eating) and an improvement in cholesterol and blood pressure, even 6 months post intervention (Bacon et al.,

2005). In broader multidisciplinary settings (e.g. community health centers) HAES interventions have also been applied. Studies in the United States, Canada, and Brazil have implemented HAES programs at community health centers, typically consisting of group workshops that teach intuitive exercise and eating as well as body acceptance, with positive results including decreased incidence of disordered eating, increased self-esteem, improved physical capacity (related to ability to engage in exercise/muscle strength), improved body image, and an improvement in cardiometabolic health (measured by blood pressure and cholesterol) (Bégin et al., 2019; Carbonneau et al., 2017; Dimitrov Ulian et al., 2018; Leblanc et al., 2012; Mensinger et al., 2016; Provencher et al., 2009). Clearly, the use of HAES in interdisciplinary settings has shown to have many positive outcomes for individuals.

Unfortunately, in the realm of mental health and counseling, there is significantly less research on training clinicians to apply HAES. Typically in the application of HAES, mental health professionals work with clients on how to increase their body acceptance (tenet 1 of HAES), how to cope with stressors, and to increase skills such as mindfulness which are key to engaging in intuitive eating/exercising (tenets 4 and 5; Bacon, 2010). In the counseling literature, there has been conceptual discussion of HAES, encouraging counselors to recognize their own implicit and explicit weight biases and to challenge these biases, to conceptualize clients from a HAES lens (viewing larger body size as an oppressed identity) and to work with clients on body acceptance (Kinavey & Cool, 2019; Warchal & West, 2013). In encouraging providers to examine and challenge their own biases related to body size, to advocate for the equitable treatment of fat clients, and to work with clients to be able to do the same, the use of HAES also aligns with the counseling profession's commitment to multicultural competence (Erickson Cornish et al., 2010).

It is important to acknowledge some of the limitations of how HAES has been generally applied. The first is that, almost every study of HAES interventions has been conducted on clients who identify as women, particularly White, cisgender, heterosexual women who are middle class (Bacon et al., 2005; Bégin et al., 2019; Dimitrov Ulian et al., 2018; Leblanc et al., 2012; Mensinger et al., 2016; Provencher et al., 2009). This means that there is scant research on how effective HAES can be applied to diverse populations and what, if any, modifications need to be considered in its use. Another limitation of the current application of HAES is that it has primarily been conducted in group settings for long periods of time (e.g. 6-7 months) (Bégin et al., 2019; Dimitrov Ulian et al., 2018; Provencher et al., 2009). Because of this modality and time frame, it is difficult to assess the effectiveness of HAES in short term individual sessions (e.g. a 50 minute therapy session, a 15 minute visit with a medical provider). Lastly, the current application of HAES has not explicitly incorporated a social justice/advocacy approach. To date, there is no empirical study on HAES application that teaches patients/participants/clients about weight discrimination and teaches advocacy skills in how individuals experiencing size oppression can work to end it by dismantling weightist structures in society. While there is still much scholarship needed to further examine the efficacy for HAES with clients, there is also research needed to examine the HAES training of mental health providers themselves. Since clinicians are the ones to support clients in their use of HAES, it follows that scholarly attention needs to be directed towards providers' process examining and challenging their own weight biases to provide competent care and HAES training to ensure fidelity in its implementation.

Pros & Cons of HAES in Counseling

Although research on the use of HAES in counseling is relatively new, there do appear to be benefits to utilizing a HAES approach in counseling. The first is that it helps clients achieve a

greater level of wellness. As previously mentioned, when individuals learn and self-apply HAES principles, it is associated with increases in self-esteem, body appreciation, lower rates of mental health concerns including disordered eating, improved sexual functioning and pleasure, and an increase in engaging in positive health behaviors such as intuitive eating and exercising (Bacon et al., 2005; Cox et al., 2019; Kim et al., 2019; Satinsky et al., 2012; Schwartz et al., 2006). The second benefit using a HAES approach in counseling is that it is in line with the ethics of our profession. The Multicultural and Social Justice Counseling Competencies (MSJCC) mandate counselors to have awareness of our privileged and marginalized identities and how the privileged and marginalized identities of our clients impact them (Ratts et al., 2015a). Also, the American Counseling Association (ACA, 2014) code of ethics mandates counselors to consider multicultural/identity concerns throughout their work with clients, to engage in advocacy with and for clients, to do no harm to clients (nonmaleficence), and to do good for clients (beneficence). Given that HAES conceptualizes large body size as a marginalized identity, using HAES directly aligns with our profession's ethical codes and, I would argue, that not using a HAES perspective with clients is doing harm to clients by engaging in counseling that is complicit in continuing weight oppression.

There are also some areas of caution when using a HAES approach in counseling. The first, as previously mentioned, is that there is not a large empirical backing of HAES use in counseling, particularly in individual counseling and particularly not in using HAES with diverse populations. This presents two sub problems: (1) lack of evidence equals difficulty with insurance payments and (2) it is unclear if HAES is effective for individuals other than White, cisgender, heterosexual, middle class women. The second challenge in utilizing HAES in counseling is that it is easy to apply HAES incorrectly in a way that could potentially do harm to

clients. Even studies on the efficacy of HAES have measured successful outcomes in terms of weight loss (which the theory does not use at all as a metric of health), and has often been misunderstood as being an anti-healthy behaviors approach (e.g. people wrongfully believe that HAES is against eating nutritious foods and exercising) (Bondy et al., 2019; Dimitrov Ulian et al., 2018; Gaesser, 2006; Penney & Kirk, 2015). Encouraging active weight loss in clients, not acknowledging/using the social justice component of HAES, and applying HAES incorrectly can lead to negative and harmful outcomes (Bacon, 2010; Bacon & Aphramor, 2011). A third critique of HAES is that it still has oppressive components. Critical scholars have criticized HAES for its healthist tendencies, basically the premise that it is ‘good’ for one to work on the self and that we should engage in certain efforts to constantly improve or maintain our health, because this is a privileged and narrow view of holistic wellbeing (Brady et al., 2013; Welsh, 2011). This is particularly true of intuitive eating principles, which often do not take into account the environment (e.g. how can one eat a specific food their body is craving if they do not have access to any food?). However, if a counselor is knowledgeable about the application of HAES and takes into account intersecting client identities, tailoring the approach to each individual client, I believe that it is an appropriate and effective approach to use. This potential for harm underscores the need for clinicians to receive training in the HAES framework so that they can properly implement it both on a personal level by challenging their implicit and explicit weight biases and on a clinical level in session with clients.

HAES & Weight Stigma Trainings for Mental Health Practitioners

There have been only a few attempts to address weight stigma in training, from a non-HAES-aligned perspective, into mental health training programs (Cravens et al., 2016b; Lawrence et al., 2012). Lawrence et al. (2012) created set of guidelines to address weight bias

for master's of social work (MSW) trainees which covered content such as health, stigma, and cultural competence and specific examples of how this content can be integrated into their training sequence (e.g., videos of the impact the media's focus on thinness on weight bias). Another important component of this training is to increase trainees' awareness of their own weight biases while also teaching them how to work with clients to lose weight (Lawrence et al., 2012). This sequence was meant to infuse weight bias and working with clients of size throughout the entire training sequence of MSW trainees and across multiple areas of coursework/classes from micro level interventions (e.g. helping clients build self-acceptance) to policy level interventions (e.g. advocating and writing to legislators to provide protective laws for fat individuals) (Lawrence et al., 2012). While this training provides an important first step in starting the conversation around addressing weight bias in mental health training programs, it is important to note, however, that this training is conceptual in nature and has not yet been empirically tested to see if it actually increases efficacy at working with clients of size or in decreasing weight bias in trainees. Another critique of this study is that it still conceptualizes "obesity" as a problem to be solved and advocates for trainees to learn cognitive behavioral strategies for weight delayed intervention, a strategy that, as discussed previously in this chapter, is wholly ineffective in the long-term.

Building upon the conceptual work of Lawrence (2012), Cravens et al., (2016) developed a training program for MFT trainees with the intent of increasing trainee self-awareness in regards to weight bias. The training was comprised of five experiential activities which exposed trainees to diverse issues related to working with overweight clients: (1) write a privilege and oppression narrative based on body size, (2) examine the dominant themes in the media related to what bodies are considered desirable, (3) the application of biological, psychological, ethical,

and social considerations to a clinical vignette, (4) discussing one's own understanding of weight bias, and (5) clinical setting considerations (e.g., how might physical office settings such as lack of accessible seating impact clients of size?). In addition to the experiential activities, a Weight Bias Questionnaire (adapted from Puhl & Brownell, 2007) was included to help trainees evaluate their own biases on issues of body size and weight, for a training that took a total of 1-2 hours to complete (Cravens et al., 2016b). In their pilot study of this training, in which trainees provided feedback via focus groups, Cravens and colleagues (2016) found that the training was met with a positive reception. Themes from the trainee feedback included a strong sentiment that this type of training should occur at some point in training before one graduates, and that all of the activities were useful in increasing their self-awareness about weight bias (Cravens et al., 2016). In terms of areas of improvement, participants identified a desire for content that was more in-depth and more specifics on how to apply this knowledge to a clinical setting, that is, how to transfer that self-awareness into working with clients of size (Cravens et al., 2016). It is important to note that this training, while it did address issues related to the oppression of fat bodies and gaining awareness of how weight bias impacts clinical care, was not grounded in the HAES philosophy of body acceptance, as an important component of the training was to teach students how to support clients in losing weight and making weight loss the focus of therapy, again a practice that is not beneficial for clients in the long-term. Because of the lack of emphasis on pursuing health without pursuing weight loss and the pathologization of fat bodies component of a HAES-informed training, this training is still perpetuating the harmful idea that fat bodies are inherently bad and should be changed. While the initial findings from the focus groups of this pilot study are promising in terms of increasing self-awareness of weight bias, this training has not been tested for practical efficacy, statistical significance, or used to examine changes to

implicit and explicit weight bias, so further research is needed to test if the training actually decreases different types of weight bias.

To date, there is no HAES-aligned weight stigma training published that is specifically for mental health professionals, but there is a HAES curriculum that was developed as a joint venture by the Association for Size Diversity and Health (ASDAH), the National Association for the Advancement of Fat Acceptance (NAAFA) and the Society for Nutrition Education and Behavior (SNEB). This curriculum is designed for use in higher education including, but not limited to introductory and advanced health and nutrition courses and professional training programs (*HAES® Curriculum*, n.d.). The curriculum consists of three PowerPoint modules: (1.) Overview of HAES, (2.) Developing a Healthy Relationship with Food and Exercise, and (3.) Size Acceptance (*HAES® Curriculum*, n.d.). The specific learning outcomes for each module can be observed in Appendix A. Each of the modules is intended to take 50 minutes to an hour, with the entire series taking around 3 hours to complete in total (*HAES® Curriculum*, n.d.). This training series appears to be effective at educating about the HAES paradigm and decreasing weight bias. In a study of dietitians-in-training conducted by Rosalez (2014), participation in all three modules decreased explicit antifat attitudes. In their study of an extended semester-long adaptation of the ASDAH HAES-grounded curriculum for college students enrolled in a health class, Humphrey et al., (2015) found that explicit antifat attitudes decreased from pre- to post-intervention and that the decrease in explicit weight bias was significantly greater for the intervention (HAES curriculum) group as opposed to the delayed intervention group who did not receive the curriculum. Lastly, utilizing an adaptation of the HAES training for dietitians in training which added components of how to use HAES in dietetic practice specifically, Brown (2009) found that participation in the three hour training helped increase efficacy and

comfortability using a HAES approach to dietetic practice . There have yet to be any studies on if or how this (or an adapted version of this) HAES training is effective with mental health trainees or practitioners. Just as the ASDAH HAES curriculum has been adapted to meet the needs of dietitians (Rosalez, 2014; Brown, 2009) and the general population of college students (Humphrey et al., 2015), it is important to have a HAES training that incorporates some specifics to mental health practitioners such as utilizing counseling skills such as broaching to initiate discussions of body size, to discuss how body size can be utilized in case conceptualizations, and how the concept of body acceptance can be integrated into the treatment of eating disorders. It is time to put the pieces together and test how a HAES-aligned weight stigma training (and not merely a generic weight stigma training as previously conducted) impacts CITs' weight biases.

Multicultural Competence

Multiculturalism is considered the fourth wave of psychology, and since the 1980's has cemented its importance as one of the primary pillars of the counseling profession (Arredondo et al., 1996; Ratts, 2009; Ratts et al., 2016; Sue et al., 1992). Multicultural competence is described as possessing the necessary skills to work effectively with clients from various cultural and/or ethnic backgrounds (Holcomb-McCoy & Myers, 1999). Initially, multicultural competence referred to the ability to integrate awareness, knowledge, and skills of working with the five main cultural groups in the United States: Black/African Americans, Asian individuals, White/Europeans, Hispanic/Latino individuals, and Native Americans (Arredondo et al., 1996). Sue and Sue's (2008) tripartite model of multicultural competence consists of awareness, knowledge, and skills. Awareness is the counselor's ability to recognize and name their own worldview and biases, thus enabling them to understand how their own worldview influences the counseling process, and have an increased comfortability and respect in working with clients

whose culture is different from theirs (Sue, Arredondo, & McDavis, 1992a, 1992b). When a counselor has multicultural knowledge, this allows them to understand cultural norms and values that impact the counseling process, relationship, and presenting concerns of clients (Barden et al., 2017; Sue et al., 1992). Multicultural skills in counseling practice are demonstrated by counselors being able to form a productive working alliance with clients of different cultural backgrounds and to use interventions that are a good fit with the client's culture and presenting concerns.

However, in line with the shift towards a stronger advocacy approach to counseling work, Ratts et al. (2015) created the Multicultural and Social Justice Counseling Competencies (MSJCC), which conceptualizes multicultural competence as a developmental approach that begins with counselor self-awareness and progresses towards action and advocacy work (Ramírez Stege et al., 2017; Ratts et al., 2016). The MSJCC framework is organized as four quadrants which reflect different combinations of privileged and oppressed identities of clients and counselors. Within each quadrant are four developmental domains (i.e., counselor self-awareness, client worldview, counseling relationship), and six levels of counseling and advocacy interventions. The first three domains of the MSJCC outline competencies in the original three areas of competence outlined by Sue et al. (1992) (i.e., attitudes and beliefs, knowledge, and skills) but expand on these to include the advocacy and action piece. The MSJCC also expanded the definition of culture, moving away from solely focusing on racial differences to include the intersections of different privileged and marginalized identities (e.g., gender, sexuality, ability status) (Ratts et al., 2016). This framework of multicultural competence highlights how counselors must first develop self-awareness of their own cultural and potential

biases before they can move on to implementing skills or advocacy interventions for marginalized clients.

The importance of this updated view of multicultural competence is not only codified in the MSJCC, but also in the American Counseling Association's (ACA) Code of Ethics (2014) which calls counselors to understand and appreciate the cultural differences and values of clients, as well as incorporate an active social justice and advocacy lens to counseling work. Our profession's commitment to multicultural competence is also visible in the training and accreditation standards for counseling programs. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards explicitly require that the counselor education curriculum include training on social and cultural diversity, the impact of attitudes and beliefs, power, and privilege impact clients from diverse identities and how to work with clients of differing cultural identities (Section 2, F.2.a-h).

Multicultural competence is associated with a number of positive outcomes. A high degree of counselor multicultural competence is related to many positive therapeutic outcomes including increased satisfaction and disclosures for clients with marginalized identities in counseling and decreased early termination of the counseling relationship (Constantine, 2007; Hook et al., 2013; Kim et al., 2019; Owen et al., 2011). When clients perceive their counselors as being more multiculturally competent (e.g. counselors do not say microaggressive statements to clients), this is associated with a stronger therapeutic working alliance and a greater decrease in client symptomatology (Hook et al., 2013; Lee, 2011; Tao et al., 2015). Counselors who have moderate to high levels of multicultural competence also tend to have greater counselor self-efficacy (Barden et al., 2017), racial identity development, and confidence in working with marginalized clients (Chao, 2012). It is however, important to note that counselors and trainees

tend to overestimate their amount of multicultural competence as compared to what is perceived by their clients (Soto et al., 2018). Taken in sum, multicultural competence is an important factor for positive clinical outcomes, yet can be easy to overestimate. As previously discussed, HAES advocates argue that larger body size is a marginalized identity, particularly given the rampant negative effects of weight discrimination (Brown & Saltus, 2015). Since the counseling profession places great importance on multicultural competence, including the awareness of one's biases and the impact they may have on clients, particularly those with marginalized identities, teaching counseling students about the impact of sizeism feels like a natural and necessary component of counselor education.

Weight Bias & Multicultural Competence in Counselor Education

In counselor education, there are many opportunities for students to increase their multicultural competence. Some of these opportunities which have been associated with increases in multicultural competence include: specific culturally based learning activities, multicultural immersion projects, diversity workshops, and graduate coursework (Barden et al., 2014; Collins et al., 2015; Gillem et al., 2016). Much of the scholarship of increasing multicultural competence in CITs focuses on developing self-awareness and knowledge, which are developmentally appropriate goals for CITs when conceptualized through the MSJCC framework. Given the emphasis the counseling profession places on multicultural competence, including the awareness of one's biases and the impact they may have on clients, particularly those with marginalized identities, teaching counseling students about the impact of sizeism feels like a natural and necessary component of counselor education.

Unfortunately, this is not the current state of affairs. Discussion of sizeism in counselor education is woefully an understudied area of scholarship. To date, the only study which

explicitly examines sizeism training in mental health practitioner training was a qualitative study conducted by Pratt et al. (2014) who found that MFT trainees reported feeling that they had received inadequate training to work with clients of size, with many participants reporting that they had never discussed the topic in any of their classes. In a follow up qualitative study Pratt et al. (2016) study found that MFT trainees, despite having general multicultural coursework (not coursework specific to sizeism), still reported high levels of explicit weight (Pratt et al., 2016). These findings suggest that weight bias should be a more explicitly discussed topic in training and that multicultural coursework alone may not be enough to decrease weight bias. While sizeism, given its status as a form of oppression, would be a natural fit for inclusion within multicultural counseling classes and textbooks, Kasardo (2015; 2018) found that of the 29 mental health training textbooks published since 2000, only 1 discussed sizeism and the rest either made no mention of it or spoke of body size in a pathologizing way (e.g. that fat bodies must be changed via weight loss). This finding, along with the lack of research on counselors in training specifically, again, highlights the need for explicit inclusion of weight bias training in the counselor education curriculum.

While there have been a few researchers who examined and advocated for training around weight bias in mental health training more generally (e.g., Pratt et al., 2016), there have also been several calls for sizeism to be taught from a HAES-aligned perspective in multicultural counseling training alongside topics such as racism and sexism and anecdotal use of sizeism training for students studying to be mental health practitioners (Bergen & Mollen, 2019; McHugh & Chrisler, 2019; Rothblum & Gartrell, 2019). The calls, all from the 2019 edition of *Women & Therapy's* special issue which focused on weight stigma, collectively advocate that weight stigma should be taught from a social justice informed HAES perspective (as opposed to

the traditional medicalized view that equates body size with health), by incorporating discussions of the lived experiences of fat people, advocating for social justice for fat rights, and providing information about the detrimental impact of diet culture (Bergen & Mollen, 2019; McHugh & Chrisler, 2019; Rothblum & Gartrell, 2019). These researchers, who are also counselor educators, anecdotally report that they use these strategies in their classrooms which seem to be helpful in increasing student awareness of weight biases they may hold and increase student confidence in working with clients of size (Bergen & Mollen, 2019; R. M. Calogero et al., 2019; Rothblum & Gartrell, 2019). However, these strategies have yet to be empirically tested for efficacy, which is a much needed next step in arguing for the inclusion of a new approach to discussing weight bias in counseling and counselor education.

Putting the Pieces Together

While there has yet to be a study which tests the effectiveness of a HAES-aligned weight stigma training for CITs, the separate parts of this intervention have shown promising results. As previously discussed in this chapter participation in a HAES-aligned training has been documented as helping decrease explicit weight bias in college students and nutrition professionals (Humphrey et al., 2015; Rosalez et al., 2015). While implicit weight bias has been documented in CITs, there have not been any studies which examine interventions to decrease implicit weight bias with this population. Discrete training interventions about weight bias do appear to decrease explicit weight bias across different contexts (e.g. obstetric nurses, physicians, college students) it also appears that they are unsuccessful in shifting implicit weight bias (Breithaupt et al., 2020; Burke, 2019). The first reason for this lack of change is that it could be that, since these trainings were not grounded in a HAES perspective, that is they still pathologized fat bodies, the training material could actually be further entrenching weight stigma

and therefore reinforcing implicit weight biases due to its conflicting messaging (i.e. do not stigmatize larger bodies but also prioritize changing larger bodies because they are inherently unhealthy). The second reason is that implicit biases in general are notoriously difficult to change quickly, mostly due to their unconscious nature, their difficulty to access, and how they can be misaligned with one's explicitly stated values and beliefs (De Houwer, 2019; Greenwald et al., 1998). This is where training in multicultural competence offers an important opportunity. As previously discussed, the current view of multicultural competence conceptualizes it as developmental process which begins with self-awareness to recognize one's own biases and culture then integrates knowledge and skills to manage these biases to work with individuals who are culturally different (Gonzalez et al., 2018; Holcomb-McCoy & Myers, 1999; Vuletich & Payne, 2019). In one study conducted by Castillo et al. (2007) CITs who had taken a semester-long multicultural competence course experienced significantly decreased implicit racial bias. While it has been documented that CITs can simultaneously score highly in multicultural competence and have high levels of implicit bias against marginalized groups (Boysen & Vogel, 2008), interventions which include taking implicit measures to raise implicit bias awareness combined with time for reflection have actually been shown to decrease implicit biases (van Ryn et al., 2015; Vuletich & Payne, 2019). This finding suggests that a training that implements an assessment of implicit bias could help to shift implicit bias.

As I have argued throughout chapters I and II, weight bias is a problem to be addressed within counselor education and training counselors about weight stigma from a HAES perspective is the most competent way to do this. This brings us to the purpose of the present study, which is to examine how a HAES-informed training on sizeism will impact the amount of change counseling trainees' levels of implicit and explicit weight bias, and how multicultural

competence is related to any change in implicit and explicit weight bias. In the next chapter, the methodology and design of the study will be presented, with subsequent chapters detailing the findings of the study and their implications for counseling and counselor education.

CHAPTER III: METHODOLOGY

The rationale and need for the study presented in Chapter I and II, argues for the importance of utilizing a HAES-aligned approach to teach counselors-in-training about working with clients with larger sized bodies as a way to decrease both their implicit and explicit weight biases which are harmful to them. The study outlined here is examination of the impact of a HAES training session on counseling Master's students, on counselors-in-trainings' levels of implicit weight bias, explicit weight bias, HAES competency, and how their level of multicultural competency impacts change in biases. This chapter will include a detailed description of the methodology for the study, including research questions and hypotheses, participants, intervention development, instruments, procedures, and planned statistical analyses.

Research Questions and Hypotheses

The present study examined the following questions:

Research Question I: What is the impact of participation in a HAES-aligned weight stigma training on implicit weight bias from pre to post-test among Master's counseling students?

Hypothesis I: Participation in the training will result in a significant decrease in implicit weight bias.

Research Question II: What is the impact of participation in a HAES-aligned weight stigma training on explicit weight bias from pre to post test among Master's counseling students?

Hypothesis II: Participation in the training will result in significant decrease in explicit weight bias.

Research Question III: How does HAES-aligned training impact the change in implicit weight bias from pre to post-test compared to participants in the delayed intervention group?

Hypothesis IIIa: Participants in the HAES-aligned training intervention group will have a decrease in implicit weight bias above and beyond that of the delayed intervention group.

Research Question IV: How does HAES-aligned training impact the change in explicit weight bias from pre to post-test compared to participants in the delayed intervention group?

Hypothesis IVa: Participants in the intervention group will have a decrease in explicit weight bias above and beyond that of the delayed intervention group.

Research Question V: How does HAES-aligned training impact HAES practice competency?

Hypothesis V: Participation in HAES-aligned training will increase HAES practice competency.

Research Question VI: What is the impact of MCC on change in implicit and explicit bias?

Methodology

The present study utilized a quantitative two-group switched replication quasi experimental design. This is an appropriate design given several considerations. The first is that due to practical limitations, it was not possible to randomly assign counseling students in the same program to different conditions, particularly since the program studied has a cohort model, in which students take the same classes at the same time. However, given the importance of the training's content, the crossover design still allowed both treatment and delayed intervention groups to receive the training while still providing delayed intervention comparison to determine the stability of change. The second is that collecting multiple time points of data pre and post training allowed for multiple points of comparison to be demonstrated by comparing to the post-intervention results, allowing for within group comparisons, and minimizing error in the study, while also allowing comparison with the delayed intervention group (Heppner et al., 1992). Given that the study was an intervention study, the design allowed the researcher to

evaluate the impact of the intervention in its natural setting, the counselor education classroom, which helped to increase the study's external validity.

Participants

Convenience sampling was used to obtain the target sample for the present study. The target sample was counseling Master's students enrolled at one full-time, CACREP accredited counseling program in the United States (note that the participants could be from other countries, but must be attending a US-based program). For the purposes of this study, students could be either first or second year Master's students. Participants had to be 18 years of age or older. Student track (e.g., Clinical Mental Health, School Counseling) was not an exclusion criterion. According to G*Power a priori power analysis, to achieve a statistical power of 0.80 with a moderate effect size at the .05 level of significance with two measurements, a total of 34 participants was needed for the most robust analysis used within this study. A moderate effect size is appropriate given that studies that use the IAT in a pre-post intervention task to change bias typically yield a moderate effect size of bias change, particularly with student populations (Forscher et al., 2019).

Intervention

The intervention presented was a HAES-informed training for counselors-in-training (CITs) on weight stigma (see Appendix B). Given the amount of material to be covered, and in line with previous studies of the efficacy of HAES trainings for graduate students (Cravens et al., 2016; Rosalez, 2014), the training was three hours long. The purpose of the training was to increase CITs' awareness of the negative consequences of weight stigma, to increase CITs' knowledge of how their own weight bias may impact the therapeutic relationship with clients of size, and to introduce the HAES framework as an approach to combating weight stigma in

counseling. The training draws from the ASDAH HAES curriculum (utilized by Rosalez (2014) and Brown, 2009)), the experiential activities of Pratt and Cravens (2014) for increasing awareness for working with higher weight clients, the training competencies outlined by Abakoui and Simmons, (2010), and original content from the researcher based off of clinical experience working with higher weight clients. During the training, students were provided with opportunities for internal reflections, knowledge and examples about weight stigma and discrimination, the impact of weight stigma on higher weight individuals. The training began with a free association activity to the words “fat/overweight/obese” modified from Pratt and Cravens’ (2014). Then, the training provided information regarding definitions and origins of weight stigma and discrimination and its negative impact on higher weight individuals both generally and in the context of the therapeutic relationship, current HAES-aligned terminology to utilize when working with fat clients (e.g. using clients of size or larger bodied clients as opposed to “overweight” or “obese” clients) and potential microaggressions for counselors to avoid in terms of language. The training also introduced the HAES paradigm for counseling practice and other resources to grow in competency in working with fat clients.

Instruments

Weight Attitudes Implicit Associations Test (IAT): To assess implicit weight bias, the Weight Attitudes Implicit Associations Test (IAT) was utilized (Greenwald et al., 1998). The Weight Attitudes IAT is a widely used measure which assesses implicit social cognitions. It does this by assessing the association between constructs such as body size (thin vs. fat) and an evaluation (bad vs. good) (Greenwald et al., 1998). In the online version, which was utilized for the present study, participants are shown images of fat or thin people and are asked to rapidly sort and pair these images with words (e.g. “nasty,” “failure,” “pleasure,” “happy”) as they

appear on a computer screen (see Appendix C for images and words). The response time for each pairing is recorded. The Weight Attitudes IAT posits that constructs that are strongly associated for the participant (e.g. thin silhouette and the word “happy”) will be paired more quickly than concepts with a less strongly associated for the participant (e.g. fat silhouette and the word “pleasure”) (Cunningham et al., 2001). Consistent with prior research (Carels et al., 2010; Teachman & Brownell, 2001), implicit bias scores were calculated by subtracting the number of correct responses in the mismatched condition from correct responses in the matched condition. For the IAT, “mismatched” refers to word-image pairings that do not follow the directions of the task (e.g. if the directions state to pair only good words with larger body silhouettes but the respondent pairs the word “disgusting” with a larger body silhouette instead). “Matched” pairs refer to responding correctly to the directions of the task (e.g. the directions state to pair only good words with larger body silhouettes and the respondent pairs the word “happy” with a larger body silhouette). The IAT achieves good validity, similar to those of the race and gender versions of the IAT (Greenwald et al., 1998). It also is modestly correlated with explicit measures of weight bias (Gapinski et al., 2006; Teachman et al., 2003). The Weight Attitudes IAT also demonstrates predictive validity in predicting prejudiced behaviors towards higher weight individuals (Bessenoff & Sherman, 2000). The observed reliability of the measure for the present study was Cronbach’s $\alpha=.803$.

The Multicultural Awareness, Knowledge, and Skills Survey-Counselor

Edition-Revised (MAKSS-CE-R): To assess multicultural competence, the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) was used (Kim et al., 2003)). The MAKSS-CE-R identifies competencies in three domains for working with diverse populations: awareness, skills and knowledge. This 33 item scale is measured on a 4-point Likert-type scale

ranging from very limited/strongly disagree (1) to very good/strongly agree (4). Sample items from each of the MAKSS-CE-R subscales include: "In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that white mainstream clients receive" (awareness item), "At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?" (knowledge item), "How would you rate your ability to effectively secure information and resources to better serve culturally different clients?" (skills item)(Kim et al., 2003). This inventory can be broken into three subscales, but the present study only utilized the total score in the final analysis. The total score is calculated by summing all items, with items 1, 2, 3, 4, 6, 8, and 9 reverse scored. Higher scores indicate higher multicultural competence. The researcher will add one item to the MAKSS-CE-R skills subscale: "How would you rate your ability to accurately assess the mental health needs of higher weight individuals?" to examine multicultural competence specific to higher weight individuals particularly. This adaptation is in line with other questions on the MAKSS-CE-R skills subscale which ask about ability to work with other marginalized identity groups (e.g. women, gay men). The MAKSS-CE-R is a revised version of the original Multicultural Awareness, Knowledge, and Skills Survey-Counselor Edition(MAKSS-CE; D'andrea et al., 1991) which was a 60 item scale. The revised version was used for this study due to its decreased item amount which increased ease of use and its improved reliability with the Awareness-R scale $\alpha = .80$, Knowledge-R scale $\alpha = .87$, Skills-R scale $\alpha = .85$ and the entire scale having an $\alpha = .81$ which are either comparable or greater alphas than were observed in the original version (D'andrea et al., 1991; Kim et al., 2003). Content validity of the items have been demonstrated by their significant positive correlation with items of other measures of multicultural competence including the Multicultural

Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002) and the Multicultural Counseling Inventory (MCI; Sadowsky et al., 1994; Kim et al., 2003). The items on the MAKSS-CE-R also demonstrate discriminant validity in that they do not significantly correlate with self-esteem as measured by the Rosenberg Self-Esteem Inventory (RSEI; Rosenberg, 1965; Kim et al., 2003). Discriminant validity of the items has been further demonstrated by the items not correlating with social desirability as measured by Strahan and Gerbasi's (1972) Social Desirability Scale-XX (Kim et al., 2003). For the present study, the Cronbach's alpha was .838, which is consistent with prior studies (e.g. Kim et al., 2003).

Antifat Attitudes Questionnaire-Revised (AFA-R): To assess explicit weight bias, the revised version of the Antifat Attitudes Questionnaire was utilized (Quinn & Crocker, 1999). The AFA assesses three dimensions of explicit weight bias: prejudice towards fat people (Dislike), belief in the controllability of one's body weight/size (Willpower), and the fear of oneself being fat (Fear of Fat). This twenty-one item scale is measured on a 9-point Likert-type scale ranging from *very strongly disagree* (0) to *very strongly agree* (9). Sample items from the three dimensions include "I really don't like fat people that much" (Dislike); "I feel disgusted with myself when I gain weight" (Fear of Fat); "Some people are fat because they have no willpower" (Willpower) (Crandall, 1994). The total score is calculated by summing all items, with higher scores indicating higher antifat attitudes. While scores can be calculated for each of the dimensions, the researcher utilized only the total score in the analyses. The AFA is moderately positively correlated with implicit weight bias as measured by the Weight Attitudes IAT as well as weight discrimination in hiring practices (O'Brien et al., 2008). Quinn and Crocker (1999) updated the AFA by adding three items to the Dislike dimension and five items to the Willpower dimension. This revised version of the AFA had an increased internal consistency of alpha = .89

for the Dislike dimension, a .08 increase from the original version, and a increased internal consistency of $\alpha=.84$, a 0.12 increase from the original version (Crandall, 1994; Quinn & Crocker, 1999). For the complete measure that was used, please refer to Appendix D. Due to the substantial increase in internal consistency provided by the extra items Quinn and Crocker (1999) added to the AFA, the researcher utilized this revised version. In the present study, the observed Cronbach's alpha was .911.

Counselor HAES Competence Scale (C-HAES-CS): To assess HAES competence, a new scale developed for the purposes of this study entitled the Counselor HAES Competence Scale was utilized. This scale was developed using Abakoui & Simmons' (2010) competencies for working with higher weight clients from a HAES perspective which are also broken into values and attitudes, knowledge, and skills. These competencies were developed in line with other more general multicultural competencies in our field combined with HAES-specific information and practice (Abakoui & Simmons, 2010). Items from the scale were selected from each of the areas (values and attitudes, knowledge, and skills) to provide items that were representative of each of the competency areas. The C-HAES-CS is a 15 item scale that assesses counselors' HAES competence in three areas: Knowledge, Skills, and Values & Attitudes. Items are measured on a 4 point Likert-type scale ranging from *disagree* (1) to *agree*(4). Sample items include "I understand the research on the relationship between weight and health" (Knowledge item); "I can build a therapeutic relationship that is trusting, safe, and affirming to discuss issues related to body size" (Skills item); and "I work to challenge my biases I have related to body size" (Values & Attitudes item). The final score is calculated by summing all items, with higher scores indicating higher counselor HAES competence. Item 2 "Weight loss is a good goal for counseling" is reverse scored. The observed Cronbach's alpha for the present study was .654.

Training Feedback Questions: To gain information about participants' views of the training itself and any areas of improvement, the researcher used a combination of scaled Likert-type questions and open-ended questions. Five scaled questions ranging from *strongly disagree* (1) to *strongly agree* (5) will be utilized (e.g. "Participating in this training helped me to increase my knowledge of weight stigma and its impact on higher weight individuals"). There were also 3 open ended questions for participants to provide additional feedback on their experience of the training (e.g. "What, if any, parts of the training were unclear or confusing?").

Demographics: Participants were asked to provide demographic information including: year in the program (1st or 2nd year), track in the counseling program (i.e., Clinical Mental Health, School Counseling, Couple and Family Counseling), gender identity, age, race, ethnicity, and country of origin. Please refer to Appendix G for the specific list of questions that were used.

Procedures

Convenience sampling was used to recruit participants from the Master's counseling program at the researcher's current institution. At the start of the spring semester, the researcher first implemented the intervention in the Diagnosis class, referred to as the treatment group in this study design, a class that was composed of both first and second year students. At the start of the training, all participants took the measures, but students could elect whether or not they wanted to consent to having their data be utilized for research. Once students agreed to participate, they were assigned a de-identified ID number using some demographic information provided so that their pre and post test scores could be kept together without identifying the student. All participation was voluntary and anonymous, as students would only input their unidentifiable demographic information and not their name. The order that participants completed the measures was randomized to delayed intervention for order effects. The intervention, a three

hour training which describes the negative impact of weight stigma and diet culture, as well as HAES tenets and practice was implemented as one class session. One week following the intervention, the researcher sent the second survey with the posttest measures of the AFA-R, Weight Attitudes IAT, the HAES competency scale, and feedback on the training. Two weeks later, participants were asked to take the AFA-R and Weight Attitudes IAT one final time, and were then thanked for their participation in the study.

The delayed intervention group for the study was first and second year students in the Career Counseling class. At the start of the spring semester, the researcher came into the class and invited students to take the pretest measures following their class time in the week prior to when the intervention and pretest measures were given for the treatment group. Those who were interested in participating were sent the pre-test measures via a Qualtrics link. The measures were randomized to delayed intervention for order effects. Then, one week after they took the baseline measures, the researcher returned to the Career Counseling class to have participants take the pretest measures which included the AFA-R, IAT, MAKSS, and C-HAES-CS. Just as with the treatment group, participants in the delayed intervention group were assigned a de-identified ID number to link their pre and posttest scores using some of the questions in the demographics section. After completing the pretest measures at the start of their class, the researcher implemented the 3-hour training intervention in the class. One week after the intervention, participants were asked to take the posttest measures of the AFA-R, IAT, C-HAES-CS, and training feedback. At the completion of the study, participants were thanked for their participation and awarded extra credit in their classes and their monetary incentives for their participation.

Planned Statistical Analyses

To answer research questions I and II, measuring pre- and post- intervention changes in implicit and explicit weight bias for the counselors-in-training in the HAES-aligned intervention, the researcher utilized a repeated measures ANOVA with the pre and post test scores of the Weight Attitudes IAT (Greenwald et al., 1998) and the AFA (Crandall, 1994; Quinn & Crocker, 1999) combined for the treatment and intervention groups. This equates time points 1 and 2 for the treatment group, and times points 2 and 3 for the delayed intervention group. For research questions III and IV, the researcher utilized a repeated measures ANOVA using the scores on the IAT and AFA for both groups at time points 1 and 2 . To test question V, a repeated measures ANOVA was conducted with the pre and post C-HAES-CS scores as the within factor and group status as the between factor. Finally, to test question VI, change scores were calculated for the AFA by subtracting the post test scores from the pre test scores. A correlation analysis was conducted to examine the relationship between explicit weight bias change scores and the score on the MAKSS. Change in implicit weight bias was not able to be determined due to IAT scores ranging from negative to positive, thus making creating a meaningful change score not possible.

The researcher also ran preliminary analyses to explore the impact of demographic factors on implicit weight bias, explicit weight bias, multicultural competence to help determine if these factors need to be controlled for in the subsequent analyses. The only significant differences found, were group status, particularly related to year in the program and as a result group status was delayed interventioned for in the ANOVA analyses by using group as a between factor.

Pilot Study

Given that the intervention training is a new training that has yet to be used before, the purpose of the pilot study was to test the training itself. Specifically, the pilot study sought to answer the following questions:

Research Question 1: What is the resulting length of the intervention?

Research Question 2a: Did the content of the intervention help participants better understand weight stigma and its negative impact on higher weight individuals?

Research Question 2b: Did the content of the intervention help participants be able to identify ways to competently work with clients of size?

Research Question 2c: Did the content of the training help participants better understand the HAES model?

Research Question 3: Does the altered language on the MCC, changing “when working with minority clients,” to “when working with clients with marginalized identities,” encourage participants to think of oppressed identities other than race (i.e. larger body size).

Participants

Convenience sampling was used to obtain the target sample for the present pilot study. While the target sample for the dissertation study is counseling Master’s students, in order to avoid decreasing sample size due to members of the target sample having already completed the training and measures as part of the pilot study, the researcher utilized graduate students in the class *CED 613: Helping Skills for Non-majors*. Students in this class, of which the researcher serves as the instructor, are pursuing graduate degrees in Student Affairs and Higher Education (SAAHE), Sports Psychology, and Social Work, and thus hope to engage in helping relationships as part of their careers. Students in the course have been trained in basic counseling skills as well

as multicultural competence within the CED 613 course, similar to how counselors-in-training are taught at UNCG. For the purposes of the pilot study, a minimum of 2 to 4 participants was needed. However, 36 students ended up participating in the pilot study, with the bulk of participants either being SAAHE or Sports Psychology graduate students.

Intervention

The pilot study intervention consisted of the researcher engaging the participants in the three hour HAES-aligned weight stigma training intervention, as noted above in methodology for the full study. There were three deviations from the aforementioned methodology. The first was that only four items from the MCI were included in the pretest measures so as to provide ample time to discuss the wording changes. The second is that, after the pretest measures were taken, the researcher engaged the participants in a discussion of the wording changes to the MCI. The third was that the case conceptualization activity was not included in the training, due to error on the researcher's part.

Instruments

Items from the MCI: To assess the utility of changing the wording of the MCI from “when working with minority clients” to “when working with clients with marginalized identities” four items, one from each of the four domains, from the MCI with the language change were provided to participants. One item from each domain was utilized to ensure that the language change makes sense across all four of the domains of the MCI. Please refer to Appendix H for the questions with the new language and Appendix I for the open-ended feedback questions on the wording change.

Length of Intervention: To measure the length of time of the intervention, a timer was utilized. It was started as soon as the researcher began the training intervention and was stopped at the end of the concluding activity.

Feedback Questions: To assess the appropriateness of the intervention's content, a combination of scaled responses and open-ended feedback questions was utilized. For a complete list of questions, please refer to Appendix I.

Procedures

Convenience sampling was used to recruit participants for the pilot study. The researcher advertised an extra credit opportunity to the students in CED 613, one of the researcher's courses, for their voluntary participation in the pilot study. The extra credit offered was full credit on 3 discussion posts and 3 quizzes, the equivalent of three hours of work for *CEd 613*. The researcher explained that the pilot study was part of her dissertation and the participants' role was to provide feedback on the intervention training. After participants signed up, the researcher and participants coordinated a 3.5 hour block of time to complete the pilot study intervention. At the time of the intervention, the researcher started with having the participants take the pretest measures, including our items from the MCI and discussed if they thought the language was more inclusive. This occurred as a group discussion, with further probing from the researcher as needed. For the questions the researcher used to guide this conversation, please refer to Appendix H. After this discussion, a timer was started and the researcher provided the intervention training to the participants. After the training, the timer was stopped and participants were asked to provide written feedback via a Google Forms survey on the training.

Data Analysis

In order to answer the first research question, the researcher simply kept track of the time it took to complete the training from start to finish to see if it fit within a 3 hour time frame. To answer the second research question in its , the researcher examined both the verbal and written feedback to the open-ended questions as well as examined the scaled questions. Means and standard deviations of the scaled questions were computed, and general content of the open ended questions was explored. To examine the third research question, the verbal feedback from participants was utilized to inform if the wording change to the MCI helped participants think of working with fat clients and/or if further changes to the wording or of defining marginalized identities was warranted.

Results of Pilot Study

Research Question I: The total resulting time of the training was just under two hours (1 hour 55 minutes to be exact). This time was solely for the training itself and did not include time to take the measures. It also did not include the case conceptualization activity which is estimated by Pratt and Cravens (2014) to take around 30 minutes to complete. The majority of participants in the study also thought that the timing was appropriate ($M=4.5$, $SD=0.81$). This finding suggests that the training is appropriate for the three hour time frame.

Research Question 2a: In response to RQ 2a, 94.4% of participants agreed that the content of the intervention helped them better understand weight stigma and its negative impact on higher weight individual. The remaining percentage had a neutral (neither agreed or disagreed) that their knowledge increased ($M=4.67$, $SD=0.59$). This finding suggests that the training helps to increase knowledge of weight stigma.

Research Question 2b: In response to RQ2b, 100% of participants agreed that the content of the intervention helped them to identify ways to competently work with clients of size in a therapeutic setting ($M=4.61$, $SD=0.49$). This suggests that the intervention does appear to help increase competence in working with clients of size.

Research Question 2c: In response to RQ2c, 100% of participants agreed that the content of the intervention helped them to better understand the HAES model ($M=4.83$, $SD=0.38$), which suggests that the training does a good job of increasing knowledge of HAES.

Research Question 3: In response to RQ3, which asked if the altered language on the MCC encouraged participants to think of oppressed identities other than race (i.e., larger body size), the consensus of the participants was that the language shift was helpful in thinking of identities other than race (e.g. gender, sexuality, socioeconomic status), but did not necessarily make them think of larger body size. In follow-up questions, participants said that they felt the wording change was more inclusive and invited the opportunity to reflect on various identities other than race. Participants also discussed how, even if a more explicit mention of body size as a marginalized identity (e.g. as a list or definition before the measure) that it would not have shifted how they answered the questions. This suggests that the language change on the MCC is useful in opening up the possibility of participants to think of their competence in working with a variety of marginalized identities but not necessarily of body size.

Implications of Pilot Study

The findings of the pilot study informed the next steps for the dissertation study in several important ways. The first is that the timing of the training was appropriate for the three-hour class period it is meant to take place in. Since the training took roughly 2 hours, this leaves around 50 minutes for participants to take the pretest measures and to engage in the case

conceptualization activity. Knowing that this intervention is appropriate to the time frame both by the literal time measurement as well as anecdotal feedback from the participants will make it highly feasible to implement moving forward in the dissertation study. The findings from RQ2a-RQ2c, are important because they suggest that participants find the training useful in increasing their knowledge of the HAES model, weight discrimination, and how to competently work with clients of size, the stated purpose of the training. While the researcher did not ask any questions about bias reduction in the pilot, the findings of RQ2a-c do present promising initial support that the training may shift at least explicit weight bias, as increasing knowledge about HAES (a weight bias reducing framework) as well as the harms of weight discrimination could help to shift this bias. It is important to note that there is a strong possibility that socially desirable responding occurred in the pilot study, as the participants could have felt pressured to respond in a positive way due to the researcher also being their course instructor. The finding of RQ3, that participants found that the language shift of the MCC to include marginalized identities instead of minority identities, was helpful in increasing the breadth of identities considered when responding, which was the goal of the language shift. While participants did not specifically consider body size when thinking of marginalized identities, they did feel that the door was open to consider it when the new wording and that, even if body size was explicitly named as a marginalized identity that they would not have changed the way they responded to the items since the items are meant to be an aggregate of how they work with a variety of marginalized identities instead of a specific singular identity. Moving forward, the researcher will keep the changed language (“clients with marginalized identities” instead of “minority clients”) and will not add additional descriptors about what constitutes a marginalized identity.

Based on the findings of the pilot study, the current intervention training and wording changes to the MCI will be kept and used in the dissertation study itself.

After the pilot study was completed, there was difficulty in receiving the full version of the MCI from the publisher. In order to not cause further delay to the study, the researcher opted to use the MAKSS instead of the MCI due to ease of access and its language being less specifically tied to measuring racial multicultural competence and therefore a more general measure better aligned with the purposes of this study.

CHAPTER IV: RESULTS

The purpose of this study was to examine whether a HAES-aligned weight stigma training intervention decreased implicit and explicit weight bias and increased HAES competence in counselors-in-training. An exploration of whether multicultural competencies influenced the impact of the training program was also explored. Results of the study are presented in this chapter, including demographics of study participants, descriptive statistics, and results of the analyses that were used to test the research hypotheses.

Sample

Table I. Sample Demographics by Treatment Group

	Total (N= 55)	Treatment (Diagnosis) (N=32)	delayed intervention (Career) (N=23)
Age <i>Mean & SD</i>	26.16 (SD=5.06)	26.56 (SD=6.15)	25.61 (SD=2.98)
Track	26 CMHC 14 School 14 Couples & Family	16 CMHC 8 School 8 Couples & Family	10 CMHC 6 School 6 Couples & Family
Gender Identity	6 Cisgender males 45 Cisgender females 3 Non-binary/Third gender individuals	5 Cisgender males 25 Cisgender females 2 Non-binary/Third gender individuals	1 Cisgender male 20 Cisgender females 3 Non-binary/Third gender individuals
Racial & Ethnic Identities	38 White 5 Black/African American 2 Hispanic/Latinx 2 Asian 6 Multiracial 1 Race not listed	23 White 2 Black/African American 1 Hispanic/Latinx 1 Asian 4 Multiracial 1 Race not listed	15 White 3 Black/African American 1 Hispanic/Latinx 1 Asian 2 Multiracial 0 Race not listed
Social Class	4 Lower class 12 Working class 26 Middle class 12 Upper Middle class	4 Lower class 8 Working class 15 Middle class 4 Upper Middle class	0 Lower class 4 Working class 15 Middle class 4 Upper Middle class

	1 Upper class	0 Upper class	0 Upper class
Disordered Eating Lived Experience	42 Yes 13 No	22 Yes 10 No	20 Yes 3 No
Weight Related Difficulties Lived Experience	48 Yes 7 No	28 Yes 4 No	20 Yes 3 No
Previous HAES Experience	8 Yes 47 No	4 Yes 28 No	4 Yes 19 No

A total of sixty-one CED students consented to participate in the study, for a complete breakdown of all demographics by group see Table I above. Thirty-five students were in the treatment group (diagnosis class) and twenty-five were in the delayed intervention group (career class), with one participant not indicating any demographic information who was removed and not included in the analyses for this reason. Of the entire sample ($N = 61$), there were thirty-five first year students and nineteen second year students, with seven students not indicating their year in the program. Twenty-six students indicated they were on the Clinical Mental Health Counseling (CMHC) track, fourteen on the School Counseling track, and fourteen on the Couples and Family track, with seven students not indicating their track. Of the entire sample, 45 students identified as being cisgender females, 6 as cisgender males, and 3 as non-binary or third gender individuals, again with seven students not indicating their gender. Ages of participants in the full sample ranged from 22 to 49, with a mean age of 25.56, $SD = 6.15$ ($median = 25$) for the treatment group and a mean age of 25.6, $SD = 2.98$ ($median = 25$) for the delayed intervention group. The variance of the treatment group was impacted by the presence of a singular outlier, whose age was 42. Participants were predominantly white and middle class.

In the initial online survey, participants were asked “Have you or someone close to you struggled with an eating disorder or disordered eating,” 68.9% of the entire sample responded “yes” with the remainder of participants indicating “no.” Participants were also initially asked “Have you or someone close to you experienced difficulties or struggles related to your/their weight?” with 78.7% responding “yes.” Finally, participants were asked if they had any prior experience with the Health At Every Size (HAES) paradigm, with 85.5% of the sample responding they had no prior HAES experience.

While 61 participants initially consented to participate in the study, the number of participants across the three time points in the study varied. At time point 1 for the treatment group, 35 participants completed the survey while 23 participants completed the survey in the delayed intervention group, contributing to a total of 58 participants at time point 1. At time point 2, there were 30 surveys completed by the treatment group and 27 completed by the delayed intervention group, contributing to a total of 57 participants at time point 2. At time point 3, 21 responses were recorded for the treatment group and 24 for the delayed intervention group, for a total of 45 participants at time point 3. For each of the time points, participants could be marked as “completing” the survey even if they left items blank so that the numbers presented above are not representative of the amounts of missing data on the AFA. These numbers also demonstrate that some attrition of participants occurred across the study.

Feedback on the training was also collected. Due to an error with the Qualtrics set up for the feedback questions, about half of participants could not respond. When the researcher was made aware of this issue, the questions were fixed so that some of the delayed intervention group and all of the treatment group could respond. Feedback was limited. However, some general trends in the feedback were that participants found the training to be helpful and important to

their work as counselors, and that they felt they had been made aware of weight bias and its negative impact in ways they had not been before. Participants named that some of the most impactful parts of the training were learning about the connection of weight bias and racism and getting to practice using HAES with clients (e.g broaching body size). Several participants wanted to know more from the training including topics such as: using HAES with children/teens, more on the practical use of HAES, and more on the history of weight stigma. This limited feedback suggests that participants did get something out of the training and that they would be interested in learning more about these topics.

Testing of Hypotheses

All survey responses were inspected for outliers using box plot analyses. The only outliers that appeared in the box plot analyses were the aforementioned age outliers. As the data was being inspected for outliers and missing data, it quickly became evident from visual inspection that there was a great deal of missing data from the Antifat Attitudes Questionnaire, with a further visual trend of participants not answering the first several questions on the measure. Followup frequency count analyses revealed that 75.57% of participants (approximately 46 participants out of the 61 total) would be excluded from the analyses due to missing data, if listwise deletion was used. Followup pattern analysis graphs were created for the AFA at each timepoint (see Figures I-III) which highlighted that the majority of respondents did not respond to the first 10 items on the AFA. These 10 items roughly correspond to the *Dislike* subscale of the AFA which assesses dislike of fat people. The lack of complete responses to the AFA was equivalent across treatment and delayed intervention groups and all timepoints.

In order to still utilize the scale, without having to remove the majority of participants, the researcher opted to create mean scores for each participant by counting the number of

questions they responded to, adding their responses for the questions answered, and then dividing their raw score by their number of responses. For example, if a participant responded to 5 questions on the AFA and had a raw score (by adding their response to the 5 questions answered) of 15, their mean score would be 3, which would be used as their total AFA scale score. Using the AFA as it is originally intended to be scored, total scores could range from 0-189, with higher scores indicating higher amounts of explicit weight bias. With the modified scoring, scores range from 0-9 (congruent with the Likert scale used to score each item) with higher scores indicating higher explicit weight bias. It is acknowledged that there are limitations in continuing to use the data from participants in the AFA, with the amount of missing data that exists on this scale. However, the mean scores were used to do exploratory analysis that will be used to answer the current research questions, but more so inform future studies that might use the AFA or another explicit bias measure. The researcher explored the possibility of using multiple imputation for the missing data, but this was contraindicated given that the data was not missing at random, and therefore any multiple imputation data used would likely be inaccurate (Sterne et al., 2009).

Figure I: Missing Data AFA Time 1

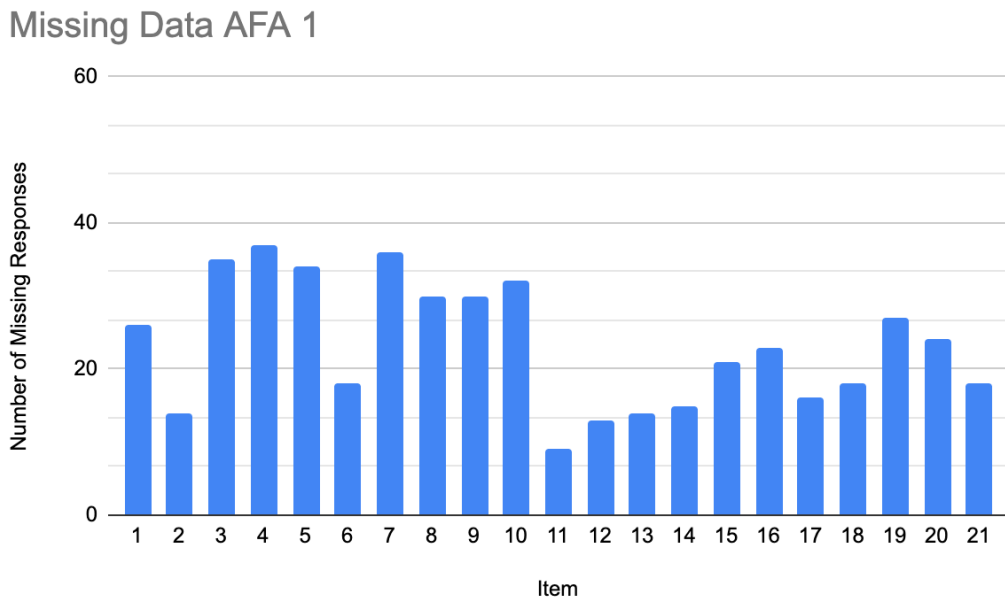


Figure II: Missing Data AFA Time 2

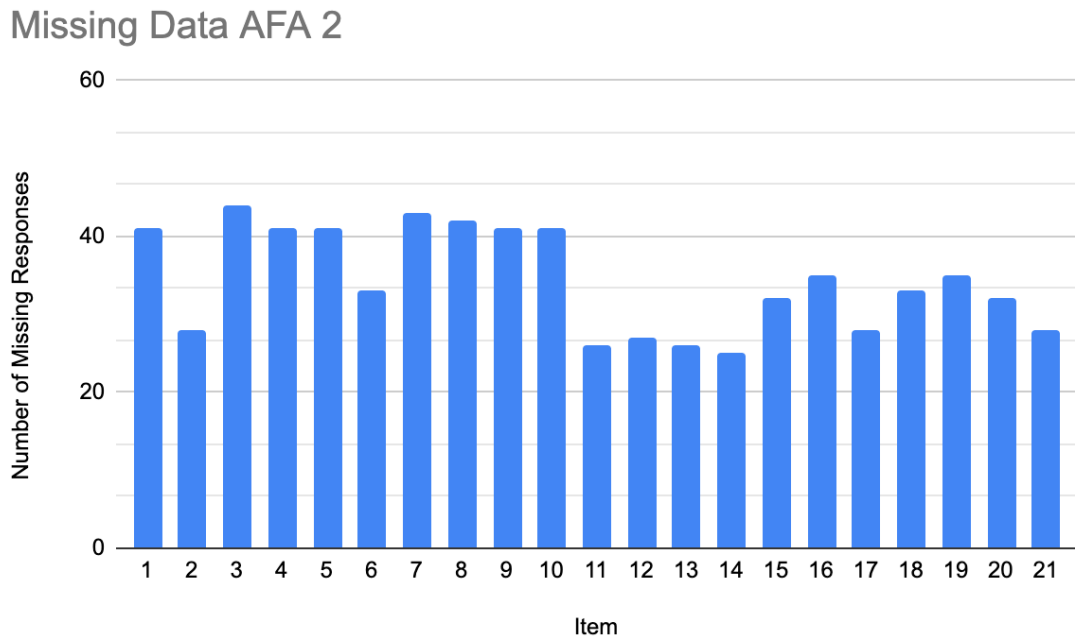
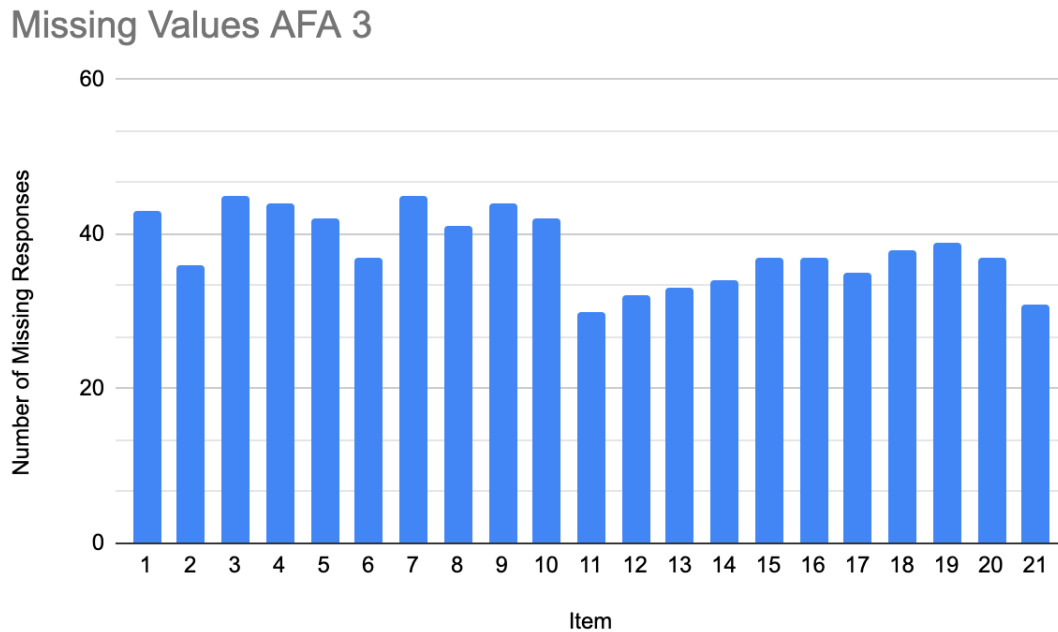


Figure III: Missing Data AFA Time 3



To analyze the MAKSS and C-HAES-CS, participants who were missing 2 or greater responses were removed from the analyses. In total, 52 participants had complete MAKSS scores, for the C-HAES-CS pretest there were 53 complete responses, and for the C-HAES-CS posttest there were only 37 complete responses. Scores on the MAKSS can range from 33 to 132 and on the C-HAES-CS can range from 15 to 60. To analyze the IAT, the online software IATGEN was utilized (Carpenter et al., in press). This software excludes any trials over 10,000 ms or participants for whom > 10% of their trials are faster than 300 ms. For time 1 IAT there were 54 included responses, for the time 2 IAT 50 included responses, and for the time 3 IAT 43 included responses. IAT scores can range from -2 to 2, with scores closer to -2 indicating higher implicit anti-fat weight bias and scores closer to 2 indicating implicit pro-fat weight bias. Positive scores indicate a pro-fat bias whereas negative scores indicate an anti-fat bias.

Means for the IAT, AFA, MAKSS, and C-HAES-CS were calculated for each of the groups and timepoints and are presented below in Table II and an enlarged copy can also be viewed in Appendix J.

Table II. Means for Each Measure by Group & Time

Means for Each Measure by Group

Group		AFA _{Total}	AFA _{Total2}	AFA _{Total3}	MAKSS _{Total}	HAES _{Total}	HAES _{Total2}	IAT1	IAT2	IAT3
Tx (Diagnosis)	Mean	2.9923	2.8457	2.0532	85.2000	40.8000	44.9524	-.470300140	-.481449664	-.437729648
	N	30	14	19	30	30	21	31	27	21
	Std. Deviation	1.41854	1.73801	1.36457	11.00282	8.07465	6.31250	3.665271114	3.631446695	4.250986853
Control (Career)	Mean	2.3840	2.0400	1.0328	85.7273	40.7826	49.0625	-.255286002	-.285149914	-.231705815
	N	25	25	25	22	23	16	23	23	22
	Std. Deviation	1.43059	1.36420	1.25170	8.43000	5.90036	4.13874	4.470259830	4.753592771	4.173496527
Total	Mean	2.7158	2.3292	1.4734	85.4231	40.7925	46.7297	-.378720044	-.391151779	-.332322106
	N	55	39	44	52	53	37	54	50	43
	Std. Deviation	1.44351	1.53691	1.38395	9.90810	7.14778	5.79103	4.129277479	4.256705220	4.289527395

The design implemented was a quasi-experimental crossover design, utilizing two groups. Table III shows the times points and when the HAES-aligned weight stigma training intervention was provided to each group.

Table III. Intervention & Measures Schedule

Group	Time 1 Date & Measures		Time 2 Date & Measures		Time 3 Date & Measures
Diagnosis (Treatment)	Pretest February 9 <ul style="list-style-type: none"> • Demo graphics • AFA • IAT • MAKSS • C-HAES-CS 	February 9 Intervention	Posttest February 16 <ul style="list-style-type: none"> • AFA • IAT • C-HAES-CS • Training Feedback 		Followup February 23 <ul style="list-style-type: none"> • AFA • IAT
Career (delayed intervention)	Baseline February 4 <ul style="list-style-type: none"> • Demo 		Pretest February 11 <ul style="list-style-type: none"> • AFA 	February 11 Intervention	Posttest February 18 <ul style="list-style-type: none"> • AFA

	<ul style="list-style-type: none"> • AFA • IAT 		<ul style="list-style-type: none"> • IAT • MAK • SS • C-HA • ES-C • S 		<ul style="list-style-type: none"> • IAT • C-HA • ES-C • S • Training • Feedback
--	--	--	---	--	--

Table IV: Means for IAT Pre & Post by Group

Descriptive Statistics

	Group	Mean	Std. Deviation	N
IATPre	Tx (Diagnosis)	-.4826	.33539	24
	Control (Career)	-.3094	.39085	21
	Total	-.4018	.36860	45
IATPost	Tx (Diagnosis)	-.4851	.36734	24
	Control (Career)	-.2255	.42662	21
	Total	-.3640	.41282	45

Impact of HAES-Aligned Weight Stigma Training

Research Question 1: What is the impact of participation in a HAES-aligned weight stigma training on implicit weight bias from pre to post-test among Master’s counseling students?

Hypothesis 1: Participation in the training will result in a significant decrease in implicit weight bias.

To test hypothesis I, a repeated measures ANOVA was conducted with IAT data prior to and immediately following the HAES-aligned intervention as the within factor and the treatment group serving as the between factor. This includes the pooled data from both the treatment and delayed intervention groups using data from timepoints 1 and 2 from the treatment group and timepoints 2 and 3 from the delayed intervention group (see Table III). Mean, standard deviation, and N for each timepoint and group can be found in Table IV. For both groups combined, mean scores on the IAT decreased by .038 from pre intervention to post intervention, indicating a slight

decrease in implicit weight bias for participants. Results indicated that there was not a significant difference in the pre and post IAT scores, $F(1, 43) = .294, p = .591, \eta_p^2 = .007$. The interaction between time point and group was nonsignificant $F(1, 35) = .331, p = .568, \eta_p^2 = .008$. These findings indicate that the implicit weight bias scores did not significantly decrease after the HAES-aligned training nor could not be attributed to group differences. Hypothesis 1 was not supported. However, these findings could have been influenced by small sample size, and low power (.083). Even with low power and lack of statistical significance, the effect size was small.

Table V. Means for AFA Pre and Post by Group

Descriptive Statistics

	Group	Mean	Std. Deviation	N
AFAPre	Tx (Diagnosis)	3.5917	1.41426	12
	Control (Career)	2.0400	1.36420	25
	Total	2.5432	1.54729	37
AFAPost	Tx (Diagnosis)	2.8467	1.66831	12
	Control (Career)	1.0328	1.25170	25
	Total	1.6211	1.62356	37

Research Question II: What is the impact of participation in a HAES-aligned weight stigma training on explicit weight bias from pre to post test among Master’s counseling students?

Hypothesis II: Participation in the training will result in significant decrease in explicit weight bias.

To test hypothesis II a repeated measures ANOVA was conducted with pre and post AFA scores as the within factor and the treatment group as the between factor. Similar to research question 1, this entails utilizing the pooled data from both the treatment and delayed intervention groups, using time 1 and 2 for the treatment group, and times 2 and 3 for the delayed intervention group - data points immediately prior to and following the intervention (see Table III). As noted

above, given the amount of missing data and altering this scale from total scale score to mean score of items responded to, this analysis is preliminary and exploratory for the AFA. Mean, standard deviation, and n for each timepoint and group can be found in Table V. Mean scores on the AFA decreased by .922 from pre intervention to post intervention for both groups combined, indicating a decrease in explicit weight bias for participants. Results indicated that there was a significant difference in the pre and post AFA scores, $F(1, 35)=12.526$, $p=.001$, $\eta_p^2 = .264$. The interaction between time point and group was nonsignificant $F(1, 35)=.280$, $p=.600$, $\eta_p^2 = .008$. These findings indicate that the explicit weight bias scores decreased after the HAES-aligned training and this difference could not be attributed to group differences. Hypothesis II was supported.

Table VI. Means for IAT Times 1 & 2 by Group
Descriptive Statistics

	Group	Mean	Std. Deviation	N
IAT1	Tx (Diagnosis)	-.482577998	.3353904832	24
	Control (Career)	-.242483867	.4658699314	21
	Total	-.370534070	.4148799899	45
IAT2	Tx (Diagnosis)	-.485109528	.3673365173	24
	Control (Career)	-.309437334	.3908464070	21
	Total	-.403129171	.3844827997	45

Comparison of Treatment vs Delayed Intervention

Research Question III: How does HAES-aligned training impact implicit weight bias from time 1 to time 2 (pre to post training intervention for the treatment group and baseline and pretest for the delayed intervention group) compared to participants in the delayed intervention group?

Hypothesis III: Participants in the HAES-aligned training intervention group will have a decrease in implicit weight bias above and beyond that of the delayed intervention group.

To test hypothesis III a repeated measures ANOVA was completed using the time 1 scores for both groups (pretest scores for the treatment group and baseline scores for the delayed intervention group) and time 2 scores for both groups (posttest for the treatment group and pretest for the delayed intervention group) as the within factor and group status as the between factor (see Table III). Mean, standard deviation, and n for each timepoint and group can be found in Table VI. Mean scores on the IAT for the treatment group demonstrated a small increase of .002, that is a strengthening of implicit weight bias for the treatment group from times 1 and 2 (after they received the intervention) while scores for the delayed intervention group from times 1 and 2 showed a .067 point increase in implicit weight bias. Results of the analysis indicated that there was not a significant difference in the IAT scores from time point 1 to time point 2, $F(1, 44)=.215, p=.645, \eta_p^2 =.006$. The interaction between time point and group was nonsignificant $F(1, 43)=.205, p=.653, \eta_p^2 =.005$. These findings indicate that there were not significant differences between the groups from time 1 to time 2 in implicit weight bias scores and that the training does not appear to impact implicit weight bias. This finding could be due to low statistical power (observed power=.077), however, it is also acknowledged that change in mean score was minimal for both groups and effect size was small.

Table VII. Means for AFA Times 1 & 2 by Group

Descriptive Statistics

	Group	Mean	Std. Deviation	N
AFA Total1	Tx (Diagnosis)	3.5917	1.41426	12
	Control (Career)	2.3840	1.43059	25
	Total	2.7757	1.51791	37
AFA Total2	Tx (Diagnosis)	2.8467	1.66831	12
	Control (Career)	2.0400	1.36420	25
	Total	2.3016	1.49589	37

Research Question IV: How does HAES-aligned training impact explicit weight bias from pre to post-test compared to participants in the delayed intervention group?

Hypothesis IV: Participants in the intervention group will have a decrease in explicit weight bias above and beyond that of the delayed intervention group.

To test hypothesis IV a repeated measures ANOVA was completed using the time 1 scores for both groups (pretest scores for treatment group and baseline scores for delayed intervention) and time 2 scores for both groups (posttest for the treatment group and pretest for the delayed intervention group) as the within factor and group status as the between factor (see Table III). Mean, standard deviation, and N for each timepoint and group can be found in Table VII. Mean scores on the AFA decreased by .474 from pre intervention to post intervention, indicating a decrease in explicit weight bias for participants. Mean scores for the treatment group decreased by .745, and for the delayed intervention group decreased by .344 between time 1 and 2. Results of the analysis indicated that there was a significant difference in the AFA scores from time point 1 to time point 2, $F(1, 35)=12.568$, $p=.001$, $\eta_p^2 = .264$. The interaction between time and group was nonsignificant $F(1, 35)=1.704$, $p=.200$, $\eta_p^2 = .046$. It is difficult to interpret these findings given the large amount of missing data on the AFA and low sample size which greatly impacted power when group status was included as a between factor (observed power went from .931 to .246).

Table VIII. Means for HAES by Group

Descriptive Statistics

	Group	Mean	Std. Deviation	N
HAESTotal1	Tx (Diagnosis)	40.1500	7.82893	20
	Control (Career)	39.7333	5.49632	15
	Total	39.9714	6.83626	35
HAESTotal2	Tx (Diagnosis)	44.8500	6.45857	20
	Control (Career)	49.0000	4.27618	15
	Total	46.6286	5.93140	35

Research Question V: How does HAES-aligned training impact HAES competency?

Hypothesis V: Participation in the training will increase HAES practice competency.

To test hypothesis V, a repeated measures ANOVA was conducted with the pre and post C-HAES-CS scores as the within factor and group status as the between factor. Mean, standard deviation, and N for each timepoint and group can be found in Table VIII. The mean C-HAES-CS score increased by 6.66 points overall. The treatment group mean score increased by 4.7, and the mean score for the delayed intervention group increased 9.267 following HAES-aligned training. Results indicated that there was significant increase in HAES competency $F(1, 33)=32.86, p<.001, \eta_p^2 = .499$. The interaction between time point and group was nonsignificant $F(1, 35)=1.097, p=.302, \eta_p^2 = .032$. These findings indicate that there was a significant increase in HAES competency after the training and this could not be attributed to group differences.

The Relationship between Multicultural Competence & Weight Bias

Research Question VI: What is the impact of multicultural competence on change in implicit and explicit weight bias?

Research question VI was an exploratory question. To explore research question VI, it became apparent in the scoring of the IAT, in which scores can be either positive or negative, that creating a change score to analyze for this question was not possible, and therefore this analysis could not be conducted for the IAT specifically. To explore the impact of multicultural competence on change in explicit weight bias, change scores were calculated for the AFA by subtracting the post test scores from the pre test scores that came immediately prior to and following the HAES-aligned intervention. For this analysis, the pooled data from both the treatment and delayed intervention groups was used. A correlation analysis was conducted to examine the relationship between explicit weight bias change scores and the score on the MAKSS. Results indicated that the correlation between multicultural competence and change in explicit weight bias was not significant $r(34) = -.087, p=.625$. This finding may be due to low statistical power (observed power=.148), however, the effect size or strength of the relationship was small.

Exploratory Post-Hoc Analyses

To further explore where the most impactful changes to explicit bias occurred and to examine how time impacted change, exploratory post-hoc repeated measures ANOVAs were run. The first repeated measures ANOVA examined the treatment group AFA scores from times 1, 2, and 3. Results of the omnibus test indicated that there was a significant reduction in AFA scores $F(2, 16)=6.704, p=.008, \eta_p^2 = .456$. Pairwise post-hoc comparisons were conducted using Fisher's Least Significant Difference (LSD) test to account for multiple comparisons. Results indicated that there were significant reductions in AFA scores from times 1 to 2 $LSD=.818, p=.025$ and 1 to 3 $LSD=1.049, p=.021$ but not a significant change from times 2 to 3 $LSD=.231,$

$p=.329$. This suggests that the most change occurred directly after the intervention and that the decrease in bias lasted for at least several weeks post-intervention.

Another repeated measures ANOVA was completed to examine the delayed intervention group's AFA scores from times 1, 2, and 3. Results of the omnibus test indicated that there was a significant reduction in AFA scores from times 1, 2, and 3 $F(2,25)=12.602, p<.001, \eta_p^2 = .344$. Pairwise post-hoc comparisons were conducted using Fisher's LSD test to account for multiple comparisons. Results indicated that there was not a significant reduction in AFA scores from times 1 to 2 $LSD=.344, p=.068$. This is important as time points 1 and 2 were the baseline and pretest measures respectively, where a change in explicit weight bias was not expected. There was a significant reduction in AFA scores from 2 to 3 $LSD=1.007, p=.005$. This is important as time point 2 was immediately before the intervention and time point 3 was the posttest for the intervention. This finding suggests that it was the training that impacted change in explicit weight bias.

The researcher elected to not run repeated measures ANOVAs in the post-hoc analyses of implicit weight bias, given that the initial repeated measures ANOVA with larger sample size was insignificant, indicating that a repeated measures ANOVA run with a smaller amount of the sample would also have an insignificant omnibus test and thus no further testing would be warranted.

CHAPTER V: DISCUSSION

In Chapter II, evidence was presented for the expansive and deleterious effects of weight stigma (Andreyeva et al., 2008; Hatzenbuehler et al., 2009; Puhl & King, 2013; Swift et al., 2013; Tomiyama, 2014), the need for addressing body size as a cultural consideration in counselor education was described, and support for the utility of using HAES as a framework for discussing body size in counseling and counselor education was provided. In Chapter III, the outline of the HAES-aligned weight stigma reduction intervention for CITs and methodology for the study was presented. Chapter IV described the findings of the study. This final chapter provides a summary discussion of study findings, comparison with other studies, implications for counselor education and supervision, study limitations, and suggestions for future research.

Summary of Study Findings & Connection to Prior Research

Before discussing the key findings of the study, it is important to review the context of the various scores. For the measure of implicit weight bias, the IAT, scores can range from -2 to 2 with negative scores indicating presence of implicit anti-fat bias and positive scores indicating the presence of an implicit pro-fat bias. This means that for the mean baseline IAT score (before anyone received training) of -.379 indicates a moderate amount of implicit anti-fat bias. For the measure of explicit weight bias, the AFA, given the modified scoring due to missing data, scores could range from 0-9. A score of 0 would indicate no explicit weight bias whereas a score of 9 would indicate the highest amount of explicit weight bias. This means that for the mean baseline AFA score of 2.712, this would indicate a low to moderate amount of explicit weight bias. It should be acknowledged though that this mean score of 2.7 is contextualized in a large amount of missing data for the AFA scale, with many participants (70% to 80% across time points) not responding to items that specifically assess dislike for individuals with larger bodies. Responses

to these items could change the overall results, as it is not clear the reason for the avoidance and non-response of the majority of the AFA items. For the C-HAES-CS, the measure of HAES competency that was created for this study, scores could range from 15-60, with scores closer to 60 indicating higher HAES competency. This means that for the initial baseline mean of 40.79 indicated a moderate amount of HAES competency. This level of HAES competency was surprising given that 13% indicated at the start of the study that they knew and were familiar with HAES. Taken together, this indicates that the counseling students surveyed in this study had moderate amounts of implicit and explicit weight bias prior and a moderate amount of HAES competency prior to receiving training.

Implicit Weight Bias

Implicit weight bias started at a moderate amount for the treatment group and at a low to moderate amount for the delayed intervention group. While implicit weight bias has been previously documented in mental health trainees (e.g. Adams, 2008; Forristal et al., 2021), it is difficult to compare amounts of bias across studies because the present study is the first study to use the IAT as a measure for implicit bias in mental health trainees, as others (e.g. Adams, 2008; Forristal et al., 2021) used the diagnosis and expected treatment outcomes task as opposed to an implicit association task to measure implicit bias. In the present study, both groups showed a decrease in their IAT scores post receiving the intervention, although with some interesting effects of time. The treatment group demonstrated the largest drop in implicit weight bias from time 2 (their posttest measurement after the intervention) to time 3 (their followup measurement) whereas for the delayed intervention group, those participants they demonstrated a greater drop from their pretest (time point 2 for this group) and their posttest (time point 3). The treatment group showed a tiny increase in implicit scores from pre to post (time 1 to time 2, immediately

following the HAES-aligned training), but then from post to follow up demonstrated a larger decrease. This means that a differing pattern emerged in the data, with the treatment group showing an initial tiny increase in IAT scores directly post-intervention and a larger decrease from their initial scores at the followup measurement (time 3). Whereas the delayed intervention group showed a larger drop directly after receiving the intervention. This difference in pattern could have occurred because the majority of participants in the treatment group (78.13%) were first year Master's students whereas the majority of students in the delayed intervention group (65.22%) were second year Master's students. This means that participants had differences in training as well as clinical experience. Since the second year students had more clinical experience (and potentially more experience working with fat clients) this could have better primed them to be more prepared to challenge implicit biases about fat people. Given that the decreases in IAT occurred around the time for both groups (time 2 to time 3), it could suggest that something may have occurred external to the study around this time that impacted the decrease in scores. Testing effects of taking the IAT multiple times could also be a factor, however IAT testing effects are most prominently observed in multiple consecutive practice sessions (one right after the other) and not spaced out weeks apart (Vaughn et al., 2011; Vuletich & Payne, 2019).

While the statistical analyses showed a nonsignificant drop in IAT scores, this could be more related to the low power observed, thus the possibility of a Type II error. Put simply, there may not have been enough participants to observe statistical significance in the small effect size. While the effect size was small, this is not to be wholly discounted. In studies with much larger samples, even small effect sizes of IATs have been able to significantly predict discriminatory behaviors (Greenwald et al., 2015; Oswald et al., 2013). Though small and statistically

insignificant, the minute decreases to the IAT from moderate to a low moderate range could make the difference in a counselor's bias causing them to miss more subtle signs of an eating disorder in higher weight clients or to make a microaggressive comment that causes a fat client to avoid seeking help.

While it has been established that overall IAT scores decreased although insignificantly, it is also important to discuss if the training itself appeared to have a direct impact on IAT scores. The mean implicit weight bias score for the treatment group did not demonstrate any meaningful changes after the intervention when compared to the treatment group. This lack of significant change as compared to the delayed intervention group could be the result of several factors. The first is that the one time training program alone was not enough to significantly change implicit weight bias within such a short time frame (i.e., 1 week from pre to post test). The second is that perhaps it takes more time for the training to take effect and for that effect to be seen, especially with bias that is implicit. This idea seems to fit with the pattern observed for the treatment group who showed the greatest decrease in IAT scores at time 3, their followup measure 2 weeks post intervention. However, since the delayed intervention group did show a larger drop than the treatment group directly after they received the intervention this could also suggest that clinical experience impacts the change, with individuals with more clinical experience showing more immediate changes to implicit biases.

While the current study did not see a significant reduction in implicit weight bias, this does fit with prior research which indicates that implicit bias is slow to change and often does not decrease even if explicit weight bias does (Breithaupt et al., 2020, Burke et al., 2019, De Houwer et al., 2019, & Greenwald et al., 1998). This lack of change can be attributed to the

difficulty of accessing unconscious biases and that this work often takes a longer amount of time and intention to shift these biases (De Houwer et al., 2019).

Explicit Weight Bias

It should be noted that any interpretation of explicit weight bias, or the AFA, in this study should be taken with caution. The amount of missing data is important to acknowledge because the picture created from this data is speculative at best; there is simply not enough complete data to determine if the picture it is painting is accurate for the sample. But the *lack* of data is of itself another form of data and paints perhaps a more complete picture than the actual data.

Participants could have not responded to the AFA for a variety of reasons. Some more likely ones are that, first, it made participants uncomfortable because it brought to their awareness biases about fat people that they may not typically think about. This discomfort could have been the result of the misalignment of their ideally perceived selves (e.g. I am a good counselor and good counselors don't have biases) and their real selves (e.g. I do have biases) creating cognitive dissonance that participants tried to assuage via avoidance (e.g. I just won't answer these questions (Festinger, 1962).

Another factor that could have been at play in the missing AFA data is the fear of negative evaluation. While I was in the classroom with participants who were taking their pretest measures, one student came up to me and claimed that they did not wish to participate any further in the study due to how they felt that "my answers could present me in a way that does not align with how I view myself." While I did not serve as a TA nor instructor for either of the two classes and was clear that participation was voluntary and anonymous, with no impact on their grade for their courses, it could be that students experienced fear of being judged or considered a "bad" counseling student if they admitted to biases. This could have been

exacerbated by the fact that I did serve as clinical supervisor for some of the students in the two classes surveyed and in the role of on-call crisis consultant in the clinic in which some of the students were seeing clients. Perhaps they felt it would look less bad if they chose not to respond instead of responding truthfully to their biases or to lie when they knew biases were present. I believe that this also connects to the pattern of missing data in which students were much less likely to respond to the items on the AFA *Dislike* subscale, which measures dislike for fat people. The other two subscales, *Fear of Fat* and *Willpower*, measure one's own fear of becoming fat and one's beliefs about the controllability of being fat respectively. This means that the *Dislike* subscale is the subscale that is most clearly tied with explicit weight bias and therefore was the most uncomfortable subscale to respond to, which may be why it was avoided by most participants. This avoidance or denial of explicit biases is well documented in counselor trainees (see Boysen, 2009 for a review).

Internalized weight bias could have also been at play with the missing AFA data. The majority of participants indicated that they or someone close to them had struggled with disordered eating and that they or someone close to them had experienced difficulties related to their weight. This could indicate that at least some portion of the sample could have internalized weight bias which made them uncomfortable answering affirmatively to disliking fat people (Durso et al., 2012). Put another way, if a person identifies as fat themselves or has people they care about that are fat, it could make them less likely to admit to disliking fat people. While there are many possible reasons why participants chose not to answer the AFA, it does seem that it would be amiss to equate missing AFA scores with a lack of explicit weight bias, and may possibly signal that, if participants did answer the full scale, that even high amounts of explicit weight bias would have been present than what was documented.

Consistent with prior studies of weight bias in mental health trainees, explicit weight bias was documented in this sample, although potentially at a slightly lower amount than previous studies (Adams, 2008; Forristal et al., 2021; Pascal & Kurpius, 2012; Pratt et al., 2016). This is to be interpreted carefully, however, because of the amount of missing data on the AFA which potentially presents an inaccurate measure of explicit weight bias. To tentatively explore and provide some interpretation of the findings for explicit weight bias, for individuals who participated in the training, they did see significantly decreased explicit weight bias scores when compared to the delayed intervention group, suggesting that the training did help to decrease explicit weight bias. The training could have impacted explicit weight bias in that it sought to directly refute the various components of explicit weight bias including the dislike of fat people and the controllability of weight. Perhaps when presented with evidence of how harmful weight bias is, particularly explicit weight bias, and how being stigmatizing to fat people is in direct misalignment with their chosen profession this caused participants to no longer endorse as strongly explicit biases about fat people to better align with the standards of their profession. Being presented with evidence that contradicts the myth of the controllability of weight could have also helped to shift weight biases, in moving weight from being viewed as a choice (or worse, a character flaw), and instead being viewed as something that is mostly out of an individual's delayed intervention. While the treatment group exhibited explicit bias changes above and beyond that of the delayed intervention group, it is also important to note that after training, both groups had a significant decrease in their explicit weight bias scores, further suggesting that the training did impact explicit weight bias through the aforementioned channels. The current study's findings are in alignment with the findings of previous research which has demonstrated how HAES-aligned training decreases explicit weight bias (e.g. Rosalez, 2014).

However, we must interpret these changes with caution given the amount of missing data, because if participants chose to respond to even one more or one less item on their time 2 or time 3 AFA this could significantly alter their score, which then led to the significant change in scores across time. It is also interesting to note that the delayed intervention group, which was composed mostly of second year Master's students, started almost an entire point lower on mean explicit bias scores than the treatment group which was primarily first year counselors in training. While this is difficult to interpret due to missing data, this one point difference (on a 9 point scale) does suggest that the delayed intervention group started with 11% less explicit bias than the treatment group, which could again suggest the impact of more counseling experience and training on explicit weight bias. This aligns with Pratt et al.'s (2016) findings that explicit weight bias was higher for Master's students as compared to doctoral students and Schwartz et al.'s (2012) findings that weight bias is most heavily associated with younger and less experienced clinicians.

While the findings discussed here related to both implicit and explicit weight biases are difficult to fully interpret, what is clear is that the presence of even moderate amounts of implicit and explicit weight bias in CITs, as documented in this study, are problematic. In the counseling room, when counselors weight bias can lead to decreased client comfort, trust, client disclosures, and an increased likelihood of dropping out of treatment for clients of size (Akoury et al., 2019), and also a significantly increased likelihood of being misdiagnosed with a mental health disorder (Davis-Coelho et al., 2000; Warchal & West, 2013; Young & Powell, 1985), all of which equate to poor clinical care and outcomes for fat clients. I believe that this further signals that weight bias is present and a problem to be addressed within our counselor training.

HAES & Multicultural Competency

One of the major intentions of the training was to increase participant HAES efficacy as a means of increasing multiculturally competent treatment of higher weight clients. Participants initially started with moderate HAES scores even though only 13% of the entire sample endorsed previous HAES knowledge/experience. While on the surface this can appear surprising, but, when taken in context, I believe this is a heartening piece of data. While there are some discrete components of HAES competency (e.g. understanding the research on weight and health), many of the components of HAES competence align with multicultural competence (e.g. broaching, creating a safe space to discuss body size identity). So, in context, it makes sense that the sample, who had all received training in multicultural competence would also score at a moderate level on the HAES competence scale even before HAES training. Having a preexisting framework and foundation in multicultural competence helps explain the demonstrated significant increase in HAES competency from pre to post test. The significant increase in competency first suggests that the intervention did increase HAES competency, which makes sense given that the training had a large focus on teaching participants about the HAES tenets and how to practice from a HAES lens. However, this significant increase could have also been supported by participants already having experience and a framework (i.e. multicultural counseling skills and competence) to map their new knowledge onto which helped them increase competence more quickly. Connecting and mapping new knowledge onto a preexisting knowledge framework has been shown to be an effective teaching and learning strategy (e.g. Ambrose et al., 2010). However, while there have been scant studies on HAES efficacy, the findings of the present study that HAES competency increases after training do fit with previous research on dietitians in training

conducted by Brown (2009) that indicated that HAES competency increased after a three-hour training.

Scores on the MAKSS-CE-R can range from 33-132, with higher scores indicating a greater amount of general multicultural competence. The mean MAKSS-CE-R score for the present study was 85.42 which is considered a moderately high score that indicates a moderately high amount of multicultural competence. This is unsurprising given the importance that the counseling profession and the program participants in the study attend place on multicultural competence. In seeking to examine how this moderately high amount of multicultural competence related to the change in explicit weight bias was not significant, the results of the statistical analyses suggested that these two constructs are not significantly nor strongly related. This could be for several reasons. The first is that, as previously mentioned earlier in this chapter, in depth interpretation of the AFA is impossible given the amount of missing data and it could be that the missing data, particularly that of the *Dislike* scale, would be the parts of the AFA that would most relate to multicultural competence. The second is that perhaps for individuals who are already high in general multicultural competence that they are already doing the work of recognizing and challenging their explicit biases so they would see less of a change after intervention. A third possibility is that of social desirability in responding to both the MAKSS and AFA in which individuals rated themselves artificially higher on their multicultural competence and lower in their explicit weight bias which would make it difficult to see a relationship between the two. The findings of this study that both groups had higher levels of multicultural competence is consistent with the tendency for counselors and counselor trainees to highly rate (and oftentimes overestimate) their multicultural competence (Soto et al., 2018). This high amount of multicultural competence and moderate explicit weight bias are also consistent

with the findings of Pratt et al. (2016) in which MFT trainees documented high amounts of explicit weight bias despite multicultural training, further suggesting that general multicultural training alone is not sufficient to impact weight bias.

Limitations

To paraphrase my wise dissertation chair, limitations in research studies are inevitable, they pop up like air bubbles in stickers on flat surfaces and as you try to push one bubble down, another appears somewhere else to take the first one's place. The following is a discussion of the bubbles in my study.

I would be absolutely amiss to not first discuss the glaring limitation that is the staggering amount of AFA missing data. Approximately 75% of the AFA data when examined across all 3 timepoints was missing. The scoring for the scale, as previously discussed, had to be modified to by using mean scores of items answered which drastically limited the range of scores from 0-189 to 0-9, which decreases the variability in scores significantly making only very large changes noticeable while also not truly capturing the diversity of explicit weight bias in the sample. The extensive missing data also means that the scores that were captured are not necessarily accurate nor representative of the actual amount of explicit weight bias present in the sample, meaning that no definitive examination of the existence or change in explicit weight bias for the studied sample can be made.

Another important “bubble” in this study is the potential for social desirability to have impacted responding. Socially desirable responding has been well documented with multicultural counseling competence measures (e.g. Soto et al., 2018; Constantine & Ladany, 2000) with counseling trainees typically overrating themselves in multicultural competence. Therefore, the observed multicultural competence in this study could have been artificially inflated due to

socially desirable responding. The same could be said for the responding to the C-HAES-CS which could have had artificially inflated posttest results due to participants responding in the way that they believed was more correct after the training. Social desirability in responding to the AFA is also possible, and could be the cause of seeing the decreased explicit bias scores across time. However, the IAT is a measure that is much less susceptible to social desirability in responding given how the task is set up (the more time one takes to think of the correct response, the higher their bias score and the more incorrect they get the higher their bias score; (Greenwald et al., 1998). Given that scores on the IAT and explicit bias measures are typically modestly correlated (Hofmann et al., 2005), it follows that, since in this study moderate amounts of implicit and explicit biases were documented that socially desirable responding was less of a factor in responding. Yet again, the *lack* of data could also be the most informative piece of data and speak to socially desirable responding in a different way—perhaps participants could not so blatantly go against how they actually feel about fat people (the bias is so ingrained) that it was easier and more comfortable to omit answers.

Participant attrition and overtaxing are another limitation to the present study. As discussed in Chapter IV, while 61 participants consented to the study, only 58 completed the study at time point 1 and this number continued to drop across the other two time points for a total of 45 responses on the final survey, a loss of 13 participants. The attrition of participants impacted the overall power of the study particularly given that the bulk of the analyses relied on the comparison of participants scores across timepoints, and if the participant did not complete one of the timepoints their data could not be compared. The study did also ask participants to complete the measures at 3 different times which could have further added to attrition by overtaxing participants. This attrition could also be related to the discomfort that filling out the

measures, particularly the AFA, may have caused participants to avoid taking the survey after completing the first one. Ultimately this could mean that participants who completed the measures at all three times were particularly invested in the study and thus may have already had lower biases and higher HAES competence than those who did not complete the study, thus presenting an inaccurate picture of weight bias and HAES competence in the sample.

There are also some threats to the ability to demonstrate causality in the intervention causing a decrease in weight bias. The first is that, students who choose to participate in the study may have already had a preexisting interest in learning about HAES and decreasing weight bias, and this preexisting desire to learn more about this topic could have contributed to observed change instead of the intervention itself. Testing effects could also be present. Participants had to all take the AFA and IAT three times which could help them to get better at responding to both measures, although this is somewhat questionable due to the consistent missing data on the AFA and that the IAT is always presented in a different order which makes practicing association order unlikely.

A final limitation of this study is that there are great limits to its generalizability. The sample of the study was predominantly white, cisgender, female, middle class, and in their mid-twenties, which roughly aligns with the demographics of individuals enrolled in CACREP-accredited programs (Council for Accreditation of Counseling and Related Educational Programs, 2018). There is one notable misalignment in that the sample in this study had noticeably less Black-identifying students than the national demographics (Council for Accreditation of Counseling and Related Educational Programs, 2018) which further limits the generalizability of the findings to counseling programs that have a more racially diverse student makeup. Given that the participants in the study were all from the same CACREP-accredited

program which is a full-time in-person program that follows a cohort model, it also means that these findings may not generalize to non-CACREP-accredited programs, part-time programs, programs that do not use a cohort model, or online programs. It is also important to acknowledge that, due purely to researcher oversight, the sexual/affectational orientation of participants was not collected, which further limits the generalizability of the data. Given that the majority of the sample had multiple intersecting privileged identities, this also limits the ability of the researcher to make claims about how this training would be received by individuals with multiple intersecting marginalized identities. Certainly further research is needed to examine the impact of the training from a lens of intersectionality (e.g. how is the training received for various intersecting identities such as Black women).

Implications for Counselor Education & Supervision

I believe that there are several important implications from this present study in how the counseling profession trains future counselors. I first would like to echo the sentiments of the from authors of the the 2019 edition of *Women & Therapy's* special issue who collectively advocate that weight stigma *must* be talked about as a vital component of counselor education and that it is best taught from a social justice informed HAES perspective, by incorporating discussions of the lived experiences of fat people, advocating for social justice for fat rights, and providing information about the detrimental impact of diet culture (Bergen & Mollen, 2019; McHugh & Chrisler, 2019; Rothblum & Gartrell, 2019). The present study does indicate that weight bias is present in CITs despite them having received training in multicultural competence, which further argues that weight should be discussed as an explicit component of multicultural counseling training in line with Kasardo's (2015; 2018) recommendations. We can no longer be

tacit in the counselor education classroom on weight bias; to do so is to poorly prepare our next generation of counselors.

I do have some more specific recommendations for what HAES-aligned counselor training should look like. The results of this study suggest that the second year trainees started out with lower implicit and explicit biases than the first year trainees and that the training seemed to have a faster and larger impact on the second years than the first years. I believe that could be related to their different developmental levels as counselors. In the program surveyed, the first year participants at the time of the study, were just entering their first clinical experience of seeing clients whereas the second years had already been seeing clients for a year at the time of the study. Speaking from personal experience as a former first year counseling trainee and as a current supervisor to these trainees, the start of one's first clinical experience is a highly stressful time. During times of great stress and emotional activation, the brain is not well-equipped to learn new material or to engage in the taxing process of challenging biases (Arthur & Achenbach, 2002; Constantine, 2002; Johnson & Taylor, 2011). For this reason, I believe that HAES-aligned weight stigma training should begin well in advance of trainees' first clinical experience so that the seeds can be planted early and into soil that is more receptive.

This early infusion of HAES-aligned weight stigma training I believe would be to integrate it into the Counseling Diverse populations course or equivalent course in counseling programs. Specifically, I would envision the training tested in this study, or a version of it that includes the fundamentals of practicing from a HAES perspective and information about weight discrimination, to be covered as a class period or unit within the class to set the stage for future learning about the topic. As previously championed by other voices in the field (e.g. Kasardo, 2018; Bergen and Mollen, 2019), HAES aligned training is a natural fit for the multicultural

counseling classroom, particularly given its conceptualization of fat as a marginalized identity and strong slant towards awareness of biases and social justice, fits the best with the content of Counseling Diverse Populations and diversity education standard set forth by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016; Section 2, F.2.a-h).

I took great care in the development of the training intervention to ensure that it aligned with CACREP (2016) standards. CACREP standard 2.2.b “theories and models of multicultural counseling, cultural identity development, and social justice and advocacy” in several important ways. HAES, although a relatively new approach, is gaining support in the counseling field and other disciplines including dietetics, psychology, social work, and public health as a multicultural and social justice theory/framework given its development and utility by and for marginalized individuals and its strong ground in social justice (Kinavey & Cool, 2019; McHugh & Chrisler, 2019). Recall that HAES tenet 3 explicitly states that individuals who work from this approach must acknowledge their personal biases, and work to end weight discrimination, weight stigma, and weight bias and must provide information and services from an understanding that socioeconomic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities (*ASDAH: Trademark Guidelines*, 2003). This firmly situates HAES in line with other multicultural and social justice theories which address issues of oppression and power in counseling (Erickson Cornish et al., 2010; Ratts et al., 2016). The proposed training not only introduces students to HAES and its empirical support, but it also describes ways in which HAES can be applied in working with clients (e.g. case conceptualization activity, broaching body size, etc.). This training further fulfills the

CACREP standard by providing students with information on HAES-centric social justice and advocacy efforts (e.g. writing legislators to support legal protection of fat individuals).

Another CACREP (2016) standard that the proposed HAES training aligns with is 2.2.h “strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination.” Admittedly HAES itself does not have specific strategies for identifying and eliminating oppression and discrimination, perhaps other than practicing body acceptance (valuing all bodies), and can be seen as an ideological approach. This idea is the foundation, from a HAES point of view, in ending weight oppression--if we all believe and operate behaviorally from the standpoint that all bodies are good and worthy of respect and equitable care, this makes it difficult for weight discrimination to occur. However, to specifically align with CACREP standards, the HAES training, in addition to discussing the HAES theoretical and ideological underpinnings, offers numerous concrete and specific strategies that CITs can use to identify and work to eliminate weight discrimination. The training offers resources for CITs to build their awareness and ability to identify areas of potential weight biases (e.g. IAT) along with skills they can use in session with clients in a way that does not engender oppression (e.g. broaching body size), and concrete actions CITs can take to work towards ending weight oppression. With the combination of the understanding of a HAES approach, the negative impact of weight stigma, and concrete strategies to increase awareness/knowledge, skills, and actions CITs will be able to prevent and mitigate weight stigma in their counseling practice.

But as both this data and prior research findings (e.g. Ambrose et al., 2010) suggest, a single training alone is not enough to create lasting learning and change. It is therefore my recommendation that the training could then be further infused across coursework to solidify

learning and understanding. A few examples of what an infusion of core HAES principles, particularly body acceptance, holistic health, and working to acknowledge and end weight bias, throughout the coursework are provided below:

- Career Counseling: assignments and discussion on helping clients address weight discrimination in the workplace
- Diagnosis & Treatment Planning: discussion and practice of using HAES principles and interventions (e.g. intuitive eating & exercise) to work with clients with eating disorders
- Professional Orientation: discussion and opportunities for students engage in advocacy work for fat individuals (e.g. writing to legislators in support of legal protection of weight stigma)

As with any multicultural competence skills, having the knowledge of them is important, but this knowledge lacks utility if it is not actively used in practice (Erickson Cornish et al., 2010). After students have received their HAES training, directly in their multicultural counseling class and reinforced throughout their coursework, it would be important to encourage students to use their knowledge of HAES in counseling practice which suggests the need for HAES-infused supervision in counselor training. Some examples of HAES-infused supervision include:

- Working with CITs on broaching body size with clients
- Encouraging CITs to consider weight bias when conceptualizing clients
- Teaching CITs concrete strategies to manage their own weight biases (e.g. mindfulness) so that they do not negatively impact their work with clients of size

With these recommendations in mind, I believe that we can work to better prepare our trainees to provide competent and compassionate care to clients of every body size.

Areas for Future Research

“The outcome of any serious research can only be to make two questions grow where only one grew before”--Thorstein Veblen

The present study was an important first step in testing the efficacy of a HAES-aligned weight stigma reduction intervention for CITs, however, there is still much work to be done. The next step in this area of research would be to first replicate the present study with a much larger and more diverse sample. This would enable greater generalizability as well as increased statistical power to examine changes in smaller effect sizes, particularly related to implicit bias. A larger scale replication study would also allow for further examination of explicit weight bias and provide a more accurate and interpretable measurement of explicit weight bias and explicit weight bias changes in CITs. This would also provide further insight into the pattern of missing AFA data, to see if this pattern is replicated on a larger scale. Perhaps in future studies, a qualitative interview component could be added to examine the cognitive and emotional impact of the training intervention for participants to provide further elucidation into the process of weight bias change. However, given the uncomfortability of students and fears of negative evaluation, a content analysis study of anonymous reflective journal prompts could help to get more truthful and in-depth information without the pressure of a face-to-face interview.

Another important next step in this research would be to conduct longitudinal followup to see if the observed bias reduction is lasting, or if more time is required to see more drastic reduction of biases (basically did it need time to germinate). This could be examined either in further followup testing using the AFA, IAT, and C-HAES-CS, or could be examined in looking at the clinical work and outcomes of participants(e.g. did participants broach body size with

clients, did they recommend weight loss) or other measures of weight bias such as the diagnosis case review activities used by researchers such as Adams (2008) or Forristal (2021).

Further work is also certainly needed in the validation of the C-HAES-CS as a measure of HAES competence for counselors. Future studies on item development and factor analysis of the scale along with reliability and validity studies are needed to ensure that this measure is a strong tool for counselors, counselor educators, and counseling researchers to use in training, teaching, and researching.

In the realm of counselor education and supervision research, another important step in this research would be to explore how infusing HAES-aligned weight stigma reduction content across coursework and clinical practica could impact the lasting changes in weight bias and HAES competency.

While the focus of this research has been on counselors in training, it is also important to study weight bias reduction and HAES competency in practicing counselors. Future studies could replicate the present study with practicing counselors to determine the impact of clinical experience on weight bias. Studies of the impact of a discrete training incident could also be useful in determining if a one-time training vs spaced out multi-part training are more impactful in decreasing weight bias and increasing HAES competency for practicing clinicians.

I believe that another vital step in the research would be to explore client perceptions of their counselor's HAES competence and weight bias for clinicians who have and have not received the training. Basically, can clients tell if their counselor received this training and thus feel that their counselor is more competent to work with them and/or makes them feel safer in the counseling room as a fat client. Ultimately any successful training and counselor education

intervention can only be as useful as its ability to actually improve the clinical experience of clients.

Concluding Thoughts

The present study began as a class assignment in my first year as a doctoral student at UNCG, when I was just learning about what it meant to be a HAES-aligned practitioner. Throughout my time in the doctoral program, this training intervention has been with me every step of the way, growing and improving as I gained knowledge from immersing myself in HAES and weight bias research and experience working with fat clients as a HAES practitioner. It is a beautiful and vulnerable experience to be at this part of the process and to see that the intervention has had an impact on our trainees, as the creation and implementation of this intervention has truly been a labor of love and an expression of advocacy as a HAES-aligned practitioner.

Just as the process of developing this study was complex and challenging, so are the results. The large amount of missing explicit bias data paints a picture that is simultaneously fascinating and frustrating. It makes meaningful interpretation of the change in explicit bias all but impossible, but also suggests that being confronted with one's own weight biases is a challenging and potentially transformative experience. The small changes in implicit weight bias provide initial hope and insight that even deeply unconscious harmful beliefs about fat people can be changed if they are brought to light and continually challenged. The initially moderately high HAES competency scores prior to training combined with their significant increase after training further speak that our trainees are ready and willing to learn to practice from this new framework because it maps onto our profession's understanding of multicultural competent counseling while still providing skills, knowledge, and awareness that are unique.

It is my hope that the findings of this present study can add to the growing push in counseling and counselor education to work to rectify the harms of weight bias and to train clinicians to practice in a way that makes the counseling room a space of healing for **every** body.

REFERENCES

- Abakoui, R., & Simmons, R. (2010). Sizeism: An unrecognized prejudice. In *Handbook of Multicultural Counseling Competencies* (1st ed., pp. 317–349). John Wiley & Sons, Inc. (Abakoui & Simmons, 2010)
- Adams, L. (2008). *Weight Bias Amongst Counselors-In-Training: A Qualitative Inquiry*.
<https://etd.auburn.edu/handle/10415/1438>
- Agell, G., & Rothblum, E. D. (1991). Effects of clients' obesity and gender on the therapy judgments of psychologists. *Professional Psychology: Research and Practice*, 22(3), 223–229. <https://doi.org/10.1037/0735-7028.22.3.223>
- Akoury, L. M., Schafer, K. J., & Warren, C. S. (2019). Fat women's experiences in therapy: "You can't see beyond... unless I share it with you." *Women & Therapy*, 42(1–2), 93–115.
<https://doi.org/10.1080/02703149.2018.1524063>
- Allison, D. B., Downey, M., Atkinson, R. L., Billington, C. J., Bray, G. A., Eckel, R. H., Finkelstein, E. A., Jensen, M. D., & Tremblay, A. (2008). Obesity as a disease: A white paper on evidence and arguments commissioned by the Council of the Obesity Society. *Obesity (Silver Spring, Md.)*, 16(6), 1161–1177. <https://doi.org/10.1038/oby.2008.231>
- Altman Bruno, B. (2013, August 6). the HAES® files: History of the Health At Every Size® Movement—The Mid- to Late 1990s (Part 4). *Health At Every Size® Blog*.
<https://healthateverysizeblog.org/2013/08/06/the-haes-files-history-of-the-health-at-every-size-movement-the-mid-to-late1990s-part-4/>
- Ambrose, S. A., Bridges, M. W., DiPietro, M., Lovett, M. C., Norman, M. K., & Mayer, R. E. (2010). *How Learning Works: Seven Research-Based Principles for Smart Teaching : Seven Research-Based Principles for Smart Teaching*. John Wiley & Sons, Incorporated.

- Amigo, I., & Fernández, C. (2007). Effects of diets and their role in weight delayed intervention. *Psychology, Health & Medicine, 12*(3), 321–327.
<https://doi.org/10.1080/13548500600621545>
- Andreyeva, T., Puhl, R. M., & Brownell, K. D. (2008). Changes in perceived weight discrimination among Americans, 1995–1996 through 2004–2006. *Obesity, 16*(5), 1129–1134. <https://doi.org/10.1038/oby.2008.35>
- APA. (2021). *One year on: Unhealthy weight gains, increased drinking reported by Americans coping with pandemic stress*.
<https://www.apa.org/news/press/releases/2021/03/one-year-pandemic-stress>
- Arcleus, J., Mitchell, A., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: A meta-analysis of 36 studies. *Archives of General Psychiatry, 68*(7).
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*(1), 42–78.
<https://doi.org/10.1002/j.2161-1912.1996.tb00288.x>
- Arthur, N., & Achenbach, K. (2002). Developing multicultural counseling competencies through experiential learning. *Counselor Education and Supervision, 42*(1), 2–14.
<https://doi.org/10.1002/j.1556-6978.2002.tb01299.x>
- ASDAH: Trademark Guidelines. (2003).
<https://www.sizediversityandhealth.org/content.asp?id=159>
- Ata, R. N., & Thompson, J. K. (2010). Weight bias in the media: A review of recent research. *Obesity Facts, 3*(1), 41–46. <https://doi.org/10.1159/000276547>

- Bacon, L. (2010). *Health At Every Size: The Surprising Truth About Your Weight*. BenBella Books, Inc. <http://ebookcentral.proquest.com/lib/uncg/detail.action?docID=544573>
- Bacon, L., & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal, 10*, 9. <https://doi.org/10.1186/1475-2891-10-9>
- Bacon, L., Keim, N. L., Van Loan, M. D., Derricote, M., Gale, B., Kazaks, A., & Stern, J. S. (2002). Evaluating a “non-diet” wellness intervention for improvement of metabolic fitness, psychological well-being and eating and activity behaviors. *International Journal of Obesity and Related Metabolic Disorders: Journal of the International Association for the Study of Obesity, 26*(6), 854–865. <https://doi.org/10.1038/sj.ijo.0802012>
- Bacon, L., Stern, J. S., Van Loan, M. D., & Keim, N. L. (2005). Size acceptance and intuitive eating improve health for obese, female chronic eaters. *Journal of the American Dietetic Association, 105*(6), 929–936. <https://doi.org/10.1016/j.jada.2005.03.011>
- Barden, S. M., Mobley, K., & Shannonhouse, L. (2014). Cultural immersion in counselor education in the United States: A quasi experimental study. *S. M., 6*, 15.
- Barden, S. M., Sherrell, R. S., & Matthews, J. J. (2017). A national survey on multicultural competence for professional counselors: A replication study. *Journal of Counseling & Development, 95*(2), 203–212. <https://doi.org/10.1002/jcad.12132>
- Baum, C. L., & Ford, W. F. (2004). The wage effects of obesity: A longitudinal study. *Health Economics, 13*(9), 885–899. <https://doi.org/10.1002/hec.881>
- Bégin, C., Carbonneau, E., Gagnon-Girouard, M.-P., Mongeau, L., Paquette, M.-C., Turcotte, M., & Provencher, V. (2019). Eating-related and psychological outcomes of Health at Every Size intervention in health and social services centers across the Province of Québec. *American Journal of Health Promotion, 33*(2), 248–258.

- Bergen, M., & Mollen, D. (2019). Teaching sizeism: Integrating size into multicultural education and clinical training. *Women & Therapy, 42*(1–2), 164–180.
<https://doi.org/10.1080/02703149.2018.1524065>
- Bernard, M., Riedel-Heller, S. G., & Luck-Sikorski, C. (2019). Weigh more, pay more? Public opinion on varying health insurance contributions among divergent weight groups. *Obesity Facts, 12*(5), 509–517. <https://doi.org/10.1159/000502799>
- Blodorn, A., Major, B., Hunger, J., & Miller, C. (2016). Unpacking the psychological weight of weight stigma: A rejection-expectation pathway. *Journal of Experimental Social Psychology, 63*, 69–76. <https://doi.org/10.1016/j.jesp.2015.12.003>
- Bombak, A. (2013). Obesity, Health at Every Size, and public health policy. *American Journal of Public Health, 104*(2), e60–e67. <https://doi.org/10.2105/AJPH.2013.301486>
- Bondy, R., Weeks, C., Grainger, S., Villella, K., & Petek, G. (2019). Registered dietitians perception and acceptance of Health at Every Size. *Journal of the Academy of Nutrition & Dietetics, 119*(9), A45–A45. <https://doi.org/10.1016/j.jand.2019.06.122>
- Boyes, A. D., & Latner, J. D. (2009). Weight stigma in existing romantic relationships. *Journal of Sex & Marital Therapy, 35*(4), 282–293. <https://doi.org/10.1080/00926230902851280>
- Boysen, G. A., & Vogel, D. L. (2008). The relationship between level of training, implicit bias, and multicultural competency among counselor trainees. *Training and Education in Professional Psychology, 2*(2), 103–110. <https://doi.org/10.1037/1931-3918.2.2.103>
- Boysen, G. A. (2009). A review of experimental studies of explicit and implicit bias among counselors. *Journal of Multicultural Counseling and Development, 37*(4), 240–249.
- Brady, J., Gingras, J., & Aphramor, L. (2013). Theorizing health at every size as a relational–cultural endeavour. *Critical Public Health, 23*(3), 345–355.

- Breithaupt, L., Trojanowski, P., & Fischer, S. (2020). Implicit and explicit anti-fat attitude change following brief cognitive dissonance intervention for weight stigma. *Obesity*, 28(10), 1853–1859. <https://doi.org/10.1002/oby.22909>
- Brewis, A. A., Hruschka, D. J., & Wutich, A. (2011). Vulnerability to fat-stigma in women’s everyday relationships. *Social Science & Medicine*, 73(4), 491–497. <https://doi.org/10.1016/j.socscimed.2011.05.048>
- Brewis, A. A., Wutich, A., Falletta-Cowden, A., & Rodriguez-Soto, I. (2011). Body norms and fat stigma in global perspective. *Current Anthropology*, 52(2), 269–276. <https://doi.org/10.1086/659309>
- Brown, H., & Saltus, K. (2015). *Body of truth: How science, history, and culture drive our obsession with weight--and what we can do about it* (Unabridged, Vol. 1–6 audio discs (7 hr.) : digital; 4 3/4 in.). Gildan Audio ;
- Brown, L. B. (2009). Teaching the “Health At Every Size” paradigm benefits future fitness and health professionals. *Journal of Nutrition Education and Behavior*, 41(2), 144–145. <https://doi.org/10.1016/j.jneb.2008.04.358>
- Burke, M. E. A. (2019). *Obesity Stigma and Women’s Health: Challenges of Decreasing Healthcare Provider Bias to Improve Outcomes*. <https://sigma.nursingrepository.org/handle/10755/17556>
- Burmeister, J. M., Kiefner, A. E., Carels, R. A., & Musher-Eizenman, D. R. (2013). Weight bias in graduate school admissions. *Obesity*, 21(5), 918–920.
- Calogero, R. M., Tylka, T. L., Mensinger, J. L., Meadows, A., & Daniélsdóttir, S. (2019). Recognizing the fundamental right to be fat: A weight-inclusive approach to size acceptance and healing from sizeism. *Women & Therapy*, 42(1–2), 22–44.

- Calogero, R., & Pedrotty-Stump, K. (2010). Incorporating exercise into eating disorder treatment and recovery. In *Treatment of Eating Disorders: Bridging the Research-Practice Gap* (pp. 425–441). Elsevier Academic Press.
- Carbonneau, E., Bégin, C., Lemieux, S., Mongeau, L., Paquette, M.-C., Turcotte, M., Labonté, M.-È., & Provencher, V. (2017). A Health at Every Size intervention improves intuitive eating and diet quality in Canadian women. *Clinical Nutrition, 36*(3), 747–754.
<https://doi.org/10.1016/j.clnu.2016.06.008>
- Carels, R. A., Rossi, J., Borushok, J., Taylor, M. B., Kiefner-Burmeister, A., Cross, N., Hinman, N., & Burmeister, J. M. (2015). Changes in weight bias and perceived employability following weight loss and gain. *Obesity Surgery, 25*(3), 568–570.
<https://doi.org/10.1007/s11695-014-1522-5>
- Carels, R. A., Wott, C. B., Young, K. M., Gumble, A., Koball, A., & Oehlhof, M. W. (2010). Implicit, explicit, and internalized weight bias and psychosocial maladjustment among treatment-seeking adults. *Eating Behaviors, 11*(3), 180–185.
<https://doi.org/10.1016/j.eatbeh.2010.03.002>
- Castelnuovo, G., Pietrabissa, G., Manzoni, G. M., Cattivelli, R., Rossi, A., Novelli, M., Varallo, G., & Molinari, E. (2017). Cognitive behavioral therapy to aid weight loss in obese patients: Current perspectives. *Psychology Research and Behavior Management, 10*.
<https://doi.org/10.2147/PRBM.S113278>
- Castillo, L. G., Brossart, D. F., Reyes, C. J., Conoley, C. W., & Phoummarath, M. J. (2007). The influence of multicultural training on perceived multicultural counseling competencies and implicit racial prejudice. *Journal of Multicultural Counseling and Development, 35*(4), 243–254. <https://doi.org/10.1002/j.2161-1912.2007.tb00064.x>

- CDC. (2020, June 29). *Obesity is a Common, Serious, and Costly Disease*. Centers for Disease delayed intervention and Prevention. <https://www.cdc.gov/obesity/data/adult.html>
- CDC. (2021, June 7). *Obesity is a Common, Serious, and Costly Disease*. Centers for Disease delayed intervention and Prevention. <https://www.cdc.gov/obesity/data/adult.html>
- Chao, R. C.-L. (2012). Racial/ethnic identity, gender-role attitudes, and multicultural counseling competence: The role of multicultural counseling training. *Journal of Counseling & Development, 90*(1), 35–44. <https://doi.org/10.1111/j.1556-6676.2012.00006.x>
- Chen, E. Y., & Brown, M. (2005). Obesity stigma in sexual relationships. *Obesity Research, 13*(8), 1393–1397. <https://doi.org/10.1038/oby.2005.168>
- Chu, D.-T., Minh Nguyet, N. T., Nga, V. T., Thai Lien, N. V., Vo, D. D., Lien, N., Nhu Ngoc, V. T., Son, L. H., Le, D.-H., Nga, V. B., Van Tu, P., Van To, T., Ha, L. S., Tao, Y., & Pham, V.-H. (2019). An update on obesity: Mental consequences and psychological interventions. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews, 13*(1), 155–160. <https://doi.org/10.1016/j.dsx.2018.07.015>
- Collins, S., Arthur, N., Brown, C., & Kennedy, B. (2015). Student perspectives: Graduate education facilitation of multicultural counseling and social justice competency. *Training and Education in Professional Psychology, 9*(2), 153–160. <https://doi.org/10.1037/tep0000070>
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16. <https://doi.org/10.1037/0022-0167.54.1.1>
- Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case

- conceptualization ability. *Journal of Counseling Psychology*, 47(2), 155–164.
<https://doi.org/10.1037/0022-0167.47.2.155>
- Constantine, M. G. (2002). Racism attitudes, white racial identity attitudes, and multicultural counseling competence in school counselor trainees. *Counselor Education and Supervision*, 41(3), 162–174. <https://doi.org/10.1002/j.1556-6978.2002.tb01281.x>
- Cooney, L. G., Milman, L. W., Hantsoo, L., Kornfield, S., Sammel, M. D., Allison, K. C., Epperson, C. N., & Dokras, A. (2018). Cognitive-behavioral therapy improves weight loss and quality of life in women with polycystic ovary syndrome: A pilot randomized clinical trial. *Fertility and Sterility*, 110(1), 161-171.e1.
<https://doi.org/10.1016/j.fertnstert.2018.03.028>
- Council for Accreditation of Counseling and Related Educational Programs. (2018). CACREP vital statistics 2017: Results from a national survey of accredited programs. Alexandria, VA: Author.
- Correll, J., Park, B., Judd, C. M., Wittenbrink, B., Sadler, M. S., & Keesee, T. (2007). Across the thin blue line: Police officers and racial bias in the decision to shoot. *Journal of Personality and Social Psychology*, 92(6), 1006–1023.
<https://doi.org/10.1037/0022-3514.92.6.1006>
- Cox, A. E., Ullrich-French, S., Tylka, T. L., & McMahon, A. K. (2019). The roles of self-compassion, body surveillance, and body appreciation in predicting intrinsic motivation for physical activity: Cross-sectional associations, and prospective changes within a yoga context. *Body Image*, 29, 110–117.
<https://doi.org/10.1016/j.bodyim.2019.03.002>

- Cramer, P., & Steinwert, T. (1998). Thin is good, fat is bad: How early does it begin? *Journal of Applied Developmental Psychology, 19*(3), 429–451.
[https://doi.org/10.1016/S0193-3973\(99\)80049-5](https://doi.org/10.1016/S0193-3973(99)80049-5)
- Crandall, C. S. (1994). Prejudice against fat people: Ideology and self-interest. *Journal of Personality and Social Psychology, 66*(5), 882–894.
<https://doi.org/10.1037/0022-3514.66.5.882>
- Cravens, J. D., Pratt, K. J., Palmer, E., & Amar, R. (2016). Marriage and family therapy students' views on including weight bias training into their clinical programs. *Contemporary Family Therapy, 38*(2), 210–222.
<https://doi.org/10.1007/s10591-015-9366-2>
- Daumeyer, N. M., Onyeador, I. N., Brown, X., & Richeson, J. A. (2019). Consequences of attributing discrimination to implicit vs. Explicit bias. *Journal of Experimental Social Psychology, 84*, 103812. <https://doi.org/10.1016/j.jesp.2019.04.010>
- Davis-Coelho, K., Waltz, J., & Davis-Coelho, B. (2000). Awareness and prevention of bias against fat clients in psychotherapy. *Professional Psychology: Research and Practice, 31*(6), 682–684. <https://doi.org/10.1037/0735-7028.31.6.682>
- De Houwer, J. (2019). Implicit bias is behavior: A functional-cognitive perspective on implicit bias. *Perspectives on Psychological Science, 14*(5), 835–840. h
- Deloitte Access Economics. (2020). *The social and economic cost of eating disorders in the United States of America: A report for the strategic training initiative for the prevention of eating disorders and the academy for eating disorders* (Deloitte Access Economics). Harvard University.
<https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/>

- Denny, K. N., Loth, K., Eisenberg, M. E., & Neumark-Sztainer, D. (2013). Intuitive eating in young adults. Who is doing it, and how is it related to disordered eating behaviors? *Appetite, 60*, 13–19. <https://doi.org/10.1016/j.appet.2012.09.029>
- Dimitrov Ulian, M., Pinto, A. J., de Morais Sato, P., B Benatti, F., Lopes de Campos-Ferraz, P., Coelho, D., Roble, O. J., Sabatini, F., Perez, I., Aburad, L., Vessoni, A., Fernandez Unsain, R., Macedo Rogero, M., Toporcov, T. N., de Sá-Pinto, A. L., Gualano, B., & B Scagliusi, F. (2018). Effects of a new intervention based on the Health at Every Size approach for the management of obesity: The “Health and Wellness in Obesity” study. *PloS One, 13*(7), e0198401. <https://doi.org/10.1371/journal.pone.0198401>
- Dovidio, J. F., & Gaertner, S. L. (2010). Intergroup bias. In *Handbook of social psychology, Vol. 2, 5th ed* (pp. 1084–1121). John Wiley & Sons, Inc. <https://doi.org/10.1002/9780470561119.socpsy002029>
- Drury, C. A. A., & Louis, M. (2002). Exploring the association between body weight, stigma of obesity, and health care avoidance. *Journal of the American Academy of Nurse Practitioners, 14*(12), 554–561. <https://doi.org/10.1111/j.1745-7599.2002.tb00089.x>
- Durso, L. E., Latner, J. D., White, M. A., Masheb, R. M., Blomquist, K. K., Morgan, P. T., & Grilo, C. M. (2012). Internalized weight bias in obese patients with binge eating disorder: Associations with eating disturbances and psychological functioning. *International Journal of Eating Disorders, 45*(3), 423–427. <https://doi.org/10.1002/eat.20933>
- Eberhardt, J. L., Goff, P. A., Purdie, V. J., & Davies, P. G. (2004). Seeing black: race, crime, and visual processing. *Journal of Personality and Social Psychology, 87*(6), 876–893. <https://doi.org/10.1037/0022-3514.87.6.876>

- Erickson Cornish, J. A., Schreier, B. A., Nadkarni, L. I., Metzger, L. H., Rodolfa, E. R., & Rodolfa, E. R. (2010). *Handbook of Multicultural Counseling Competencies*. John Wiley & Sons, Incorporated.
- <http://ebookcentral.proquest.com/lib/uncg/detail.action?docID=554978>
- Fairburn, C. G., Cooper, Z., Doll, H. A., & Davies, B. A. (2005). Identifying dieters who will develop an eating disorder: A prospective, population-based study. *American Journal of Psychiatry*, *162*(12), 2249–2255. <https://doi.org/10.1176/appi.ajp.162.12.2249>
- Festinger, L. (1962). Cognitive Dissonance. *Scientific American*, *207*(4), 93–106.
- Finkelstein, L. M., Frautschy Demuth, R. L., & Sweeney, D. L. (2007). Bias against overweight job applicants: Further explorations of when and why. *Human Resource Management*, *46*(2), 203–222. <https://doi.org/10.1002/hrm.20157>
- Flint, S. W., Čadek, M., Codreanu, S. C., Ivić, V., Zomer, C., & Gomoiu, A. (2016). Obesity discrimination in the recruitment process: “You’re not hired!” *Frontiers in Psychology*, *7*, 647. <https://doi.org/10.3389/fpsyg.2016.00647>
- Gaesser, G. A. (2006). Study “confirms” you can’t be fat and healthy—But what do the data show? *Health At Every Size; Hamilton*, *20*(1), 47–53.
- Gapinski, K. D., Schwartz, M. B., & Brownell, K. D. (2006). Can television change anti-fat attitudes and behavior? *Journal of Applied Biobehavioral Research*, *11*(1), 1–28.
- Gerber, L. (2012). Fat christians and fit elites: Negotiating class and status in evangelical christian weight-loss culture. *American Quarterly*, *64*(1), 61–84.
- Gillem, A. R., Bartoli, E., Bertsch, K. N., McCarthy, M. A., Constant, K., Marrero-Meisky, S., Robbins, S. J., & Bellamy, S. (2016). Validation of a standardized multiple-choice multicultural competence test: Implications for training, assessment, and practice.

- Journal of Multicultural Counseling and Development*, 44(3), 209–224.
<https://doi.org/10.1002/jmcd.12047>
- Gonzalez, J., Barden, S. M., & Sharp, J. (2018). Multicultural competence and the working alliance as predictors of client outcomes. *The Professional Counselor*, 8(4), 314–327.
<https://doi.org/10.15241/jg.8.4.314>
- Greenberg, B. S., Eastin, M., Hofschire, L., Lachlan, K., & Brownell, K. D. (2003). Portrayals of overweight and obese individuals on commercial television. *American Journal of Public Health*, 93(8), 1342–1348.
- Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology*, 74(6), 1464–1480. <https://doi.org/10.1037//0022-3514.74.6.1464>
- Greenwald, A. G., Banaji, M. R., & Nosek, B. A. (2015). Statistically small effects of the Implicit Association Test can have societally large effects. *Journal of Personality and Social Psychology*, 108(4), 553–561. <https://doi.org/10.1037/pspa0000016>
- Griffith, R. M. (2004). *Born Again Bodies: Flesh and Spirit in American Christianity*. University of California Press.
<http://ebookcentral.proquest.com/lib/uncg/detail.action?docID=223882>
- Grilo, C. M., & Masheb, R. M. (2005). A randomized delayed interventionled comparison of guided self-help cognitive behavioral therapy and behavioral weight loss for binge eating disorder. *Behaviour Research and Therapy*, 43(11), 1509–1525.
<https://doi.org/10.1016/j.brat.2004.11.010>
- HAES® Curriculum. (n.d.). HAES® Curriculum. Retrieved July 9, 2021, from <https://haescurriculum.com/>

- Hagan, M. M., Tomaka, J., & Moss, D. E. (2000). Relation of dieting in college and high school students to symptoms associated with semi-starvation. *Journal of Health Psychology*, 5(1), 7–15. <https://doi.org/10.1177/135910530000500105>
- Hartman McGilley, B. (2014, April 30). Intuitive exercise. *Eating Disorders Research Catalogue*. <https://www.edcatalogue.com/intuitive-exercise/>
- Hassel, T. D., Amici, C. J., Thurston, N. S., & Gorsuch, R. L. (2001). Client weight as a barrier to non-biased clinical judgment. *Journal of Psychology and Christianity*, 20(2), 145–161.
- Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). Associations between perceived weight discrimination and the prevalence of psychiatric disorders in the general population. *Obesity*, 17(11), 2033–2039. <https://doi.org/10.1038/oby.2009.131>
- Himes, S. M., & Thompson, J. K. (2007). Fat stigmatization in television shows and movies: A content analysis. *Obesity (Silver Spring, Md.)*, 15(3), 712–718. <https://doi.org/10.1038/oby.2007.635>
- Himmelstein, M. S., Belsky, A. C. I., & Tomiyama, A. J. (2015). The weight of stigma: Cortisol reactivity to manipulated weight stigma. *Obesity*, 23(2), 368–374. <http://dx.doi.org/10.1002/oby.20959>
- Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2017). Intersectionality: An understudied framework for addressing weight stigma. *American Journal of Preventive Medicine*, 53(4), 421–431. <https://doi.org/10.1016/j.amepre.2017.04.003>
- Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2018). Weight stigma in men: What, when, and by whom? *Obesity*, 26(6), 968–976. <https://doi.org/10.1002/oby.22162>
- Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2019). Overlooked and understudied: Health consequences of weight stigma in men. *Obesity*, 27(10), 1598–1605.

- Holcomb-McCoy, C. C., & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development, 77*(3), 294–302.
<https://doi.org/10.1002/j.1556-6676.1999.tb02452.x>
- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366. <https://doi.org/10.1037/a0032595>
- Humphrey, L., Clifford, D., & Neyman Morris, M. (2015). Health at Every Size college course reduces dieting behaviors and improves intuitive eating, body esteem, and anti-fat attitudes. *Journal of Nutrition Education and Behavior, 47*(4), 354-360.e1.
<https://doi.org/10.1016/j.jneb.2015.01.008>
- Hunger, J. M., Major, B., Blodorn, A., & Miller, C. T. (2015). Weighed down by stigma: How weight-based social identity threat contributes to weight gain and poor health. *Social and Personality Psychology Compass, 9*(6), 255–268. <https://doi.org/10.1111/spc3.12172>
- Johnson, S., & Taylor, K. (2011). *The Neuroscience of Adult Learning: New Directions for Adult and Continuing Education, Number 110*. John Wiley & Sons.
- Karsay, K., & Schmuck, D. (2019). “Weak, sad, and sazy fatties”: Adolescents’ explicit and implicit weight bias following exposure to weight loss reality TV shows. *Media Psychology, 22*(1), 60–81. <https://doi.org/10.1080/15213269.2017.1396903>
- Kasardo, A. E. (2018). Size as diversity absent from multicultural textbooks. *Women & Therapy*.
<http://www.tandfonline.com/doi/abs/10.1080/02703149.2018.1524069>
- Kavic, M. S. (2001). Obesity – An “acceptable” prejudice. *JSLs: Journal of the Society of Laparoendoscopic Surgeons, 5*(3), 201–202.

- Kim, N., Oh, S., & Mumbauer, J. (2019). Supporting international students: Enhancing college counselors' multicultural counseling competence. *Journal of College Counseling, 22*(2), 179–192. <https://doi.org/10.1002/jocc.12129>
- Kinavey, H., & Cool, C. (2019). The broken lens: How anti-fat bias in psychotherapy is harming our clients and what to do about it. *Women & Therapy, 42*(1–2), 116–130. <https://doi.org/10.1080/02703149.2018.1524070>
- Latner, J. D., O'Brien, K. S., Durso, L. E., Brinkman, L. A., & MacDonald, T. (2008). Weighing obesity stigma: The relative strength of different forms of bias. *International Journal of Obesity (2005), 32*(7), 1145–1152. <https://doi.org/10.1038/ijo.2008.53>
- Lawrence, S. A., Hazlett, R., & Abel, E. M. (2012). Obesity related stigma as a form of oppression: Implications for social work education. *Social Work Education, 31*(1), 63–74. <https://doi.org/10.1080/02615479.2010.541236>
- Leblanc, V., Provencher, V., Bégin, C., Corneau, L., Tremblay, A., & Lemieux, S. (2012). Impact of a Health-At-Every-Size intervention on changes in dietary intakes and eating patterns in premenopausal overweight women: Results of a randomized trial. *Clinical Nutrition, 31*(4), 481–488. <https://doi.org/10.1016/j.clnu.2011.12.013>
- Lee, E. (2011). Clinical significance of cross-cultural competencies (CCC) in social work practice. *Journal of Social Work Practice, 25*(02), 185–203. <https://doi.org/10.1080/02650533.2011.573654>
- Lier, H. Ø., Biringer, E., Stubhaug, B., & Tangen, T. (2012). The impact of preoperative counseling on postoperative treatment adherence in bariatric surgery patients: A randomized control trial. *Patient Education and Counseling, 87*(3), 336–342. <https://doi.org/10.1016/j.pec.2011.09.014>

- Major, B., Eliezer, D., & Rieck, H. (2012). The psychological weight of weight stigma. *Social Psychological and Personality Science*, 3(6), 651–658.
<https://doi.org/10.1177/1948550611434400>
- Marcus, M. D., & Wildes, J. E. (2012). Obesity in DSM-5. *Psychiatric Annals*, 42(11), 431–435.
<http://dx.doi.org.libproxy.uncg.edu/10.3928/00485713-20121105-10>
- Martin, C. B., & Ogden, C. L. (2018). *Attempts to Lose Weight Among Adults in the United States, 2013–2016*. 313, 8.
- McHugh, M. C., & Chrisler, J. C. (2019). Making space for every body: Ending sizeism in psychotherapy and training. *Women & Therapy*, 42(1–2), 7–21.
<https://doi.org/10.1080/02703149.2018.1524062>
- Mensingher, J. L., Calogero, R. M., Stranges, S., & Tylka, T. L. (2016). A weight-neutral versus weight-loss approach for health promotion in women with high BMI: A randomized-delayed control trial. *Appetite*, 105, 364–374.
<https://doi.org/10.1016/j.appet.2016.06.006>
- Meyer, C., & Taranis, L. (2011). Exercise in the eating disorders: Terms and definitions. *European Eating Disorders Review*, 19, 169–173.
- Mokdad, A. H., Ford, E. S., Bowman, B. A., Dietz, W. H., Vinicor, F., Bales, V. S., & Marks, J. S. (2003). Prevalence of obesity, diabetes, and obesity-related health risk factors, 2001. *JAMA*, 289(1), 76–79. <https://doi.org/10.1001/jama.289.1.76>
- Moller, N., & Tischner, I. (2019). Young people’s perceptions of fat counsellors: “How can THAT help me?” *Qualitative Research in Psychology*, 16(1), 34–53.
<https://doi.org/10.1080/14780887.2018.1536384>

- Mulherin, K., Miller, Y. D., Barlow, F. K., Diedrichs, P. C., & Thompson, R. (2013). Weight stigma in maternity care: Women's experiences and care providers' attitudes. *BMC Pregnancy and Childbirth*, *13*(1), 19. <https://doi.org/10.1186/1471-2393-13-19>
- Murakami, J. M., & Latner, J. D. (2015). Weight acceptance versus body dissatisfaction: Effects on stigma, perceived self-esteem, and perceived psychopathology. *Eating Behaviors*, *19*, 163–167. <https://doi.org/10.1016/j.eatbeh.2015.09.010>
- Naylor, H., Mountford, V., & Brown, G. (2011). Beliefs about excessive exercise in eating disorders: The role of obsessions and compulsions. *European Eating Disorders Review*, *19*, 226–236.
- Neumark-Sztainer, D., Story, M., & Harris, T. (1999). Beliefs and attitudes about obesity among teachers and school health care providers working with adolescents. *Journal of Nutrition Education*, *31*(1), 3–9. [https://doi.org/10.1016/S0022-3182\(99\)70378-X](https://doi.org/10.1016/S0022-3182(99)70378-X)
- Nutter, S., Russell-Mayhew, S., Alberga, A. S., Arthur, N., Kassin, A., Lund, D. E., Sesma-Vazquez, M., & Williams, E. (2016). Positioning of weight bias: Moving towards social justice. *Journal of Obesity*, *2016*. <https://doi.org/10.1155/2016/3753650>
- O'Brien, K. S., Latner, J. D., Halberstadt, J., Hunter, J. A., Anderson, J., & Caputi, P. (2008). Do antifat attitudes predict antifat behaviors? *Obesity*, *16*(S2), S87–S92.
- O'Hara, L., & Gregg, J. (2006). The war on obesity: A social determinant of health. *Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals*, *17*(3), 260–263. <https://doi.org/10.1071/he06260>
- Olson, C. L., Schumaker, H. D., & Yawn, B. P. (1994). Overweight women delay medical care. *Archives of Family Medicine*, *3*(10), 888–892. <https://doi.org/10.1001/archfami.3.10.888>
- Oswald, F. L., Mitchell, G., Blanton, H., Jaccard, J., & Tetlock, P. E. (2013). Predicting ethnic

- and racial discrimination: A meta-analysis of IAT criterion studies. *Journal of Personality and Social Psychology*, 105(2), 171–192. <https://doi.org/10.1037/a0032734>
- Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Multicultural approaches in psychotherapy: A rejoinder. *Journal of Counseling Psychology*, 58(1), 22–26. <https://doi.org/10.1037/a0022222>
- Pagán, J. A., & Dávila, A. (1997). Obesity, occupational attainment, and earnings. *Social Science Quarterly*, 78(3), 756–770.
- Pantenburg, B., Sikorski, C., Luppá, M., Schomerus, G., König, H.-H., Werner, P., & Riedel-Heller, S. G. (2012). Medical students' attitudes towards overweight and obesity. *PLoS ONE*, 7(11). <https://doi.org/10.1371/journal.pone.0048113>
- Panza, E., Olson, K., Goldstein, C. M., Selby, E. A., & Lillis, J. (2020). Characterizing lifetime and daily experiences of weight stigma among sexual minority women with overweight and obesity: A descriptive study. *International Journal of Environmental Research and Public Health*, 17(13), 4892. <https://doi.org/10.3390/ijerph17134892>
- Pascal, B. (2011). *Counselors-in-training's Perceptions of Clients: The Influences of Client Weight and Job Status* [M.C., Arizona State University]. <http://www.proquest.com/docview/893804337/abstract/30D6BB6515C4B6FPQ/1>
- Pascal, B., & Kurpius, S. E. R. (2012). Perceptions of clients: Influences of client weight and job status. *Professional Psychology: Research and Practice*, 43(4), 349–355. <https://doi.org/10.1037/a0028525>
- Pearl, R. L. (2018). Weight bias and stigma: Public health implications and structural solutions. *Social Issues and Policy Review*, 12(1), 146–182. <https://doi.org/10.1111/sipr.12043>

- Pearl, R. L., & Schulte, E. M. (2021). Weight bias during the COVID-19 pandemic. *Current Obesity Reports, 10*(2), 181–190. <https://doi.org/10.1007/s13679-021-00432-2>
- Penney, T. L., & Kirk, S. F. L. (2015). The Health at Every Size paradigm and obesity: Missing empirical evidence may help push the reframing obesity debate forward. *American Journal of Public Health, 105*(5), e38–e42. <https://doi.org/10.2105/AJPH.2015.302552>
- Phelan, S. M., Burgess, D. J., Puhl, R., Dyrbye, L. N., Dovidio, J. F., Yeazel, M., Ridgeway, J. L., Nelson, D., Perry, S., Przedworski, J. M., Burke, S. E., Hardeman, R. R., & van Ryn, M. (2015). The adverse effect of weight stigma on the well-being of medical students with overweight or obesity: Findings from a national survey. *Journal of General Internal Medicine, 30*(9), 1251–1258. <http://dx.doi.org/10.1007/s11606-015-3266-x>
- Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews: An Official Journal of the International Association for the Study of Obesity, 16*(4), 319–326. <https://doi.org/10.1111/obr.12266>
- Phelan, S. M., Dovidio, J. F., Puhl, R. M., Burgess, D. J., Nelson, D. B., Yeazel, M. W., Hardeman, R., Perry, S., & van Ryn, M. (2014). Implicit and explicit weight bias in a national sample of 4732 medical students: The medical student CHANGES study. *Obesity (Silver Spring, Md.), 22*(4), 1201–1208. <https://doi.org/10.1002/oby.20687>
- Phelan, S. M., Puhl, R. M., Burke, S. E., Hardeman, R., Dovidio, J. F., Nelson, D. B., Przedworski, J., Burgess, D. J., Perry, S., Yeazel, M. W., & van Ryn, M. (2015). The mixed impact of medical school on medical students' implicit and explicit weight bias. *Medical Education, 49*(10), 983–992. <https://doi.org/10.1111/medu.12770>

- Pitt, P. D. (2018). Treating youth obesity: Review and application of APA practice guidelines. *Journal of Health Service Psychology, 44*(2), 54–60. <https://doi.org/10.1007/BF03544663>
- Pitter, J. (2015, August 11). Weighing in: Fat discrimination on public transit. *Spacing Toronto*. <https://spacing.ca/toronto/2015/08/11/weighing-fat-discrimination-public-transit/>
- Pomeranz, J. L., & Puhl, R. M. (2013). New developments in the law for obesity discrimination protection. *Obesity, 21*(3), 469–471. <https://doi.org/10.1002/oby.20094>
- Ponterotto, J. G. (1996). *Handbook of multicultural assessment: Assessing the multicultural competence of counselors and clinicians*. Jossey-Bass.
- Ponterotto, J. G., Rieger, B. P., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling & Development, 72*(3), 316–322. <https://doi.org/10.1002/j.1556-6676.1994.tb00941.x>
- Pratt, K. J., Holowacz, E., & Walton, N. L. (2014). Marriage and family therapists' perspectives on treating overweight clients and their weight-related behaviors. *The American Journal of Family Therapy, 42*(5), 364–385. <https://doi.org/10.1080/01926187.2013.878170>
- Pratt, K. J., Palmer, E., Cravens, J. D., Ferriby, M., Balk, E., & Cai, Y. (2016). Marriage and family therapy trainees' reports of explicit weight bias. *Journal of Marital and Family Therapy, 42*(2), 288–298. <https://doi.org/10.1111/jmft.12116>
- Provencher, V., Bégin, C., Tremblay, A., Mongeau, L., Corneau, L., Dodin, S., Boivin, S., & Lemieux, S. (2009). Health-At-Every-Size and eating behaviors: 1-year follow-up results of a size acceptance intervention. *Journal of the American Dietetic Association, 109*(11), 1854–1861. <https://doi.org/10.1016/j.jada.2009.08.017>
- Puhl, R., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research, 9*(12), 788–805. <https://doi.org/10.1038/oby.2001.108>

- Puhl, R. M., Andreyeva, T., & Brownell, K. D. (2008). Perceptions of weight discrimination: Prevalence and comparison to race and gender discrimination in America. *International Journal of Obesity*, 32(6), 992–1000. <https://doi.org/10.1038/ijjo.2008.22>
- Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity*, 17(5), 941–964. <https://doi.org/10.1038/oby.2008.636>
- Puhl, R. M., & King, K. M. (2013). Weight discrimination and bullying. *Best Practice & Research. Clinical Endocrinology & Metabolism*, 27(2), 117–127. <https://doi.org/10.1016/j.beem.2012.12.002>
- Puhl, R. M., Latner, J. D., King, K. M., & Luedicke, J. (2014). Weight bias among professionals treating eating disorders: Attitudes about treatment and perceived patient outcomes. *International Journal of Eating Disorders*, 47(1), 65–75. <https://doi.org/10.1002/eat.22186>
- Puhl, R. M., Lessard, L. M., Larson, N., Eisenberg, M. E., & Neumark-Stzainer, D. (2020). Weight stigma as a predictor of distress and maladaptive eating behaviors during COVID-19: Longitudinal findings from the EAT study. *Annals of Behavioral Medicine*, 54(10), 738–746. <https://doi.org/10.1093/abm/kaaa077>
- Puhl, R. M., Luedicke, J., & Heuer, C. (2011). Weight-based victimization toward overweight adolescents: Observations and reactions of peers. *Journal of School Health*, 81(11), 696–703. <https://doi.org/10.1111/j.1746-1561.2011.00646.x>
- Puhl, R. M., Phelan, S. M., Nadglowski, J., & Kyle, T. K. (2016). Overcoming weight bias in the management of patients with diabetes and obesity. *Clinical Diabetes : A Publication of the American Diabetes Association*, 34(1), 44–50. <https://doi.org/10.2337/diaclin.34.1.44>

- Quinn, D. M., & Crocker, J. (1999). When ideology hurts: Effects of belief in the Protestant ethic and feeling overweight on the psychological well-being of women. *Journal of Personality and Social Psychology, 77*(2), 402–414.
<https://doi.org/10.1037/0022-3514.77.2.402>
- Ramírez Stege, A. M., Brockberg, D., & Hoyt, W. T. (2017). Advocating for advocacy: An exploratory survey on student advocacy skills and training in counseling psychology. *Training and Education in Professional Psychology, 11*(3), 190–197.
<https://doi.org/10.1037/tep0000158>
- Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *Journal of Humanistic Counseling, Education & Development, 48*(2), 160–172. <https://doi.org/10.1002/j.2161-1939.2009.tb00076.x>
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28–48.
<https://doi.org/10.1002/jmcd.12035>
- Reece, R. L. (2019). Coloring weight stigma: On race, colorism, weight stigma, and the failure of additive intersectionality. *Sociology of Race and Ethnicity, 5*(3), 388–400.
<https://doi.org/10.1177/2332649218795185>
- Robinson, T., Callister, M., & Jankoski, T. (2008). Portrayal of body weight on children’s television sitcoms: A content analysis. *Body Image, 5*(2), 141–151.
- Roehling, M. V. (2002). Weight discrimination in the american workplace: Ethical issues and analysis. *Journal of Business Ethics, 40*(2), 177–189.
<https://doi.org/10.1023/A:1020347305736>

- Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders, 48*(2), 187–198. <https://doi.org/10.1002/eat.22270>
- Rosalez, A. M. (2014). *Teaching the Health at Every Size® curriculum to dietetics students: A look at anti-fat attitudes*. <https://commons.lib.niu.edu/handle/10843/17746>
- Rosalez, A., Ozier, A., Kubal, A., & Parker, J. (2015). Teaching the Health At Every Size® curriculum to dietetics students: Do anti-fat attitudes change? *Journal of Nutrition Education and Behavior, 47*(4), S11. <https://doi.org/10.1016/j.jneb.2015.04.030>
- Rothblum, E. D., & Gartrell, N. K. (2019). Sizeism in mental health training and supervision. *Women & Therapy, 42*(1–2), 147–155. <https://doi.org/10.1080/02703149.2018.1524074>
- Sabin, J. A., Marini, M., & Nosek, B. A. (2012). Implicit and explicit anti-fat bias among a large sample of medical doctors by BMI, race/ethnicity and gender. *PLOS ONE, 7*(11), e48448. <https://doi.org/10.1371/journal.pone.0048448>
- Saguy, A. C., & Ward, A. (2011). Coming out as fat: Rethinking stigma. *Social Psychology Quarterly, 74*(1), 53–75. <https://doi.org/10.1177/0190272511398190>
- Satinsky, S., Reece, M., Dennis, B., Sanders, S., & Bardzell, S. (2012). An assessment of body appreciation and its relationship to sexual function in women. *Body Image, 9*(1), 137–144. <https://doi.org/10.1016/j.bodyim.2011.09.007>
- Schafer, M., & Ferraro, K. (2011). The stigma of obesity. *Social Psychology Quarterly, 74*(1), 76–97.
- Schwartz, M. B., Chambliss, H. O., Brownell, K. D., Blair, S. N., & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research, 11*(9), 1033–1039. <https://doi.org/10.1038/oby.2003.142>

- Schwartz, M. B., Vartanian, L. R., Nosek, B. A., & Brownell, K. D. (2006). The influence of one's own body weight on implicit and explicit anti-fat bias. *Obesity, 14*(3), 440–447. <https://doi.org/10.1038/oby.2006.58>
- Shannonhouse, L., O'Hara, C., & Erford, B. (2020). Psychometric synthesis of the multicultural counseling inventory. *Measurement and Evaluation in Counseling and Development, 53*(2), 131–148. <https://doi.org/10.1080/07481756.2018.1476028>
- Sheu, H.-B., & Lent, R. W. (2007). Development and initial validation of the Multicultural Counseling Self-Efficacy Scale—Racial Diversity Form. *Psychotherapy (Chicago, Ill.), 44*(1), 30–45. <https://doi.org/10.1037/0033-3204.44.1.30>
- Sikorski, C., Luppia, M., Kaiser, M., Glaesmer, H., Schomerus, G., König, H.-H., & Riedel-Heller, S. G. (2011). The stigma of obesity in the general public and its implications for public health—A systematic review. *BMC Public Health, 11*(1), 661. <https://doi.org/10.1186/1471-2458-11-661>
- Sims, C. (2018). Personal/physical appearance stigmatizing in the workforce. In *Diversity in the Workforce* (2nd ed.). Routledge.
- Sitton, S., & Blanchard, S. (1995). Men's preferences in romantic partners: Obesity vs addiction. *Psychological Reports, 77*(3), 1185–1186.
- Smirles, K. E., & Lin, L. (2018). Changes in anti-fat weight bias in women after exposure to thin and plus-sized models. *The Social Science Journal, 55*(2), 193–197. <https://doi.org/10.1016/j.soscij.2018.02.002>
- Smith, C. A. (2019). Intersectionality and sizeism: Implications for mental health practitioners. *Women & Therapy, 42*(1–2), 59–78. <https://doi.org/10.1080/02703149.2018.1524076>

- Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*(2), 137–148.
<https://doi.org/10.1037/0022-0167.41.2.137>
- Soto, A., Smith, T. B., Griner, D., Domenech Rodríguez, M., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology, 74*(11), 1907–1923. <https://doi.org/10.1002/jclp.22679>
- Sterne, J. A. C., White, I. R., Carlin, J. B., Spratt, M., Royston, P., Kenward, M. G., Wood, A. M., & Carpenter, J. R. (2009). Multiple imputation for missing data in epidemiological and clinical research: Potential and pitfalls. *The BMJ, 338*, b2393.
<https://doi.org/10.1136/bmj.b2393>
- Strings, S. (2019). *Fearing the Black Body: The Racial Origins of Fat Phobia*. New York University Press.
- Sue, D. W., Arredondo, P., & McDAVIS, R. J. (1992). *Multicultural Counseling Competencies and Standards: A Call to the Profession. 70*, 10.
- Sue, D. W., & Sue, D. (2015). *Counseling the Culturally Diverse: Theory and Practice*. John Wiley & Sons, Incorporated.
<http://ebookcentral.proquest.com/lib/uncg/detail.action?docID=4189578>
- Suh, Y., Puhl, R., Liu, S., & Milici, F. F. (2014). Support for laws to prohibit weight discrimination in the united states: Public attitudes from 2011 to 2013. *Obesity, 22*(8), 1872–1879. <https://doi.org/10.1002/oby.20750>
- Sutin, A. R., Stephan, Y., & Terracciano, A. (2015). Weight discrimination and risk of mortality. *Psychological Science, 26*(11), 1803–1811. <https://doi.org/10.1177/0956797615601103>

- Sutin, A., Stephan, Y., Luchetti, M., & Terracciano, A. (2014). Perceived weight discrimination and C-reactive protein. *Obesity*, 22(9), 1959–1961.
- Swift, J. A., Hanlon, S., El-Redy, L., Puhl, R. M., & Glazebrook, C. (2013). Weight bias among UK trainee dietitians, doctors, nurses and nutritionists. *Journal of Human Nutrition and Dietetics*, 26(4), 395–402. <https://doi.org/10.1111/jhn.12019>
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology*, 62(3), 337–350. <https://doi.org/10.1037/cou0000086>
- Teachman, B. A., & Brownell, K. D. (2001). Implicit anti-fat bias among health professionals: Is anyone immune? *International Journal of Obesity and Related Metabolic Disorders: Journal of the International Association for the Study of Obesity*, 25(10), 1525–1531. <https://doi.org/10.1038/sj.ijo.0801745>
- Teachman, B. A., Gapinski, K. D., Brownell, K. D., Rawlins, M., & Jeyaram, S. (2003). Demonstrations of implicit anti-fat bias: The impact of providing causal information and evoking empathy. *Health Psychology*, 22(1), 68–78. <https://doi.org/10.1037/0278-6133.22.1.68>
- Tomiyaama, A. J., Ahlstrom, B., & Mann, T. (2013). Long-term effects of dieting: Is weight loss related to health?: Weight-loss diets and health. *Social and Personality Psychology Compass*, 7(12), 861–877. <https://doi.org/10.1111/spc3.12076>
- Tomiyaama, A. J., Finch, L. E., Belsky, A. C. I., Buss, J., Finley, C., Schwartz, M. B., & Daubenmier, J. (2015). Weight bias in 2001 versus 2013: Contradictory attitudes among obesity researchers and health professionals. *Obesity*, 23(1), 46–53. <https://doi.org/10.1002/oby.20910>

- Townsend, M. J., Kyle, T. K., & Stanford, F. C. (2021). COVID-19 vaccination and obesity: optimism and challenges. *Obesity*, 29(4), 634–635. <https://doi.org/10.1002/oby.23131>
- Tribole, E., & Resch, E. (2012). *Intuitive Eating: A Revolutionary Program that Works* (3rd ed.). St. Martin's Press.
- Van Dyke, N., & Drinkwater, E. J. (2014). Review article relationships between intuitive eating and health indicators: Literature review. *Public Health Nutrition*, 17(8), 1757–1766. <https://doi.org/10.1017/S1368980013002139>
- van Ryn, M., Hardeman, R., Phelan, S. M., PhD, D. J. B., Dovidio, J. F., Herrin, J., Burke, S. E., Nelson, D. B., Perry, S., Yeazel, M., & Przedworski, J. M. (2015). Medical school experiences associated with change in implicit racial bias among 3547 students: A medical student CHANGES study Report. *Journal of General Internal Medicine*, 30(12), 1748–1756. <https://doi.org/10.1007/s11606-015-3447-7>
- Vaughn, E. D., Thomas, A., & Doyle, A. L. (2011). The Multiple Disability Implicit Association Test: Psychometric analysis of a multiple administration IAT measure. *Rehabilitation Counseling Bulletin*, 54(4), 223–235. <https://doi.org/10.1177/0034355211403008>
- Vuletich, H. A., & Payne, B. K. (2019). Stability and change in implicit bias. *Psychological Science*, 30(6), 854–862. <https://doi.org/10.1177/0956797619844270>
- Wadden, T. A., & Bray, G. A. (2018). *Handbook of Obesity Treatment* (2nd ed.). The Guilford Press. <https://books-google-com.libproxy.uncg.edu/books?hl=en&lr=&id=P2s8DwAAQB-AJ&oi=fnd&pg=PP1&dq=obesity+treatment&ots=LixtsoBEZn&sig=bakdaDiORUycV5kknNMmlobg7lU#v=onepage&q=obesity%20treatment&f=false>

- Wadden, T. A., & Sarwer, D. B. (2006). Behavioral assessment of candidates for bariatric surgery: A patient-oriented approach. *Surgery for Obesity and Related Diseases*, 2(2), 171–179. <https://doi.org/10.1016/j.soard.2006.03.011>
- Warchal, J. R., & West, P. (2013). *Obesity Is Not New—Addressing It in Counseling Is*. 12.
- Williams, D. S. (2008). Design with dignity: The design and manufacturing of appropriate furniture for the bariatric patient population. *Bariatric Nursing and Surgical Patient Care*, 3(1), 39–40. <https://doi.org/10.1089/bar.2008.9993>
- Williamson, D. A., & Perrin, L. A. (1996). Behavioral therapy for obesity. *Endocrinology and Metabolism Clinics of North America*, 25(4), 943–954. [https://doi.org/10.1016/S0889-8529\(05\)70363-7](https://doi.org/10.1016/S0889-8529(05)70363-7)
- Wilson, E., Kyle, T., Nadglowski, J., & Stanford, F. (2017). Obesity coverage gap: Consumers perceive low coverage for obesity treatments even when workplace wellness programs target BMI: Obesity coverage gap. *Obesity*, 25. <https://doi.org/10.1002/oby.21746>
- Young, L. M., & Powell, B. (1985). The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behavior*, 26(3), 233–246. <https://doi.org/10.2307/2136755>

APPENDIX A: CURRICULUM LEARNING OBJECTIVES

Module 1: Overview of the Health at Every Size Paradigm

- Participants will be able to describe the drawbacks of a weight-centered approach to health.
- Participants will be able to recognize the multi-dimensionality of health and the limited role of diet and exercise on health outcomes.
- Participants will be able to define the Health At Every Size paradigm.
- Participants will be able to explain the differences between a diet and a non-diet approach to wellness.
- Participants will be able to examine the scientific research that supports non-diet approaches.

Module 2: Developing a Healthy Relationship with Food and Exercise

- Participants will be able to describe the differences between internal and external cues to eating.
- Participants will be able to utilize the hunger and fullness scale to guide eating timing and amounts.
- Participants will be able to describe the benefits of mindful eating.
- Participants will be able to apply strategies to eat more mindfully.
- Participants will be able to explain the differences between extrinsic and intrinsic motivators for physical activity.

Module 3: Size Acceptance

- Participants will be able to define body image

- Participants will be able to describe characteristics of negative and positive body image.
- Participants will be able to identify the influences of body image.
- Participants will be able to provide examples of size discrimination.
- Participants will be able to list strategies to fight against size discrimination and advocate for size acceptance.

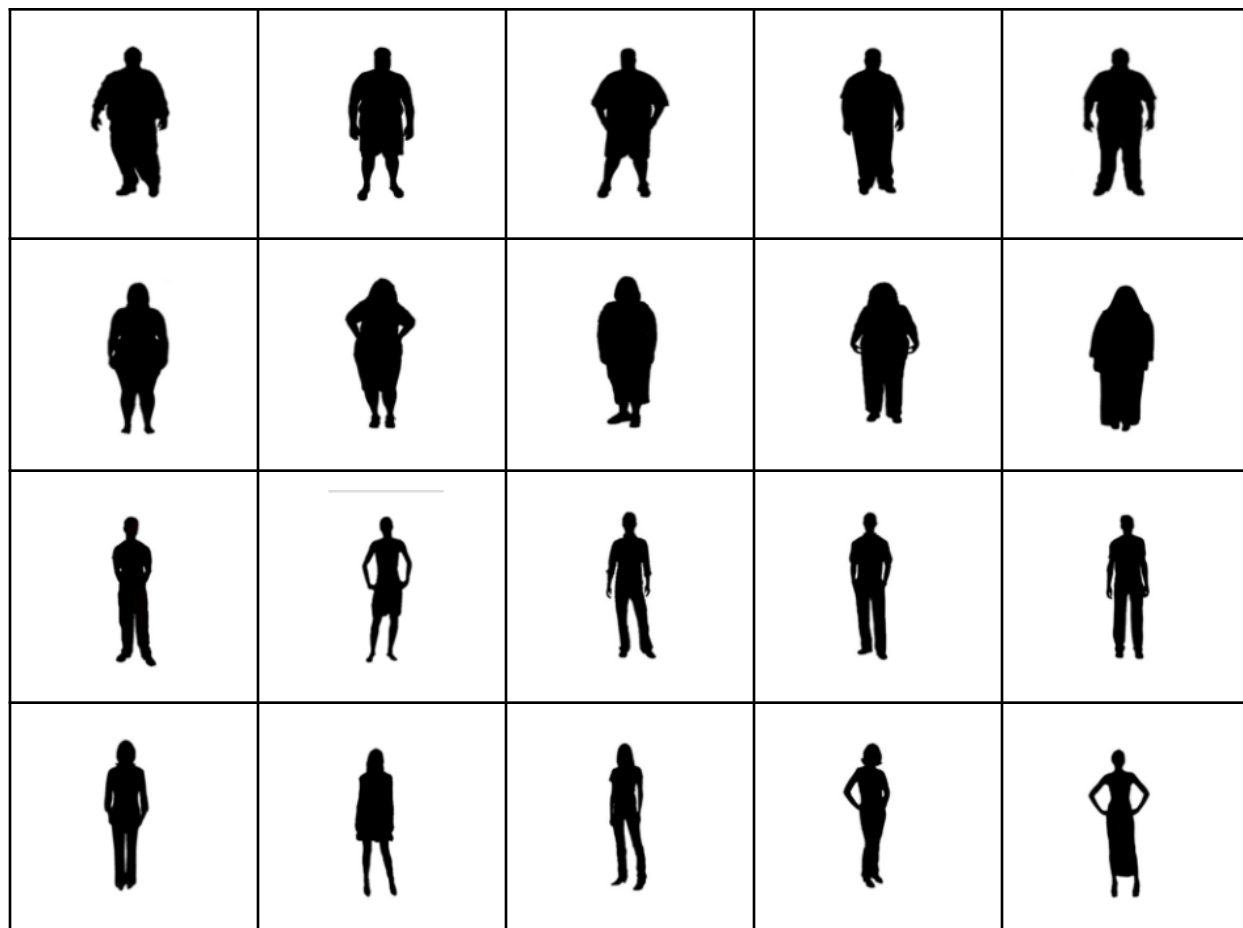
APPENDIX B: OUTLINE OF THE HAES-INFORMED WEIGHT STIGMA TRAINING
INTERVENTION

- Description/definition of weight stigma and discrimination
- Brief description of the history of the roots of weight stigma including:
 - Media
 - The medicalized view that fat=inherently sick
 - Culture (the Protestant work ethic/values of restraint; racism)
- Some information to contradict the traditional view that posits fat=bad
 - Size diversity
 - Ineffectiveness of dieting
 - No direct causal link between fatness and health
- Negative impacts of weight discrimination
 - The individual
 - Medical care, education, the workforce, etc.
 - The therapeutic relationship
 - How weight discrimination/bias shows up in the counseling room
- Working with Higher Weight Clients
- Appropriate language
 - Avoid overweight/obese
 - Use clients of size/higher weight clients/etc.
 - Description of the reclamation of the term “fat”
 - Microaggressions in session related to body size
- Broaching body size

- Clinical Setting Considerations
 - seating/furniture
 - Artwork
- Link to Ethics/MSJCC
- Introduction of HAES
 - Overview
 - HAES definition of health
 - HAES tenets
 - HAES in practice
 - Collaboration; advocacy; process
- Case of Shay activity (adapted from Pratt & Cravens (2014))
- Resource slide/time for questions

APPENDIX C: WEIGHT ATTITUDES IMPLICIT ASSOCIATION TEST (Greenwald et al., 1998)

Silhouettes



Words

Positive Stimuli	Negative Stimuli
Adore	Abuse
Beautiful	Angry
Celebrate	Annoy
Friendship	Disgust
Joyous	Horrific
Laughing	Humiliate
Pleasure	Selfish
Terrific	Ugly

APPENDIX D: ANTIFAT ATTITUDES QUESTIONNAIRE-REVISED (Quinn & Crocker,
1999)

The AFA is scored using a Likert-type response format (0 = very strongly disagree; 9 = very strongly agree). Higher scores indicate stronger anti-fat attitudes.

Dislike

1. I really don't like fat people much.
2. I don't have many friends that are fat.
3. I tend to think that people who are overweight are a little untrustworthy.
4. Although some fat people are surely smart, in general, I think they tend not to be quite as bright as normal weight people.
5. I have a hard time taking fat people too seriously.
6. Fat people make me somewhat uncomfortable.
7. If I were an employer looking to hire, I might avoid hiring a fat person.
8. I feel repulsed when I see a fat person.
9. Fat people disgust me.
10. I have an immediate negative reaction when I meet a fat person.

Fear of Fat

11. I feel disgusted with myself when I gain weight.
12. One of the worst things that could happen to me would be if I gained 25 pounds.
13. I worry about becoming fat.

Willpower

14. People who weigh too much could lose at least some part of their weight through a little exercise.

15. Some people are fat because they have no willpower.
16. Fat people tend to be fat pretty much through their own fault.
17. Fat people can lose weight if they really want to.
18. Through a combination of exercise and dieting, anyone can lose weight and keep it off indefinitely.
19. The medical problems that fat people have are their own fault.
20. Fat people are responsible for their own problems.
21. Weight is something which is under a person's delayed intervention.

APPENDIX E: DEMOGRAPHIC VARIABLE QUESTIONS

1. What is the 3rd letter of your first name?
2. What is the 2nd letter of your last name?
3. What are the last two numbers of your street address?
4. What year are you in your program?
 - a. First year Master's student
 - b. Second year Master's student
 - c. Other
5. What is your track in the program?
 - a. Clinical Mental Health
 - b. Couple and Family
 - c. School Counseling
6. What is your gender identity?
 - a. Cisgender Male
 - b. Transgender male
 - c. Cisgender Female
 - d. Transgender female
 - e. Non-binary/third gender
 - f. Prefer not to say
7. How old are you? (open-ended)
8. Which category/ies best describe your racial and ethnic background? Select as many as are applicable to you.
 - a. White

- b. Black or African American
 - c. Hispanic, Latinx or Spanish origin
 - d. American Indian or Alaska Native
 - e. Asian
 - f. Native Hawaiian or Pacific Islander
 - g. Middle Eastern or North African
 - h. Multiracial
 - i. My race and/or ethnicity is not listed here
9. How would you categorize your social class?
- a. Lower class
 - b. Working class
 - c. Middle class
 - d. Upper Middle class
 - e. Upper class
10. Have you or someone close to you struggled with an eating disorder or disordered eating?
(Y/N)
11. Have you or someone close to you experienced struggles or difficulties related to your weight? (Y/N)
12. Have you ever received training or do you have experience with the Health At Every Size paradigm? (Y/N)

APPENDIX F: INTERVENTIONS & MEASURES SCHEDULE

Group	Time 1 Date & Measures	Time 2 Date & Measures	Time 3 Date & Measures
Diagnosis (Treatment)	February 9* <ul style="list-style-type: none"> ● Demographics ● AFA ● IAT ● MAKSS ● C-HAES-CS 	February 16 <ul style="list-style-type: none"> ● AFA ● IAT ● C-HAES-CS ● Training Feedback 	February 23 <ul style="list-style-type: none"> ● AFA ● IAT
Career (Delayed Intervention)	February 4 <ul style="list-style-type: none"> ● Demographics ● AFA ● IAT 	February 11* <ul style="list-style-type: none"> ● AFA ● IAT ● MAKSS ● C-HAES-CS 	February 18 <ul style="list-style-type: none"> ● AFA ● IAT ● C-HAES-CS ● Training Feedback

* Indicates date that intervention was received

APPENDIX G: SAMPLE WORDING CHANGES TO THE MCI

Original Item	Changed Item
When working with minority clients, I form effective working relationships with the clients	When working with clients with marginalized identities, I form effective working relationships with the clients
When working with minority clients, I use innovative concepts and treatment methods	When working with clients with marginalized identities, I use innovative concepts and treatment methods
When working with minority clients, I perceive that my race causes the clients to mistrust me	When working with clients with marginalized identities, I perceive that my race causes the clients to mistrust me
When working with minority clients, I have experience at solving problems in unfamiliar settings	When working with clients with marginalized identities, I have experience at solving problems in unfamiliar settings

APPENDIX H: FEEDBACK QUESTIONS FOR MCI WORDING CHANGE (Sodowsky et al.,
1994)

1. When you read the phrase “clients with marginalized identities” what identities did you think about?
 - a. Did you think about body size?
 - b. What wording would help you to think of body size if you did not think of it?
2. Knowing now that the questions are intended to include body size as a marginalized identity, how, if at all, would that change the way you would respond?

APPENDIX I: FEEDBACK QUESTIONS ON TRAINING INTERVENTION

- Participating in this training helped me to increase my knowledge of weight stigma and its impact on higher weight individuals? (1=strongly disagree, 5=strongly agree)
- Participating in this training helped me to be able to identify ways to competently work with clients of size in a therapeutic setting. (1=strongly disagree, 5=strongly agree)
- Participating in this training helped me to better understand the HAES model (1=strongly disagree, 5=strongly agree)
- The content presented in this training was presented in a way that was easy to understand (1=strongly disagree, 5=strongly agree)
- The content of this training was appropriate for the 3 hour time frame. (1=strongly disagree, 5=strongly agree).
- What, if any, parts of the training were unclear or confusing?
- What was the most impactful part of this training for you?
- What improvements would you suggest for this training?

APPENDIX J: ENLARGED VIEW OF TABLE II

Means for Each Measure by Group

Group		AFA Total1	AFA Total2	AFA Total3	MAKSS Total	HAEST Total1	HAEST Total2	IAT1	IAT2	IAT3
Tx (Diagnosis)	Mean	2.9923	2.8457	2.0532	85.2000	40.8000	44.9524	-.470300140	-.481449664	-.437729648
	N	30	14	19	30	30	21	31	27	21
	Std. Deviation	1.41854	1.73801	1.36457	11.00282	8.07465	6.31250	.3665271114	.3631446695	.4250986853
Control (Career)	Mean	2.3840	2.0400	1.0328	85.7273	40.7826	49.0625	-.255286002	-.285149914	-.231705815
	N	25	25	25	22	23	16	23	23	22
	Std. Deviation	1.43059	1.36420	1.25170	8.43000	5.90036	4.13874	.4470259830	.4753592771	.4173496527
Total	Mean	2.7158	2.3292	1.4734	85.4231	40.7925	46.7297	-.378720044	-.391151779	-.332322106
	N	55	39	44	52	53	37	54	50	43
	Std. Deviation	1.44351	1.53691	1.38395	9.90810	7.14778	5.79103	.4129277479	.4256705220	.4289527395