NOVICE COUNSELORS' WEIGHT AND BODY IMAGE BELIEFS: AN EXPLORATORY Q STUDY

by

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(Under the Direction of Amanda Giordano)

ABSTRACT

Weight bias and discrimination based on body size and shape is prevalent in the United States. Counselors are subject to these cultural influences, and they have an ethical obligation to avoid imposing their values and beliefs on clients. However, there is limited empirical data about sizeism in the counseling field. This study aimed to understand novice counselors' attitudes and beliefs about weight and body image using Q methodology. Q methodology is an inherently mixed-methods approach to systematically explore subjectivity. Practicing counselors who had graduated within the last three years from CACREP-accredited master's in clinical mental health counseling programs in the southern United States were selected through purposive sampling. Twenty-four participants sorted 60 statements, called a Q sort, and five of the participants also completed an optional post-sort interview. Four factors emerged in the analysis and were interpreted from the data. These factors were named Body Positivists, Body Liberators, Body Choosers, and Body Changers. The results have implications for counseling practice, counselor education, supervision, and Q methodology.

INDEX WORDS: Sizeism, weight bias, fat phobia, fatmisia, fatism, weight stigma, weight prejudice, obesity, overweight, healthism, fat liberation, body positivity, novice counselor, counseling, counselor education, supervision, Q methodology, Q sort

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A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPY

ATHENS, GEORGIA

2023

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DEDICATION

This work is dedicated to God the Father, Son, and Holy Spirit, whose image I bear and who created me for good works in His name. He had a plan and journey for me I could not have imagined, and His ways are always better. To God be the glory.

ACKNOWLEDGEMENTS

This dissertation is the culmination of decades of dreams, countless prayers, thousands of hours of work, and the personal and professional support of so many. My first expression of gratitude is to my Lord, for He is my creator, savior, and sustainer, and He walked with me and before me. I appreciate my family's steadfast love and support, some of whom are no longer with me on earth but whose love, belief in me, and passion for learning have been with me every step of the way. Thank you to my family and friends who continually cheered me on and checked in, always letting me know they were with me. The calls, texts, and cards meant the world!

Thank you, Dr. Amanda Giordano, my committee chair, for your unwavering dedication to my growth and this research, and to committee members Dr. Jolie Daigle, Dr. George McMahon, and Dr. Lloyd Rieber for your contributions and commitment to serve. Thank you to all the faculty at the University of Georgia and Dr. Lacy Till, who all helped write a chapter in my learning and experience. A special thank you goes to doctoral cohort member Deaetta Grinnage for your contributions as a dissertation research team member. To all of my cohort – Austen Bingham, Phillip Famber, Deaetta Grinnage, Tonja Simmons Lee, Brianna Stubbs-Brown, and Dr. Katherine (Katie) Wood – your presence, scholarship, and partnership were invaluable. Additional thanks go to Dr. David Lane, for whom the words supervisor and mentor do not even begin to do justice to my appreciation, honor, and respect for you. Finally, thank you to the participants. This research only exists because of you. Thank you all!

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CHAPTER 1

INTRODUCTION

Concern with body size and shape permeates Western culture and drives weight bias across multiple life domains such as employment, education, relationships, and healthcare (Puhl et al., 2014). *Weight bias* is "the inclination to form unreasonable judgments based on a person's weight" (Washington, 2011, p. 1). In the workplace, persons in larger bodies have reported discrimination in hiring, promotion, and retention (Puhl et al., 2008; Puhl & Brownell, 2001), and workplace wellness plans frequently incentivize weight loss (Centers for Disease Control and Prevention [CDC], n.d.; Koruda, 2016). School-aged children and adolescents experience weight-based bullying (Brochu, 2018), and body size may also negatively impact children and teens' peer relationships (Lombardi et al., 2019; Nutter et al., 2019). Adults, particularly women, have also expressed dissatisfaction in relationships with family, friends, and romantic partners that is tied to body size (Akers & Harding, 2021; Puhl & Heuer, 2009).

Within the United States healthcare system, persons in larger bodies may be given the disease classification of overweight or obese based on scoring above a Western population 50^{th} percentile of a height-weight ratio called Body Mass Index (BMI), thereby pathologizing the expected diverse range of body sizes present in a population (Nuttall, 2015). Additionally, BMI is a poor indicator of health that does not consider a range of health markers, genetics, race, age, social class, and other factors (Burkhauser & Cawley, 2008; Kasten, 2018, Nuttall, 2015; Wildman et al., 2008). Discrimination in

multiple settings, including healthcare, and the effects of the pressure to achieve or maintain a thin ideal may be more harmful than living in a higher-weight body (Brochu, 2018; Puhl & Brownell, 2001; Puhl et al., 2008; Sutin et al., 2015; Tomiyama et al., 2018). US studies have shown medical providers are likely to consider clients in the overweight and obese categories as undisciplined, lazy, dishonest, and noncompliant (Puhl & Brownell, 2001). In fact, some providers indicated a dislike for treating these patients (Puhl & Brownell, 2001; Tomiyama et al., 2018). Larger-bodied persons have reported stigmatizing language and experiences in healthcare settings, which can result in a hesitancy to seek healthcare services (Amy et al., 2006; Balkhi et al., 2013; Mensinger et al., 2018; Nyman et al., 2010).

Mental health providers may also exhibit implicit and explicit bias in treatment (Pratt et al., 2016; Puhl et al., 2014). Specifically, they may attribute more negative characteristics and more severe symptoms to larger-bodied clients (Davis-Coelho et al., 2000; Forristal et al., 2021; Puhl et al., 2014; Young & Powell, 1985). They may also ascribe negative stereotypes to clients in larger bodies and minimize eating disorder symptoms in higher-weight clients, which can compromise diagnosis and treatment (Veillette et al., 2018).

Overall, the stigmatization of persons based on weight, body size, and shape, known as *sizeism* (Rothblum & Gartrell, 2019), has detrimental psychological and physical consequences, including depressed mood and exercise avoidance (Selensky & Carels, 2021). Furthermore, a cultural valuation of thinness and weight gain fears are risk factors for developing eating disorders (Brownstone et al., 2021; Culbert et al., 2015; Puhl et al., 2014). Persons who experience discrimination in healthcare settings may also

delay or avoid treatment (Tomiyama et al., 2018). Moreover, there is evidence that sizeism could be linked to limitations on educational pursuits due to bias in the educational system, including in the higher education admissions process, and lack of parental and peer support for higher education (Burmeister et al., 2013; Puhl & Heuer, 2009). Additionally, when persons of size have additional marginalized identities related to race, ethnicity, religion, ability status, sexual orientation, or gender, the discrimination may be compounded in a way that is more than the sum of the effect of singular minority statuses. This compounding nature of discrimination is called *intersectionality* (Crenshaw, 1989).

Statement of the Problem

Weight stigma consciously or unconsciously affects everyone in some way, even those who hold the privileged identity of living in a smaller body. A growing number of people in the US are considered overweight or obese, and healthcare providers frequently focus on achieving and maintaining a certain weight and size profile as a health measure. However, the measurement of body mass index (BMI) is not static or without flaws. BMI quartiles were determined based on mean and median BMI (Nuttall, 2015). In 1998, BMI category limits were adjusted downward in the US to align with the World Health Organization (WHO), meaning fewer people fit in the normal and underweight categories and more fell into the overweight and graded obese classes (Nuttall, 2015). So immediately, some people lost normal weight status. Reports of the growing obesity problem in the US over the last several decades may not accurately account for this change in measurement, which could be misleading. Moreover, BMI is a ratio of body weight and height, which does not account for gender, body proportions, body fat, muscle

mass, physical functioning, genetics, racial features, or health indicators (Burkhauser & Cawley, 2008; Kasten, 2018, Nuttall, 2015; Wildman et al., 2008). Also, with WHO classifications, 50% of Western adult populations fall into overweight and obese categories, which is "prejudicial since people in this category are a major part of the expected normal distribution of BMI in the general population, and this has been the case for decades" (Nuttall, 2015, p. 120).

The understanding of an obesity problem in the US, sometimes called an *obesity epidemic* (Nuttall, 2015), is frequently publicized in the media. Cultural pressure to lose weight, whether directly or indirectly, from healthcare providers, media, educational settings, and personal relationships may result in people dieting or otherwise limiting food intake for a period of time (Nutter et al., 2019). Although body mass may decrease, studies have shown most people will regain weight, returning to their original or higher body weight (Dulloo & Montani, 2015; Guagnano et al., 2000; Outland, 2018). With continued cultural esteem of thin bodies, persons frequently restrict caloric intake again, and the cycle of weight loss and regain continues (Tomiyama, 2014). Those already living in smaller bodies may experience this pressure as a fear of weight gain and body fat (van Amsterdam, 2013), called *fat phobia* (Robinson et al., 1993). Fat phobia can result in a propensity to restrict food intake to maintain a privileged body size, mental distress, and shame and guilt (Brochu, 2018; Puhl & Brownell, 2001; Puhl et al., 2008; Rukavina & Pokrajac-Bulian, 2006). Additionally, fat phobia is connected to the stigmatization of persons living in larger bodies, as previously described. Some scholars choose the word *fatmisia,* rather than fat phobia, to more clearly express the hatred of fat delineated from the clinical use of the word phobia (Forristal et al., 2021).

Prejudice and discrimination based on body size and shape are prevalent across multiple life domains, including media (Eisenberg et al., 2015; Selensky & Carels, 2021), employment (Puhl et al., 2008; Theran, 2005), educational settings (Cardinal et al., 2014; Crosnoe, 2007; Karnehad et al., 2006; Tingstrom & Nagel, 2017), relationships (Akers & Harding, 2021; Puhl & Heuer, 2009; Rollero, 2022), and healthcare (Mulherin et al., 2013; Obara et al., 2018; Phelan et al., 2014; Sabin et al., 2012), including mental healthcare (Cravens et al., 2016; Forristal et al., 2021; Pratt et al., 2014; Puhl et al., 2014). Persons living in larger bodies are frequently marginalized and discriminated against in a sizeist culture (Frederick et al., 2020; Puhl & Brownell, 2001). Weight-based prejudice affects employability, wages, and promotion (Puhl et al., 2008), and there are no federal regulations to guard against weight-based discrimination (Theran, 2005). Within educational settings, children in larger bodies may be bullied and labeled unfairly by educators (Nutter et al., 2019). Additionally, there is some evidence that persons in larger bodies may be limited in achieving higher education due to weight bias and discrimination (Crosnoe, 2007; Karnehad et al., 2006; Puhl & Heuer, 2009), including in the field of psychology (Burmeister et al., 2013).

Sizeism also manifests in interpersonal relationships where persons face pressure from friends, partners, and family members to achieve or maintain a smaller body size (Puhl & Brownell, 2006; Puhl & Heuer, 2009; Puhl, Moss-Racusin, et al., 2008) and sizeism may correlate with difficulty forming romantic relationships (Sobal, 2005) and relationship dissatisfaction (Akers & Harding, 2021). Healthcare providers in medicine (Miller et al., 2013; Mulherin et al., 2013; Phelan et al., 2014; Sabin et al., 2012) and dietetics (Berryman et al., 2006; Harvey et al., 2002; Oberrieder et al., 1995; Puhl et al.,

2009) may exhibit implicit and explicit bias against higher-weight patients. Research indicates mental health providers show similar weight-based bias as other providers that can affect diagnosis, treatment planning, and interventions (Pratt et al., 2016; Puhl et al., 2014; Veillette et al., 2018).

Sizeism is frequently masked under the guise of health, where persons are pressured to live in smaller bodies to be healthier. This compulsion is a manifestation of *healthism*, the idea that health is individually controllable and a moral obligation (Crawford, 1980). Healthism is prevalent in Western society and frequently reinforced in many public health and media messages (Eriksson, 2022; Evans et al., 2008), supporting the social acceptability of weight stigmatization. Treatment based on healthism may emphasize BMI, which is a flawed metric (Nuttall, 2015), and disregard factors such as social class, race, environment, and genetics as contributors to health, along with a holistic view of health and wellbeing that includes psychological and physiological components (Evans et al., 2008; Krahn et al., 2021). Without a socially expansive consciousness of health, individuals who do not fit thin cultural ideals of health and beauty may be denigrated and disparaged.

The effects of sizeism are multi-dimensional. Weight stigma is a psychological stressor with "behavioral, emotional, and physiological responses" (Tomiyama et al., 2018, p. 9), and weight cycling, a frequent result of dieting to meet societal ideals, is linked to metabolic, cardiac, and hypertensive diseases in women (Dulloo & Montani, 2015; Guagnano et al., 2000). Persons of all sizes of bodies can be affected by perceptions of weight discrimination, manifesting in a drive for thinness, an increased risk for obesity, and an increased mortality risk (Sutin et al., 2015; Sutin & Terracciano,

2013). Additionally, persons in all sizes of bodies can exhibit weight bias toward others that may result in discrimination (Frederick et al., 2020). Persons in larger bodies who endure discrimination and diet in an attempt to lose weight may suffer emotional and physical effects or become caught in a cycle of obesity and weight-based stigma (Tomiyama et al., 2018). Moreover, weight bias was linked to internalized stigmatization, increased eating, and psychological distress in overweight and normal-weight participants (O'Brien et al., 2016). Persons who have faced discrimination in healthcare can be reluctant to seek continued medical care and may engage in compensating behaviors (Amy et al., 2006; Puhl et al., 2013a). Additionally, stigmatization in other areas of marginalization, such as race and gender, can intersect with weight-based stigmatization to compound adverse effects through intersectionality (Crenshaw, 1989; Puhl et al., 2008).

Counselors are not immune to cultural sizeism and may ascribe to beliefs of healthism, fat phobia, and weight bias (Davis-Coelho et al., 2000; Puhl et al., 2014). Mainstream messages of health can reinforce these ideas as normative, so beliefs about weight and body may never be explored or questioned, particularly as axes of inequality. Counselors' attitudes and beliefs about body weight and size may directly or indirectly affect their work with clients due to unexamined bias or countertransference (DeLucia-Waack, 1999). Counselors may become complicit in blaming clients' problems on weight (Drell, 1988) and disregard the impact of sizeism and other presenting issues. Additionally, although there have been several calls within the counseling profession to address sizeism (Nutter et al. 2018a, 2018b, 2020; Kinavey & Cool, 2019), there seems to

be little evidence that sizeism as an axis of inequality has been widely researched in the counseling field.

Purpose of the Study and Research Question

Since counselors are subject to these aforementioned cultural influences, and it has been demonstrated that other healthcare providers hold conscious and unconscious biases regarding weight, it is a reasonable conclusion that counselors and clients may have fat phobia and weight-based internal biases. Since weight bias is linked to negative psychological outcomes for persons of size, and counselors hold power in the counseling relationship, it is essential to understand counselors' beliefs about weight and bodies and how those may affect clients. However, although weight bias and sizeism have been researched in other mental health fields (Cravens et al., 2016; McHugh & Chrisler, 2019; McHugh & Kasardo, 2012; Pratt et al., 2014; Teachman & Brownell, 2001), it has not been substantially researched within the counseling field other than conceptual articles (Kinavey & Cool, 2019; Nutter et al. 2018a, 2018b, 2020) and one empirical study with counselor trainees (Forristal et al., 2021). Although scholars have called for the inclusion of sizeism in counselor training (Kinavey & Cool, 2019; Nutter et al., 2018a), currently, a baseline understanding of counselors' held beliefs about weight and body does not exist. Therefore, this study aims to begin filling the gap in this foundational knowledge by understanding the perspectives of novice counselors with regard to body size and weight. Specifically, the research question guiding the study was:

> RQ1: What are novice counselors' (three years or less post-graduation) from CACREP-accredited mental health counseling programs attitudes and beliefs about body weight and shape?

Significance of the Study

This study will advance the dialogue of sizeism as a necessary multicultural component of counseling practice and counselor education by exploring the current landscape of beliefs surrounding body size and weight among novice counselors. Understanding the perspectives of novice counselors can provide a view of the current state of counselor education and the profession's future as it relates to how counselors understand and may participate in cultural sizeism. Counselors must understand their cultural beliefs and values and avoid imposing them on clients (American Counseling Association [ACA], 2014). Without this awareness, counselors may be vulnerable to perpetuating sizeism in the therapeutic process, directly or indirectly.

In clinical practice, as clients present with psychological concerns that may be linked to systemic issues, it is vital that practicing counselors and clinical supervisors understand sizeism as a multicultural systemic barrier and axis of inequality that can compromise clients' health and wellness. Findings from this study may prompt counselors to examine their own beliefs about weight and body and how they may manifest in the therapeutic process with clients. As Ratts et al. (2016) outlined, developing competence in multiculturalism and social justice originates with counselors' self-awareness, which can be extended to further understanding clients' worldviews, the counseling relationship, and interventions. This self-examination can also result in counselors considering privileged and marginalized positions (Ratts et al., 2016) related to body size for themselves and clients. Thus, this study can point to areas of risk and opportunity in the counseling process regarding weight bias and its effects, oriented toward multicultural competence and social justice.

Just as this study can help counselors develop an awareness of their beliefs about weight and body and how they may affect the relationship and interventions used with clients, supervisors may also be prompted to consider their beliefs about weight and body and how they relate to their role and influence. Counseling supervisors have responsibilities to their supervisees and the clients their supervisees serve (ACA, 2014, F.) Within these responsibilities, supervisors are charged with multicultural competence in the supervisory relationship and to "help [supervisees] become prepared to serve a range of diverse clients" (ACA, 2014, p. 12). Consequently, the examination of novice counselors' attitudes and beliefs about body weight and size can inform supervisory interventions as supervisors seek to increase their supervisees' multicultural competence while simultaneously examining their own internalized biases.

Counselor educators also have a multidimensional role with students and supervisees. Their level of responsibility encompasses program development and implementation, student welfare, supervision, and gatekeeping, all while "actively [infusing] multicultural/diversity competency in their training and supervision practices" (ACA, 2014, p. 15). Moreover, they have their own development of multicultural competency and social justice practice that can influence their work. According to the multicultural and social justice counseling competencies, findings from this study may bring about self-reflection and the pursuit of additional knowledge and skills (MSJCC; Ratts et al., 2016) to incorporate into counselor training programs. Findings can inform all aspects of counselor education programs, considering how sizeism may impact student admissions, assessment, gatekeeping, and supervision. Study results can also help

counselor educators design a curriculum focused on multicultural competency in the area of body weight and shape, addressing sizeism.

Counselors have an ethical responsibility to work for the good of the individuals they serve, avoid harm, and treat individuals equitably and fairly (ACA, 2014). Understanding counselors' viewpoints about bodies and weight is a critical early marker in eliminating sizeism in counseling. This study can help guide future counseling researchers and clinicians interested in the applied practice of anti-sizeism as a social justice issue. Additionally, study results can elicit conversations among counseling educators, students, supervisors, and supervisees regarding personal beliefs and attitudes about body weight and size. Ideally, the counseling profession could use the findings of this study to inform advocacy efforts for clients in all bodies and deliver better clinician training to prepare future counselors for effective and socially just client care.

Brief Overview of the Study

This research study used Q methodology to explore the research question from quantitative and qualitative perspectives. Q methodology allows the researcher to identify factors related to the research question in conjunction with an understanding of how those factors are formed. Study participants were comprised of counselors with three years or less experience post-graduation from a Council for Accreditation of Counseling and Related Educational Programs (CACREP)-program. They were recruited and selected with purposive sampling (Watts & Stenner, 2012). The sample was a set of statements, the Q-set, which participants sorted online. At the end of the sorting process, participants provided additional data via a post-sort survey and an optional interview to provide context for interpretation (Wolf, 2014).

Each Q sort a participant completed represents a gestalt (Watts & Stenner, 2012). In the data analysis process, correlations were identified across Q-sorts, and factors were extracted. These factors "represent [groups] of persons who share a similar perspective, viewpoint, or attitude about a particular topic, or who seem to be, in this context at least, of a similar type." (Watts & Stenner, 2012, p. 18). Factors were extracted using principal component analysis (PCA), rotated using varimax rotation and further analyzed using a factor array (Dieteren et al., 2023; Watts & Stenner, 2012). Interpretations were made by the researcher using the crib sheet technique (Watts & Stenner, 2012), a systematic process for exploring the results and additional data provided to frame a holistic story of interrelated themes.

Theoretical Framework

Feminism is a perspective that elevates women's voices and places primary emphasis on women's experiences (Tisdell, 2008), traversing Eurocentrism and colonialism. Specifically, feminist theory recognizes marginalized persons in gender and race and seeks to dismantle power structures (Arinder, n.d.). Hooks (2015) described the evolution of the feminist movement to include "critical interventions around race" (p. 58) and defined it as a "movement to end sexism and sexist domination and oppression, a struggle that includes efforts to end gender discrimination and create equality…fundamentally a radical movement" (p. 113). This frame of feminist theory is salient in exploring the topic of sizeism, which is situated in intersecting constructs of race, class, religion, and gendered power structures (Crawford, 1980; Strings, 2019). Challenging predominant beauty standards and advocating for acceptance and care for all bodies is constitutionally feminist (hooks, 2015).

When applied to research, social constructionist feminist theory views researchers and research as intertwined and research as part of the social order, and thus, research is inherently subjective (Wigginton & Lafrance, 2019). A hallmark of current feminist theory is the rejection of empiricism and, to a large extent, essentialism while simultaneously recognizing the importance of social locations and shared positionality (Krolokke & Sorenson, 2006). The subjective nature of this framework aligns with the constructivist and constructionist elemental natures of Q methodology (Watts & Stenner, 2012). The person and positionality of the researcher affect each step of the research process, particularly in relation to the participants (Tisdell, 2008). Bringing together the topic of sizeism and Q methodology, a current feminist approach frames "the fragility of the ways gender is inscribed on bodies and the ways in which power is expressed, negotiated, and ever present in gendered practices" (Krolokke & Sorenson, 2006, p. 23). Finally, since social change is a core tenet of feminist theory research (hooks, 2015; Wigginton & Lafrance, 2019), feminist theory is well-positioned for addressing diversity and equality issues such as sizeism.

Limitations

Several limitations may be present in this research. First, my identity and positionality, particularly as a White female researcher, may have influenced the concourse and sample Q set as well as the interpretation of data. The concourse development in Q methodology, from which the Q statements are selected, contains inherent subjectivity as the researcher creates it, and it is not the "participants' own discourse" (Watts & Stenner, 2005, p. 71). However, participants can create and express their own meaning through their Q sorts (Watts & Stenner, 2012). Second, resulting

factors are not generalizable, a similar limitation in purely qualitative research studies, and Q cannot be used to measure "what proportion of the population belongs in one factor rather than another" (Brown, 1980, p. 192). Nevertheless, factors can represent the range of shared viewpoints among novice counselors, the participant group (Watts & Stenner, 2012).

Bias can also be present in the recruiting process and resulting participant set since this study will use purposive sampling (Saumure & Given, 2008). Watts and Stenner (2012) recommended a "strategic" (p. 71) approach to sampling that is based on the research question and seeks to "capture interesting, informative and relevant viewpoints relative to the question" (p. 71). Participants completed the screening questionnaires and Q sorts unobserved on web-based platforms, so the identity of those who completed the study cannot be verified. Response rates may be lower in online studies than in person (Lefever et al., 2007). Interviews were conducted over Zoom, and disruptions may occur due to technical failures or participants' unfamiliarity with the platform.

Additionally, persons of color who completed the Q sort and chose to complete a follow-up virtual interview with me could have adjusted their responses to my Whiteness consciously or unconsciously. *Code switching* was first defined by changes between African American English (AAE) and Standard American English (SAE), White-centric English, but has been expanded into the broader definition I am using that encompasses behavioral change as protection from racism (Spencer et al., 2022). To minimize these limitations, I have engaged a Black woman doctoral candidate in Counselor Education and Supervision as part of the research team to review the concourse and Q set.

Additionally, a Q methodology expert who is a White male will review and provide input to the interpretation phase of this study.

Definition of Terms

Healthism

Coined by Robert Crawford (1980), *healthism* emphasizes health as a measurable, moral responsibility and presumes a person's health is within their control. It is rooted in privilege. Healthism may manifest as the assignment of morality to food or eating behaviors. Terms linked to healthism in common US vernacular are health and healthy. These terms typically refer to physical or body health and may omit mental health. Moreover, they may refer to body size or a reduction in body size, such as "getting healthy" (losing body weight).

Novice Counselor

Counselors are mental health professionals trained in counseling graduate programs. Counselors follow a professional ethics code of conduct from a counseling-specific professional organization, such as the ACA. Novice counselors are defined here as counselors with three years or less experience practicing in their field post-graduation from their master's program.

Person of Size

Persons of size and *persons living in larger bodies* have similar meanings. They refer to persons frequently labeled fat, large, overweight, obese, or morbidly obese. The three latter terms are medical definitions based on a person's body mass index (BMI) and are used in US mainstream vernacular. The opposite terms are a *person in a smaller body* or a person who is *thin* or *skinny*. These persons are said to have *thin privilege*, unlike a person of size.

Fat Phobia

Fat phobia is the "pathological fear of fatness" (p. 468) or weight gain that drives behaviors to achieve or maintain a smaller body size. Fat phobia may be experienced by individuals living in any size body, including those in smaller bodies (van Amsterdam, 2013). Researchers have documented the harmful effects of fat phobia, including restrictive caloric intake and other behaviors to avoid weight gain and adverse effects on mental health. (Brochu, 2018; Puhl & Brownell, 2001; Puhl et al., 2008; Rukavina & Pokrajac-Bulian, 2006). Fat phobia also may be expressed as negative attitudes toward people in fat bodies (Robinson et al., 1993), linking it to weight bias and sizeism. The term is frequently colloquially without reference to pathology or diagnosis.

Fatmisia

Fatmisia is similar to fat phobia but does not include a pathological delineator. Fatmisia is used by Forristal et al. (2021) to describe the hatred of fat. Forristal et al. (2021) also included "bias against, and weight discrimination toward the growing number of fat people" (p. 337) in their definition of fatmisia.

Sizeism

Sizeism is prejudice or discrimination against persons based on their body shape and size or body weight (Rothblum & Gartrell, 2019). Individuals, groups, and institutions may perpetuate sizeism. *Weightism* and *weight bias* are sometimes used as comparable terms.

Weight Bias

Weight bias, *fat bias*, and *anti-fat bias* are all terms used to describe distorted Western attitudes toward and stereotypes about persons considered overweight, fat, or

obese. Brownell (2005) described this bias as “the inclination to form unreasoned judgments” (p. 10). Attitudes of weight bias are usually negative and are linked to discrimination and prejudice based on body size and shape. Weight bias has pernicious effects on persons of size (Nutter et al., 2016). Crandall’s (1994) findings suggested that anti-fat attitudes are related to beliefs that weight is controllable, individuals should be accountable for their weight, and social rejection is the natural consequence of deviance from societal weight norms.

Weight Stigma

The effects of weight bias or negative labels ascribed to persons of size based solely on weight and shape constitute weight stigma. Weight stigma is associated with prejudice and discrimination towards persons in larger bodies and is the “social sign or emblem carried by the individual who is the victim of prejudice” (Brownell, 2005, p. 10). Weight stigma may be internalized (Pearl & Puhl, 2014); internalized weight stigma is also described as internalized weight bias (Selensky & Carels, 2021; Pearl et al., 2021).

Body Positivity

Rejection of anti-fat attitudes, body size acceptance, and advocacy formed the early body positivity movement born during an era of feminist activism (Rothblum, 2012). Body positivity and acceptance represent the inclusivity of all bodies, including fat bodies, “in an effort to renounce the dominant body discourses” (Bombak et al., 2019, p. 195).

Fat Liberation

Fat liberation is a movement of fat activism and rights for fat people. This movement replaces the words overweight and obese, associated with an oppressive,

pathological stance, with the word fat. (Rothblum, 2012). The National Association to Aid Fat Americans, now the National Association to Advance Fat Acceptance (NAAFA), was formed in 1969 and represented “the beginning of an actual politics of fat” (Edison & Notkin, 2022, p. 3). This organization was followed by the Fat Underground, formed in the 1970s by a group of fat women, two of whom wrote a Fat Liberation Manifesto (Rothblum, 2012).

Chapter Summary

This chapter provided an overview of the study, including the problem statement and potential study impact, the research question, the definition of key terms, and the theoretical framework. Potential study limitations were addressed, and key terms related to the constructs of the study were defined. The problem statement explained that sizeism is present in virtually every area of US culture and causes psychological and physiological harm. Healthcare professionals, including mental health providers, are subject to cultural sizeism and may exhibit weight bias that can adversely affect patient care. Counselors may also display similar negative beliefs about weight, and more research is needed to understand the attitudes and beliefs of clinical mental health counselors.

Understanding and advocating against sizeism is important for counselors who have an ethical responsibility to cultivate an awareness of their values and beliefs to avoid imposing them on clients, avoid client harm, and advocate against injustices with or on behalf of clients (ACA, 2014). Findings from this study can help counselors, supervisors, and counselor educators expand awareness of their beliefs and develop knowledge and skills (Ratts et al., 2016) to address sizeism as an axis of inequality.

Feminist theory is the guiding framework for this research study, and feminist theory is particularly well suited for studying beliefs around weight and body since body acceptance and fat activism came about during the wave of 1960s and 1970s feminism in the US. Feminist theory aligns with counselors' ethical imperatives for multicultural competence and advocacy. Q methodology was introduced as a mixed-methods methodology to understand novice counselors' beliefs on the topic of weight and body image, and Q methodology is a flexible tool that can be used with a social constructionist feminist theory. The next chapter, Chapter Two, will provide a literature review encompassing the origins of sizeism, how it manifests, and the effects of weight bias. The research design is outlined in more detail in Chapter Three.

CHAPTER 2

REVIEW OF THE LITERATURE

Weight stigma is documented as one of the last socially acceptable forms of discrimination (Nolan & Eshleman, 2016; Puhl & Brownell, 2001). Bias against a person based on their body size or shape is also termed *weightism* or *sizeism* (Rothblum & Gartrell, 2019). Although sizeism may occur regarding bodies of any size and shape, bodies that deviate from those that are culturally accepted in Western culture, such as larger bodies, tend to experience the most stigma (Brownell et al., 2005; Chrisler & Barney, 2017; Puhl & Brownell, 2001). In this section, I will expose the prevalence of oppression based on body size, highlight the physical and psychological effects of weight bias affecting clients seeking mental health services, and propose a study to understand novice counselors' beliefs about weight and body. The results of the study can help better prepare counselors to address issues of sizeism, beginning in counselor training programs.

Terminology

In this paper, I use terms such as *higher body weight* and *larger bodies* to describe persons that otherwise might be called *overweight* or *obese* according to current societal norms in the United States. The words *overweight* and *obese* have clinical medical definitions. Still, they are often used interchangeably in common vernacular and may be ascribed to self or others without regard to medical criteria. Additionally, the medical definitions are based on body-mass index (BMI), the accuracy and usefulness of which

has been questioned (Burkhauser & Cawley, 2008; Nuttall, 2015). For example, BMI is a height and weight ratio that does not consider body composition, such as fat and muscle mass (Burkhauser & Cawley, 2008; Kasten, 2018; Nuttall, 2015; Wildman et al., 2008). As Kasten (2018) noted, BMI ranges were developed with White men and are inappropriate measures for adolescents who are still growing and those over age 65, so the usefulness of BMI is limited. As Smith (2019) described, words such as *obese* and *overweight* pathologize variations in body size, which are to be expected across a population. Smith (2019) and others have adopted the word *fat* as a reclamation of power and used terms such as fat female. In this paper, I have chosen to use person-first language to recognize individuals' inherent worth and avoid assuming and assigning identity. I use the words obese, overweight, and healthy where necessary to uphold the integrity of the referenced research.

Finally, the word “healthy” is subjective and could be aligned with healthism, a medicalized increased consciousness about health that places moral responsibility on individuals (Crawford, 1980). As it is used in everyday speech, healthy may signify a binary meaning. Krahn et al. (2021) discussed the 1948 World Health Organization (WHO) definition of health still used today, “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (p. 2), as limiting and outdated. The authors called for a redefinition of health to a dynamic multi-dimensional environmental and social construct that exists along a continuum (Krahn et al., 2021). Given the disparity between the colloquial use of the term and social consciousness that includes social determinants of health, I have chosen to eschew the use of healthy in favor of neutral language, except where the word healthy conveys the

societal messages of others. In summary, I have selected the terms *those living in larger bodies* or *persons of size* to normalize a range of body sizes and shapes and to embrace persons' subjective embodied experiences.

Body-based Bias and Oppression

Individuals living in larger bodies encounter bias and discrimination in multiple areas of life based on their size and, particularly, their weight (Puhl & Brownell, 2001). Counselors must be prepared to treat the effects of size bias (*sizeism*), avoid harming clients with their own biases, and advocate for those who are mistreated (American Counseling Association [ACA], 2014, Sections A.1.a, A.4., & A.7.a.; Ratts et al., 2016). However, there appears to be a dearth of information and guidance for counselors and counselor educators on multicultural competency related to issues of sizeism.

Social Context of Body Size

Beauty standards of body shape are not new or unique to the Western world, and fat is not a negative word everywhere. Veritably, fat bodies are idealized in some cultures, such as among Nigerian Arabs (Kulick & Meneley, 2005). In Graeco-Roman culture, narratives about body size sometimes conflicted, but most frequently, bodies at the margins of thinness or fatness were criticized and negatively stereotyped (Laes, 2016). In addition, U.S. beauty standards were established based on the characteristics of White European settlers, which stood in contrast to the features of Indigenous peoples and enslaved African-Americans (Gamby et al., 2021). Moreover, developing colonial ideals of health and wellness elevated thin, White bodies (Gamby et al., 2021; Strings, 2019). According to Kulick and Meneley (2005), body type preferences shift with the

economic system, prosperity and food availability, societal structure, and cultural values, which is a profitable insight into the development of sizeism in the US.

Race and Body Size

Sizeism in the United States has its roots in nineteenth and twentieth-century colonialism. Strings (2019) chronicled the shift in Western female beauty standards from rounder bodies to a thin aesthetic. Strings (2019) also recounted how women with white skin were held in high esteem and associated with purity, dating back several centuries. White colonial beliefs of racial superiority denigrated Black bodies, particularly those of Black women, and contributed to the rise of slender body ideals and fat aversion. With those living in fat bodies seen as greedy outsiders and overeating considered immoral in New World Protestantism, "fatness became stigmatized as both black and sinful" (Strings, 2019, p. 6.) in the US. Furthermore, Western philosophers of the time insinuated those who were fat were insipid and vapid (Strings, 2019).

Rather than denigration of fat stemming from concerns over physical wellness, Farrell (2011) and Strings (2019) posited that fat stigma preceded medical concerns regarding larger bodies, and the medicalization of fat is rooted in cultural prejudice. Fat was an attribute of uncivilized cultures, according to prominent nineteenth-century western writers and the earliest anti-fat physicians (Farrell, 2011), which was the same argument used to denigrate African-Americans and Indigenous persons. In the early years of the United States, people began to be cataloged according to physical traits and cultural practices to support arguments of inferiority, relegating those in less desirable bodies according to Eurocentric standards (e.g., people of color, persons of size) as less than and disenfranchised (Farrell, 2011).

Protestantism and Body Size

Race, religion, and aesthetics began to blend in the late eighteenth and early nineteenth centuries as the Second Great Awakening Protestant movement of revival, asceticism, and temperance gained a foothold in the US (Strings, 2019). Overeating was considered gluttonous and a sin amid the Popular Health Movement (Strings, 2019). A simple diet and lean physique grounded in asceticism gradually became a beacon of morality and spirituality (Griffith, 1999). Twentieth-century publishers such as Macfadden and Anglo-American diet reformers hailed the benefits of fasting and abstinence from gluttony, alcohol, and tobacco (Griffith, 1999). Thus, fasting expanded from a religious practice to a practice of thinness intertwined with moral righteousness.

In the twentieth century, some leaders in the modern evangelical culture began to focus on appearance and specifically criticizing fat bodies, particularly among their White peers, publishing the first Christian weight-loss books and developing weight-loss programs associated with spirituality (Gerber, 2012; Griffith, 1999). Gibbes Miller (2018) described the focus on health and fitness as a religious obligation and avoiding fatness as critical for serving God. Contrition and reliance on God for empowerment and healing of obesity became the cornerstones of the Christian weight-loss mantra (Gibbes Miller, 2018). Protestantism significantly influenced the "cultures of weight loss and the moral discourse on fat" and then, in turn, "appropriated the dominant cultural concern about weight and body size" (Gerber, 2009, p. 406).

Food and bodies are discussed in religious communities other than Protestantism; however, the literature seems to be more limited and more focused on general health than weight per se. For example, Hossain (2014) provided an overview of Islamic teaching on

dietary intake, citing the Holy Qur'an and The Prophet as guidance on what to eat and drink or abstain from for best health. The author briefly mentioned being overweight and a recommendation to control weight without explicitly linking it to religious authority (Hossain, 2014). An analysis of healthcare ethics in Catholicism only mentioned obesity in the context of bariatric surgery as a solution to a "behavioral problem" (Ashley et al., 2006, p. 108). The authors expressed that individual health is a personal responsibility with community support (Ashley et al., 2006). Health and religion are connected in most major religions (Majda et al., 2022). Still, the literature does not seem to support the same emphasis on weight and body size in other religions as in Protestantism.

According to the American Evangelical Protestant (AEP) leaders who promote weight loss as a spiritual discipline, individuals choose to be either fat or fit. The belief is that personal responsibility is at the center of the issue. With God's help and the support and accountability of others in the Christian community, individuals have the power to change their bodies (Ashley et al., 2006; Gibbes Miller, 2018). This account of personal and moral responsibility for fitness appears to reflect modern healthism, a term coined by Robert Crawford (1980) to describe the rhetoric of health as individually controllable without considering an expansive view of well-being and social and political factors. Without recognizing social determinants of health (Gibbes Miller, 2018), the aforementioned AEP philosophy on weight may serve to perpetuate *fat phobia* or *fatmisia*, a fear of fatness (Robinson, 1993) or hatred of fatness (Forristal et al., 2021), and marginalize and discriminate against those in larger bodies (Gerber, 2009).

Social Class and Body Size

Determinants of health and body size transcend individualistic ideals. One place this is apparent is the relationship between larger bodies and social class or socioeconomic status (SES). Sobal and Stunkard (1989) first reviewed the literature on SES and obesity. They noted that, particularly for women, there is a strong inverse relationship between obesity and SES, where lower SES strongly correlates with larger bodies. In this seminal analysis, the researchers found a clear connection between SES and body weight in highly developed countries, particularly with women in higher social strata in smaller bodies. Proposed explanations are these societies place a high value on thinness as attractive, and higher SES brings increased social pressure to exercise and diet, the latter of which is less common among males. The researchers found that in the U.S., 93% of the studies with women documented an inverse relationship between body size and SES, compared to 75% of the studies in other highly developed countries. This relationship was the opposite in developing countries, where lower SES correlated with smaller bodies. The authors also noted fatness was valued in many cultures with lower economic development and SES. This attitude toward obesity was markedly different in more economically developed societies, with neutral or mixed male attitudes and strong weight stigmatization among female adults and adolescents (Sobal & Stunkard, 1989).

The results were directionally similar, but not as strongly correlated, in McLaren's (2007) more recent literature analysis. McLaren's research updated the Sobal and Stunkard (1989) study by looking at research findings across societies to identify patterns in body size according to SES indicators and societal stages of economic development. For study purposes, economic development was classified as high,

medium, or low according to the 2003 Human Development Index (HDI). Longitudinal studies were omitted from the review, along with studies where participants were under 18 years of age. In the review, McLaren observed a continued pattern of an inverse relationship between body size and HDI, where 63% of the studies reviewed for women in high HDI countries indicated an inverse relationship between SES and body size.

Studies with men indicated insignificant or curvilinear relationships between body size and SES in high- and medium-HDI countries (McLaren, 2007). McLaren (2007) discussed that an obesogenic environment may affect all social classes and that a beauty ideal of thinness may be more available to women in higher social brackets and help them maintain higher social status. Education levels may be positively related to SES (McLaren, 2007), and increases in education levels have been shown to correspond with past dieting behavior and lower body and appearance esteem (McLaren & Kuh, 2004). Additionally, occupational environments with their respective social norms and power hierarchies may reasonably influence the pursuit of thinness and what is perceived as a healthy lifestyle. Thus, another possibility is that women historically marginalized in developed Western societies may find themselves pressured to achieve cultural ideals of appearance and beauty standards to achieve power and equalize the differential (McLaren, 2007).

Wardle et al. (2004) investigated weight-related attitudes and behaviors among adolescent females. They found that adolescents from higher SES reported more exposure to social pressure for thinness within their families, consistent with Sobal and Stunkard's (1989) analysis. The female adolescents also engaged in more weight-control behaviors than those with lower SES. There were no significant differences in BMI by

SES among participants. Participants from all SES selected the ideal body size as thin, one bordering on underweight according to BMI standards. Wardle et al. (2004) concluded that genetics and social class of origin might be predictors of obesity for women but less so for children and men. In summary, class and appearance seem to be intertwined in the currency of cultural capital, particularly where obesity is associated with lower SES. Focusing on appearance, specifically eschewing fatness, may be important to gaining and maintaining social power.

Oppression Based on Body Size

Social power is a fundamental component of discrimination and oppression, including body-based oppression. Weight-based prejudice and discrimination are prevalent across virtually all settings and range from overt discrimination, such as exclusion and name-calling, to prejudicial microaggressions that imply negative beliefs about a person based on body size or shape (Cardinal et al., 2014). This oppression occurs against persons perceived as fat or not meeting societal expectations for body size. According to Puhl et al. (2008), height and weight discrimination is the third most common discrimination against women, after gender and age, and fourth most common against all adults, following gender, age, and race. Weight-based discrimination infiltrates nearly every aspect of a person's life through (a) media (Greenberg et al., 2003; Himes & Thompson, 2007; Puhl & Brownell, 2001), (b) employment (Puhl et al., 2008; Puhl & Brownell, 2001), (c) education (Brochu, 2018; Lombardi et al., 2019; Meers et al., 2011), (d) interpersonal relationships (Lombardi et al., 2019; Nutter et al., 2019), and (e) healthcare (Chrisler & Barney, 2017; Tomiyama et al., 2018). This form of prejudice's

pervasiveness suggests that counselors and clients are likely affected by weight-based discrimination.

Stigmatization in Media

Sizeism is evident in the media promoting a thin ideal and fat stigmatization (Greenberg & Worrell, 2005; Himes & Thompson, 2007). Some of the news media programming tends to focus on the controllability of weight and disregard factors out of people's control (Himes & Thompson, 2007) such as SES (Fikkan & Rothblum, 2005; Koruda, 2016; Sobal & Stunkard, 1989), race (Himmelstein et al., 2017), internalization of weight bias (Selensky & Carels, 2021), genetic predispositions (Nuttall, 2015; Wardle et al., 2004), and medical conditions (Koruda, 2016). Moreover, the media can also contribute to the degradation of persons living in larger bodies with fat jokes (Fouts & Burggraf, 1999) and support of weight loss programming and advertisements (Himes & Thompson, 2007; Puhl & Brownell, 2001). Furthermore, women living in larger bodies are more often vilified in the media than men through negative comments about the women's appearances and audience laughter (Fouts & Burggraf, 1999, 2000; Himes & Thompson, 2007).

Moreover, articles and advertisements related to body, diet, and exercise also tend to target women versus men at a ratio of more than ten to one, and the amount of content steadily increased in the US from 1959 to the 1980s, when the last comprehensive studies were published (Greenberg & Worrell, 2005). Additionally, an analysis of television programming identified one in three women featured was underweight or below average weight, which was disproportionate to the general population (Fouts & Burggraf, 1999, 2000). Women in larger bodies represented 25% of the population. Still, they were only

represented in media 3% of the time, and when women in larger bodies were shown, they typically had minor roles (Fouts & Burggraf, 1999; Greenberg et al., 2003). Greenberg et al. (2003) also reported the significance of weight stigmatization by employment and race, with unemployed men shown in larger bodies than employed men and African American females in larger bodies shown more than White females in larger bodies. A more recent television content analysis supported the earlier findings. Characters with larger bodies were more likely to be ridiculed and viewed as less attractive and less intelligent than thinner characters, other than overweight Black characters who were scripted as likable (Mastro & Figueroa-Caballero, 2018). Asian characters were typically depicted as underweight, and Black characters were characterized as overweight at rates exceeding chance (Mastro & Fiueroa-Caballero, 2018). These findings could indicate the perpetuation of racial stereotypes intersecting with weight stigma and how weight discrimination in the workplace and racism are reinforced through media. Perpetuation of racial stereotypes is particularly concerning since media messages may shape and support societal ideals (Mastro & Figueroa-Caballero, 2018).

Robinson et al.'s (2008) content analysis of children's television sitcoms revealed similar findings to adolescent and adult programming: characters' body types were below average weight 38% of the time, at average weight 47%, and above average weight in 15% of the instances. Six of the 19 shows did not include above-average-weight characters (Robinson, 2008). In the same study, the researchers reported that above-average-weight characters were more likely to be African American than Caucasian (Robinson et al., 2008), which suggests stereotypes of bodies by race are reinforced through children's television shows.

Eisenberg et al. (2015) reviewed popular television programming for adolescents based on 2,793 adolescents' reports of their favorite television shows. They selected the top 10 shows and reviewed three episodes of each; they found 50% of the 30 episodes contained weight-stigmatizing dialogue. The stigmatization was reinforced by audience response of laughter 28.6% of the time for male targets and 62.5% for female targets. Interestingly, of the characters targeted with weight-stigmatizing language, 50% were considered overweight, and 40.9% were in the average weight category. Taken together, this could suggest that only skinny bodies are adequate and bodies that do not fit that criterion, particularly female bodies, deserve ridicule. Ageism and beauty standards may also intersect with weight bias since older characters were more likely to be in higher-weight bodies, and younger characters were in thinner bodies with higher rates of perceived attractiveness (Greenberg et al., 2003). Greenberg et al. (2003) provided data that showed even the lives of the fictional characters in larger bodies mirrored the cultural stigma of weight with fewer friendships, positive social interactions, and romantic interests, and they were the recipients of jokes and laughter at their expense.

The research discussed so far has focused on television media, but weight stigma seems to extend across most, if not all, media types. Advertisements on websites targeted to adolescents were found to align with television content in perpetuating the idealized bodies – thin females with accentuated breasts and skinny, muscular males – through content and images (Slater et al., 2012). Similar findings were noted in content analysis of health and fashion magazines, and the correlated body dissatisfaction mediated positive effects on depression and a drive for thinness (Swiatkowski, 2016). In *Latina* magazine, cover models are typically thin, but through 2011 there were early signs of

increasing size diversity (Franko et al., 2013). Gultzow et al. (2020) expanded the literature to look specifically at how social media portrayed ideal male bodies. The researcher analyzed 3,184 Instagram posts identified primarily by hashtags corresponding to language on fitness websites and added posts of relevant social media influencers. They found 62% of the pictures depicted low body fat, 41% showed muscular physiques, and 35% of the posts showed a combined image of low fat with high muscularity, which is out of proportion to the male population. This low-fat, high-muscularity group also received the most positive post interactions, demonstrating a significant, albeit weak, correlation between media engagement and what is frequently described as the desired male body type (Gultzow et al., 2020). It is also important to note that 55% of the posts were of White men, with fewer posts of males of color and fewer positive interactions per post for Latino men than White men (Gultzow et al., 2020).

Although women are targeted more frequently with weight stigmatization, men and women alike are negatively impacted by distorted media depictions, manifesting in more negative self-esteem and negative behaviors, including anxiety, depression, and depression (Greenberg & Worrell, 2005). Domoff et al. (2012) examined how watching *The Biggest Loser,* a popular weight loss competition show, affected weight bias in a group of predominantly White college students enrolled in an undergraduate psychology class. The researchers measured weight bias pre- and post-show exposure using three validated assessments and compared results to a control group who watched a nature show instead of *The Biggest Loser* episode. Results indicated watching the weight loss competition may have contributed to an increased dislike for persons with larger bodies and a stronger belief that weight is controllable (Domoff et al., 2012).

Furthermore, media can perpetuate thin idealism with photo-altering techniques that distort realistic body proportions (Cardinal et al., 2014) and reinforce claims that weight is within an individual's control (Domoff et al., 2012). Harrison (2003) found that both male and female undergraduate students ascribed to the distorted female body ideal seen in mainstream media, and the men supported females' extreme dieting and surgical body alterations in an attempt to attain the thin, curvy disproportional idealized body. Men and adolescent boys also may be affected by idealized male bodies and exhibit a desire to increase muscle mass to meet societal ideals (Greenberg & Worrell, 2005; Sobal & Stunkard, 1989).

Programming designed for children also depicts underweight and normal-weight characters as attractive and higher-weight characters as unattractive (Selensky & Carels, 2021). Latner et al. (2007) examined the correlation between anti-obesity bias and children's media consumption, finding a link that may be explained by the types and amount of media consumed. Additionally, Frederick et al. (2020) reported from their research that exposure to fat-negative media messages corresponded with participants' prejudice against fat people. In the study, they sought to understand how constructs of fatness affected health and fat attitudes and behaviors. Four constructs were studied: 1) fatness as a public health crisis or obesity epidemic, 2) fatness as a personal responsibility that must be controlled with diet and exercise, 3) the *Health at Every Size (HAES®)* paradigm that larger bodies are not inherently unhealthy, that pursuing health is not a moral obligation, and all bodies are to be celebrated (Association for Size Diversity and Health [ASDAH], n.d.), and 4) a fat rights position which celebrates the diversity of fat bodies and reclaims the word fat as a neutral word.

In a series of two studies, Frederick et al. (2020) randomly assigned more than 2,000 US adults ages 18 – 65 to a control group or a test group to read a fictitious article presenting physicians' health research. In one study, the researchers conducted a one-way ANOVA analysis to determine the effect on various beliefs after the test participants read fictitious articles testing different variables. Participants either read an article about high body fat being unhealthy or healthy, body fat being controllable or uncontrollable, or one that supported weight stigmatization as acceptable or unacceptable. Those who read an article that decried weight stigmatization were labeled as the fat-positive test group, and all other groups were one of the fat-negative groups. Those who read a fat-negative article were more likely than the control group and the fat-positive test cell to believe that fat is unhealthy, express more anti-fat attitudes, and accept fat discrimination. The participants in the fat-positive test group were less likely than the other groups to consider dieting after weight gain.

Frederick et al. (2020) ran a similar test with more than 2,000 US adults in the second study and added gender as a second independent variable. Not only did the fat-negative test participants express similarly significant attitudes as in the first study, but there were also statistically significant effects for less attraction to fat people, increased social distance, and acceptance of equal rights discrimination. In addition to dieting intentions, they expressed exercise intentions if they were to gain weight (Frederick et al., 2020). It has been established that media and the medical community reinforcing claims that weight is within a person’s control (Domoff et al., 2012) can reinforce stereotypes that persons in larger bodies are lazy and undisciplined, gluttonous, and non-compliant (Puhl & Brownell, 2001). The implications of Frederick et al.’s (2020) studies suggest

sizeist discrimination based on published media may lead to acceptance of discriminatory behavior against persons of size.

Furthermore, media that attempt to thwart sizeism and promote body positivity have perhaps inadvertently created a new -ism in *figurism*. Figurism depicts body-positivity as women with curvy, hourglass-shaped figures (Scott, 2019), and individuals' bodies are still judged based on physical appearance, size, and shape. *Fitnessism*, as Eriksson (2022) described, is yet another variation of healthism, where bodily appearance and particularly a distinct look of muscles with low body fat are used as proxies for health. Fitnessism may also be perpetuated by the media and adds the element of submission to rigorous routines of exercise and diet as imperatives and willpower and control as virtuous (Eriksson, 2022). Shows like *The Biggest Loser* in the US and the Swedish reality television show *The Great Health Journey* are produced in such a way as to uphold the moral discourse of health as an achievement and legitimize extreme fitness regimens as beacons of health behaviors (Eriksson, 2022).

Under these notions of healthism, figurism, and fitnessism, health, beauty, and wellness, a moral obligation to achieve societal standards begins to merge (Eriksson, 2022). One result can be to infer is that persons in larger bodies who do not meet these standards are undisciplined, lazy, or uncaring if they do not lose weight. What follows may be negative commentary regarding weight and body-related teasing and bullying, which are correlated with body dissatisfaction and adverse psychosocial outcomes (Himes & Thompson, 2007). Since most counselors are presumably consuming media, they may also be influenced by these messages of size bias grounded in healthism, figurism, and fitnessism. Counselors may have also experienced the adverse effects of

media portrayals of thin privileged bodies and the stigmatization of those living in larger bodies.

Sizeism in Employment

In addition to bias in media, persons in larger bodies experience discrimination in the employment process. Specifically, they are discriminated against in hiring, wages, and promotions, and women, in particular, are subjected to contemptuous standards (Puhl et al., 2008; Puhl & Brownell, 2001). For example, female flight attendants have been subject to supercilious weight standards in the airline industry, which were upheld by courts (Puhl & Brownell, 2001). In the United States, only the state of Michigan protects persons from weight-related employment discrimination, and there are no such federal protections in civil rights law (Theran, 2005). The lack of US civil rights protection for those in larger bodies suggests that sizeism is at least partially socially acceptable.

A belief that weight is a choice and controllable seems to contribute to weight bias in employment (Theran, 2005). Adults have reported wrongful termination, missed promotions, poor treatment in public settings, and being perceived as morally and intrinsically inferior in interpersonal relationships due to size discrimination (Puhl et al., 2008). Specifically, Puhl et al. (2008) analyzed 1995-1996 data from the National Survey of Midlife in the United States (MIDUS), which included English-speaking adults aged 25 – 74 years, to examine how weight-height discrimination might be connected to body weight and SES. The researchers noted 10% of women and 5% of men in the survey reported current or past weight-height discrimination in any arena. Of those who reported weight-height discrimination, 60% reported employment discrimination, such as lack of promotion or wrongful termination. The data was similar to the 53% of participants who

reported race-based discrimination in the workplace. Of the respondents who reported weight-height discrimination, almost one-fourth said they also faced racial or age discrimination, and 40% reported gender discrimination. Given the overlaps, the possibility of intersectional workplace discrimination may also exist. Intersectionality refers to unique challenges created by multiple burdens of discrimination, such as race and gender (Crenshaw, 1989). In the previously referenced study (Puhl et al., 2008), compounded discrimination may exist based on multiple markers, such as race, gender, body size, and age.

Women are particularly vulnerable to sizeism in the workplace, even those in lower-weight categories. Indeed, women are 16 times more likely than men to experience weight-based workplace discrimination (Rothblum & Gartrell, 2019), further compounding issues of intersectionality. Labels of overweight and obese are associated with unemployment, lower individual income, and low household income (Fikkan & Rothblum, 2005). Indeed, Fikkan and Rothblum (2005) reviewed the literature over several decades, citing numerous examples of prejudice against higher-weight job applicants and employees that unjustly affect employment status, pay, perception of performance, and disciplinary treatment. The effects were greater for women than men, particularly in higher professional status, male-dominated fields (Fikkan & Rothblum, 2005). This type of discrimination often goes unacknowledged in the legal system, where lawsuits are usually only successful with persons at the upper end of body weight who win under obesity as a disability, which remains a controversial designation (Fikkan & Rothblum, 2005).

Beyond employment discrimination, persons who identify as fat, obese, larger-bodied, or full-figured experience organizational barriers in the workplace. Van Amsterdam and van Eck's (2019) qualitative study explored how these female employees navigate stigma in work environments. They identified two primary themes of women emphasizing professional appearance and productivity in response to work cultures inhospitable to larger-bodied employees (van Amsterdam & van Eck, 2019). The women in the study, who were mostly White, tended to engage in activities to hide themselves, conceal or distract away from body size, and compensate for body size with other appearance-oriented measures to fit in or intentionally stand out for something other than size (van Amsterdam & van Eck, 2019). They also compensated for negative stereotypes of persons of size (e.g., lazy, unproductive, unhealthy) by overperforming and minimizing the use of sick leave (van Amsterdam & van Eck, 2019). Thus, weight stigma in work settings may be internalized, compounding the adverse effects.

Moreover, there is a stereotype that larger body employees are unhealthy and thus costly to companies (Koruda, 2016; van Amsterdam & van Eck, 2019). Employer wellness programs or workplace health promotions (WHP) use incentives and penalties to combat identified health problems, including obesity (CDC, n.d.; Koruda, 2016), which may cultivate environments that could further serve to stigmatize persons in larger bodies. WHPs in the US have grown substantially and are supported by public policy in many states. As of 2016, WHP incentives are protected from anti-discrimination laws in 28 states, and at least 84% of states have codified health promotion through WHP (CDC, n.d.). The CDC (n.d.) explained that WHPs are designed for employees' health and safety and can generate positive financial results for organizations.

WHPs were federally legitimized in the US in 2010 through the Patient Protection and Affordable Care Act and ensuing regulations on workplace wellness from the U.S. Department of Treasury, Labor, and Health that took effect in 2014 (Koruda, 2016). WHP proponents cite screening and interventions as important WHP components to improve health and lower healthcare costs (Orentlicher, 2014). According to Koruda (2016), one employer with a WHP claimed the program benefits employees who participate because they gain information about their health and do not have to subsidize healthcare costs for co-workers with sub-optimal health. Employers are permitted to charge up to 30% of employees' healthcare premiums to employees who fail to meet health-contingent measures or do not screen for those measures, or they can offer premium reductions for employees who do meet the targets; these surcharges can be up to 50% higher for tobacco use (Koruda, 2016; Orentlicher, 2014). There is no limit on the incentives or surcharges employers may impose regarding participation in WHPs (Orentlicher, 2014). Given the inverse relationship between body weight and SES (McLaren, 2007; Sobal & Stunkard, 1989; Wardle et al., 2004), WHPs that include body weight or obesity health measures may disproportionately affect lower-income persons.

WHP program results are mixed, with some modest positive results but a lack of sustained results (Orentlicher, 2014). Orentlicher (2014) also pointed out the risk of selection bias if only already motivated employees enroll in the programs. Several controlled studies showed insignificant changes in weight between participants with health assessments plus interventions and those receiving only health assessments (Orentlicher, 2014). In similar studies with patients at healthcare facilities, participants lost more weight than the control groups during the program, but these differences

disappeared in less than one year (Orentlicher, 2014). The CDC (n.d.) noted some positive evidence for WHP but a lack of research on the impact of WHP-related legislation. Koruda (2016) reported a lack of evidence supporting overall reduced healthcare costs and improved health outcomes, which are the typical goals of WHP. With WHP financial structures, costs may be transferred to those unable to participate in programs or achieve targets (Koruda, 2016) and thus be invisible to the program, creating incentives and opportunities for employers to reinforce WHP.

Employer-based initiatives regarding employee health and fitness blur boundaries between occupational and personal lives, and they are designed to produce favorable financial results for companies (Zoller, 2003). WHPs seem to align with a philosophy of healthism, which places health responsibility on individuals and assigns a moral value to the appearance of health and lifestyle. Healthism disregards the multi-dimensional and systemic components of well-being. WHP may disenfranchise people who are unable to participate in the incentives or achieve certain behaviors and goals, particularly minority racial groups who may have a higher prevalence of obesity (Schuler et al., 2008) and other marginalized populations, such as those with low wages, who may face undue financial pressure to participate in voluntary programs or be unable to afford healthcare premium surcharges (Orentlicher, 2014). Those with lower financial means, persons with medical conditions or disabilities, and groups more susceptible to health conditions can be disproportionately negatively impacted by WHP (Koruda, 2016). For example, one disparity is the rates of obesity among Black and Hispanic women in the US are higher than among White women (Himmelstein et al., 2017; Mensinger et al., 2018), and obesity is associated with lower household income (Fikkan & Rothblum, 2005). Due to factors

beyond their control, such as health status, income, and access (e.g., food, healthcare), marginalized groups may be unable to meet uniform standards and surcharges that do not take their individual health picture, risk factors, and SES into account (Koruda, 2016). Rather than recognizing societal factors involved in health, WHP may inadvertently promulgate an underlying message of health as individually controllable.

Taken together, when obesity is considered a disease to combat and is treated as an individual choice and responsibility through the lens of healthism, persons in larger bodies can be discriminated against in the workplace. Body size, race, social class, gender, ability, age, sexual orientation, and health status intersect in the workplace and may result in employment discrimination and limitations on access to financial benefits, such as those in WHP. Counselors and counselor educators may work in environments where messages of healthism and WHP policies are routine and unquestioned. Counselors and counselor educators can seek to understand better the structural injustices inherent in the dominant narrative of healthism and recognize disparities in employment practices. It is also germane to consider counselors' views on body weight and shape and how internalized bias may shape the nature of care for clients, particularly those who have experienced the effects of sizeism in employment.

Educational Settings

The cycle of sizeism begins early in life. Children and adolescents receive weight-biased messages from adults and peers across settings, including education. Starting in early education and childcare, children are frequently exposed to weight-related talk at a young age. Indeed, children as young as three years old expressed pro-thin ideals in relationships and fat stigmatization (Lombardi et al., 2019; Meers et al., 2011). Meers et

al. (2011) attributed preschool children's preferences for drawings of thin children to the prevalence of societal anti-fat bias. Additionally, Australian girls aged five to eight exhibited weight-based stereotyping and images of underweight girls as more desirable for friendship than normal-weight or overweight girls (Lombardi et al., 2019).

Furthermore, weight is one of the most common reasons for school-based bullying (Brochu, 2018). Even with policies to create safe educational settings, weight-based discrimination is pervasive (Nutter et al., 2019). Historically, children were frequently weighed in front of peers in physical education classes, with announced weights (Puhl & Brownell, 2001). Additionally, physical education teachers may ignore the weight-related teasing of students (Cardinal et al., 2014). Nutter et al. (2019) conducted a systematic review of original research on weight bias in educational settings from kindergarten through 12th and post-secondary education. They reported children and youth with higher body weights were generally regarded as less attractive, less popular, more sensitive, and with lower athletic and leadership abilities, across races and ethnicities (Nutter et al., 2019). Coping strategies among these students included seeking support and defensive strategies, some of which were isolation and the use of drugs and alcohol (Nutter et al., 2019).

With the percentage of children and youth identified as obese increasing from 6.5% and 5%, respectively, to 19.6% and 18% between 1980 and 2008 (Tingstrom & Nagel, 2017), obesity is frequently a focus of health and physical education classes. To better understand the attitudes of educators toward children in higher weight categories, Nutter et al. (2019) examined eight studies of pre-service teachers' attitudes toward obesity. Pre-service teachers are those in training or under supervision. These studies

explored attitudes among physical education (PE) pre-service teachers and those in general education, non-specialized. Weight bias existed across all samples, with increased bias among PE teachers who were more likely to think of body weight as controllable and weight as an indicator of health (Nutter et al., 2019), a refrain of healthism. They also wanted to help students lose weight (Nutter et al., 2019), which may be similar to mainstream attitudes in healthcare, where providers often believe it is their responsibility to help persons shrink their bodies whether they want to or not (Chrisler & Barney, 2017).

As healthcare providers, school nurses have been encouraged to assess obesity in children and intervene for prevention and weight reduction. Although a position statement on the role of school nurses in obesity in schools has been retired from the National Association of School Nurses (NASN) website (National Association of School Nurses [NASN], n.d.), academic literature exists supporting the role of school nurses in obesity prevention. Additionally, the CDC advocates that school nurses have a role in reducing obesity (CDC, 2022b), and some states and school districts require BMI screening in schools (Be Real USA, n.d.; CDC, 2022a; Sliwa, 2019). So, it is likely that school nurses and physical and health education teachers are measuring weight and BMI among children and adolescents as part of some effort at obesity reduction.

To obtain information on the prevalence of obesity screening among school nurses, Sliwa et al. (2019) analyzed CDC data from the 2014 School Health Policies and Practices Study (SHPPS). Based on SHPPS, they determined how many schools with nurses were screening students for BMI and if they were using four of the ten safeguards recommended by the CDC. These safeguards were implemented based on expert and

parental input to minimize weight stigmatization, reduced self-esteem, and problematic weight loss behaviors. The four safeguards included in the SHPPS data were: Safeguard 2 – appropriate training; Safeguard 4 – accurate equipment; Safeguard 9 – resources available for safe and effective follow-up; and Safeguard 10 – provide parents with an explanation of BMI results and follow-up actions.

A review of the data from the SHPPS national survey of schools grades kindergarten through twelfth grade revealed 223 of the 567 schools surveyed screened students for BMI through school nursing (Sliwa et al., 2019). Of these schools, 56.5% had zero or one of the four safeguards in place, and only 3.1% had all four safeguards in place. Eighty-six percent of the schools that screened students for BMI reported notifying parents of results, but only 47% referred to community providers when they identified potentially problematic results. Prevalence of parental consent was not measured in the survey (Sliwa et al., 2019), and according to the CDC, permission may be passive where all students' BMIs are measured unless parents request children not be screened (CDC, 2022a). Other unmeasured safeguards referred to the privacy of screening and deidentifying data, accurately calculating and interpreting data, avoiding the use of data to evaluate performance, and regular evaluation of the program for outcomes and unintended consequences (CDC, 2022a; Sliwa et al., 2019), all of which would be important in minimizing the potential for harm. It is important to note that BMI screenings may also occur in PE classes, which was outside the survey's scope (Sliwa et al., 2019). Interpretation of the findings may suggest that although the CDC developed safeguards to address the potential harm of weight screening in schools (CDC, 2022a;

Sliwa et al., 2019), the safeguards have not been fully adopted, and children and adolescents who are screened for BMI may be at risk for increased stigmatization.

Weight stigma may also continue beyond primary and secondary education. Puhl and Heuer (2009) identified studies documenting disparities in higher education based on weight in their systematic literature review regarding weight discrimination across domains. For example, in one study of over 700,000 Swedish men, researchers reported lower rates of higher education for men with obesity compared to lower-weight peers, adjusted for socioeconomic status (Karnehad et al., 2006). In a longitudinal study of adolescents, women with obesity attended college at half the rate of their peers, except when female obesity was predominant and the results equalized (Crosnoe, 2007). The researcher did not find the same variations for men (Crosnoe, 2007).

Additionally, Puhl and Heuer (2009) proposed several possible explanations for the disproportionate achievement of higher education by weight status, including weight bias within the educational system, low parental support, and poor or lacking peer relationships due to sizeism. Even graduate psychology programs may be less likely to admit women with larger bodies than those with thinner bodies, according to one study of admissions data at a large Midwestern university (Burmeister et al., 2013). Burmeister et al.'s (2013) findings indicated reference letters were not affected by BMI as hypothesized, yet offers of admission after interviews were inversely correlated with BMI for women, suggesting weight bias related to in-person interviews. This hypothesis was not supported for men (Burmeister et al., 2013). Discrimination in psychology graduate admissions could have broader consequences, such as filtering out larger-bodied women

from entering the psychology field, limiting their opportunities, and shaping how clients may experience psychologists as people in smaller bodies.

Sizeism in education could be particularly detrimental to youth, where teachers and counselors hold significant positions of power. Counselors who matriculated through the US educational system may have adopted biased beliefs about weight from a young age, and these may be reinforced in work in educational settings. Several studies among educators testing anti-weight bias interventions, such as increased awareness, body image education, and understanding of health decoupled from body size, showed promise in reducing explicit weight bias (Mayhew et al., 2015; Tingstrom & Nagel, 2017). In addition to educational settings, weight bias also affects interpersonal relationships.

Interpersonal Relationships

Preference for persons with smaller bodies and prejudice against those in larger bodies is woven through many facets of life, such as media, employment, education, and relationships. All kinds of relationships, including friendships, parental, romantic, and peer relationships, can be negatively impacted by weight bias. For example, in a Belgian study of more than 11,000 male and female adolescents ages 10 – 19, researchers investigated the correlation of perceived social support from classmates and teachers with the factors of BMI, sex, and family structure (Lebacq et al., 2019). Obesity status in males and females was linked to reduced health-related quality of life (HRQoL) scores, and impairment was more significant in girls than boys. Girls classified as overweight (possessing a lower BMI than obese) also had lower HRQoL scores than lower weight categories, but this was not evident in overweight boys. Underweight boys and girls demonstrated HRQoL scores similar to normal-weight adolescents. Perceived social

support scores were positively associated with HRQoL scores across all weight categories, but social support from teachers and classmates did not mediate the inverse relationship between HRQoL scores and BMI (Lebacq et al., 2019). Girls in larger bodies may experience social support differently than girls in non-overweight categories, which may impair their quality of life and carry into adulthood.

In addition to social support and quality of life, women living in larger bodies are disadvantaged in dating relationships based on perceived attractiveness, lower likelihood of romantic relationships, and lower relationship satisfaction (Puhl & Heuer, 2009). Akers and Harding (2021) used longitudinal data collected from 1994 to 2008 to examine the relationship between body weight and relationship satisfaction in females from adolescence into adulthood. They selected a sample of women who self-selected their race as Black or White, identified as heterosexual, and reported being in cohabitating or marital relationships in Wave IV of the study from 2006 to 2008. Almost 75% of the study participants were White. The researchers tracked the women's weights over time from adolescence (ages 12-18) to adulthood (ages 24-32). They noted most females in normal weight BMI categories during adolescence stayed in that weight range, and approximately one-fourth moved into the category of obesity. Rates of relationship dissatisfaction were similar across weight categories, but those who lived in larger bodies at younger ages tended to remain in larger bodies. The researchers labeled this 7.5% of the sample chronically obese. They found that women who experienced chronic obesity were more likely to report significant relationship dissatisfaction in adulthood than normal-weight peers, supporting the idea that chronic marginalization has long-term effects on relationship functioning (Akers & Harding, 2021).

Researchers have also investigated the sexual satisfaction of persons in larger bodies, noting multiple factors influence sexual functioning and satisfaction. These factors may include biological mechanisms connected to age and body size functioning, gender, and socio-cultural influences (Parchomiuk & Kirenko, 2021). Parchomiuk and Kirenko (2021) investigated the relationship between sexual satisfaction and needs and preferences in those identified as obese and non-obese. They found no significant differences between the two groups in the dimensions assessed but noted a more complex structure of associations between body size, expectations, and satisfaction. For example, activities for sexual pleasure may vary in relationship to body size, and having experienced weight-based discrimination and mental health challenges are associated with lower sexual activity and fulfillment (Parchomiuk & Kirenko, 2021). Parchomiuk and Kirenko's (2021) study results corresponded with several other studies of weight and relationship satisfaction (Akers & Harding, 2021; Rollero, 2022) demonstrating lower relationship satisfaction for those in larger bodies in heterosexual relationships.

Persons of size are also likely to experience sizeism by close family members, friends, and spouses (Puhl & Brownell, 2006; Puhl, Moss-Racusin, et al., 2008). Women commonly reported bullying from parents and siblings and generally have fewer close friends and more relationship dissatisfaction than thinner women (Puhl & Heuer, 2009). Moreover, those who live in larger bodies may be stared at and ridiculed in public spaces, and women, in particular, are subjected to scrutiny and mistreatment by strangers (Sobal, 2005), in addition to the poor treatment they receive from friends and family. Since those who have experienced discrimination and marginalization due to body size may encounter disproportionately more difficulty forming dating relationships (Sobal, 2005)

and mental health challenges than those in smaller bodies, it is essential for counselors to understand the systemic nature of the concerns and guard against a position of assigning individual responsibility.

Healthcare and Weight Stigma

Weight stigma affects mental health and physical health, but the healthcare received may serve to stigmatize persons of size further. Puhl and Brownell (2001) examined literature regarding bias and discrimination against obese persons in education, employment, and healthcare. Chrisler and Barney (2017) and Tomiyama et al. (2018) conducted similar reviews documenting the treatment of persons of size in healthcare settings and advocating for improved care. The findings were consistent over time with demonstrated adverse effects of weight bias. Indeed, sizeism seems to affect all aspects of healthcare, from less time spent with patients to less propensity to listen and compromised diagnostics and treatment (Chrisler & Barney, 2017). Sizeism may influence healthcare professionals' clinical judgment and increase perceptions of larger-bodied patients as lazy, noncompliant, gluttonous, hostile, and dishonest (Puhl & Brownell, 2001). Additionally, healthcare professionals may be uncomfortable caring for these larger-bodied patients and even avoid treating obese patients (Puhl & Brownell, 2001; Tomiyama et al., 2018).

Patients have also reported disparaging treatment and inadequate provisions in the medical setting, which can result in a lack of trust in healthcare providers and reluctance to seek health services (Amy et al., 2006; Balkhi et al., 2013; Mensinger et al., 2018; Nyman et al., 2010). For example, persons living in larger bodies have reported physical barriers in medical settings, such as inadequate furniture size, medical equipment, and

clothing (Amy et al., 2006; Balkhi et al., 2013; Nyman et al., 2010). Subsequently, patients with larger bodies may avoid seeking healthcare due to poor body image and experiences of prejudice from healthcare professionals (Amy et al., 2006; Tomiyama et al., 2018). Additionally, inappropriate comments and maltreatment from healthcare professionals can lead to persons of size placing less trust in their physicians (Balkhi et al., 2013; Puhl & Brownell, 2001). Individuals in larger bodies have also been denied healthcare services, such as fertility treatments and orthopedic surgeries, due to their weight (Giori et al., 2018; McPhail et al., 2016). Even persons living in smaller bodies can experience the effects of sizeism in healthcare since the health assessments and recommendations they receive may be predicated on body size and shape (Chrisler & Barney, 2017).

Significant literature exists recounting healthcare providers' weight biases and resulting patient experiences across types of healthcare. In prenatal and maternal care, Nagpal et al. (2020) documented a comprehensive review of studies focused on prenatal obesity. The authors highlighted several arenas where pregnant women experienced weight stigma: providers' communication, providers' judgmental assumptions of patients' eating habits based on BMI, and focus on obesity risks without discussing individualized care. Mulherin et al. (2013) also reported stigmatizing attitudes of maternity care providers towards women across bodyweight categories, and the medical providers' perceptions worsened when patients were documented as obese pre-pregnancy. Higher levels of providers' weight stigma also correlated with more negative attitudes toward patient care regardless of patients' weights (Mulherin et al., 2013), which could indicate that providers' implicit weight bias has negative implications for all patients. Mulherin et al. (2013) also noted that social desirability may have suppressed

providers' negative responses and minimized study effects. This potential risk is also a consideration across studies, that estimates of weight bias and the impact on providers' care of patients may be conservative.

Since weight bias in the healthcare community has been shown to impact patient care negatively, researchers have studied the prevalence of anti-fat discrimination among healthcare providers and students. Miller et al. (2013) sought to understand the prevalence of bias among medical students in a southeastern medical school and the students' awareness of their prejudices. They conducted a three-year survey study with three consecutive classes of students using the Weight Implicit Association Test (IAT) and a semantic differential scale to assess explicit preferences for persons of thin or fat body sizes. Of the 310 students who completed the study, 56% were male, and 73% were White. Seventy-two percent of the students self-reported a preference for thin people versus fat people, which was moderate or strong in 33% of the students. Moderate or strong anti-fat bias was twice as likely to be reported by male students than by female students (Miller et al., 2013).

Moreover, when the researchers (Miller et al., 2013) analyzed implicit weight bias data, they found 56% of students had a moderate or strong implicit bias, which was split between anti-fat bias (39% of students) and anti-thin bias (17% of students). The researchers found no significant differences in bias by race, age, or academic year, and the only significant difference by gender was in explicit anti-fat bias. Interestingly, taking into account both bias measures, only 23% of students were aware of their biases; most anti-fat biased students thought they were neutral, and even those with an anti-thin bias thought they were neutral or held the opposite (anti-fat) bias (Miller et al., 2013).

Other researchers examining implicit and explicit weight bias among medical students corroborated Miller et al.'s (2013) findings. In Phelan et al.'s (2014) study of 4,732 medical students across 49 medical schools, the researchers recorded 74% of students expressed implicit weight bias and 67% demonstrated explicit weight bias. Black students were more likely to exhibit positive weight-related attitudes, while negative anti-fat attitudes were associated with White students and males (Phelan et al., 2014). Phelan et al. (2014) suggested there may be minimal pressure to suppress obesity bias and that negative attitudes towards persons in larger bodies may be acceptable among medical students. Baker et al. (2017) assessed weight bias in medical students using the Implicit Relational Assessment Procedure (IRAP) to tease out attitudes toward fatness and thinness separate from each other. The researchers received responses from 325 medical students across five classes at a single medical school (Baker et al., 2017). The authors concluded the medical students were more pro-thin than anti-obese and that for a subset of students whose results were measured at two points in time, there was a decrease in pro-thin/anti-fat attitudes, reflecting an improvement in the results over the first two years of medical school. The improvement over time in medical school is contrary to the results found by Miller et al. (2013), where anti-fat attitudes remained consistent over time in medical school.

The weight bias findings among medical students seem to mirror the anti-fat bias among medical doctors (MDs) reported by Sabin et al. (2012). Sabin et al. (2012) accessed four years of data from the public website Project Implicit (n.d.), whereby a large sample of non-recruited participants completed the IAT and provided demographic data, including their level of education. Data were analyzed for more than 359,000

participants, most of whom resided in the US, 73% were female, and 82% were White (Sabin et al., 2012). There were 2,284 participants in the MD subsample, of whom 55% were female, 78% were White, 15% identified as African American, and 2% were Hispanic (Sabin et al., 2012). Sabin et al. (2012) determined implicit anti-fat bias was strong across all MD participants, with bias significantly stronger among males versus females. Those MDs whose BMI put them in the obese category demonstrated moderate anti-fat bias compared to a strong bias in the other BMI categories, similar to the total population of test takers (Sabin et al., 2012). Explicit bias among MDs was also strong in both genders and across all BMI categories, except the obese category, where explicit bias was lower (moderate; Sabin et al., 2012).

Other studies also point to ways that anti-fat bias may impact healthcare and can be influenced by individualism. For example, in a small study, Azevedo et al. (2014) examined the implicit bias of 12 normal-weight females against obesity by measuring neural reactivity and affect when presented with visual stimuli of persons of various body sizes (obese and non-obese) in pain. In accordance with previous studies, the participants demonstrated decreased neural responsiveness to the pain of persons in larger bodies, even when participants were instructed the higher body weight was due to a hormonal disorder, an underlying condition out of the person's control (Azevedo et al., 2014). Despite increased levels of pity when informed weight resulted from the underlying condition, levels of disgust were consistent with the responses to the other persons with obesity and in contrast to reactions to normal-weight models. Additionally, participants rated the normal-weight models as more attractive and dominant than those with obesity (Azevedo et al., 2014). Lack of responsiveness to pain, disgust toward individuals with

obesity, and finding persons in normal weight bodies as more attractive may have implications for the quality of care that persons in larger bodies receive.

Dieticians and dietetics students are also subject to body weight bias (Berryman et al., 2006; Harvey et al., 2002; Oberrieder et al., 1995; Puhl et al., 2009). In a Brazilian study, 335 undergraduate nutrition students were given four hypothetical cases, in random order, with a presenting problem that bore no relationship to nutritional status or weight (Obara et al., 2018). In this study, two cases were female, and two were male; the case data was identical other than gender and weight/BMI. The participants were not informed of the study's purpose so as not to influence the results. Students were instructed to choose as many approaches and procedures as necessary for each case (Obara et al., 2018).

On average, the students spent more time in case consultation with obese women as compared to normal-weight women, and for the obese women, the students assessed overall health, diet quality, self-care, and discipline as worse (Obara et al., 2018). The students were also less likely to believe the obese female patient's report of food intake and more likely to recommend psychological care, keeping a food diary with hunger levels, and reducing calorie intake than with normal-weight patients, even though the presenting problem was unrelated to these topics. With male patients, students were less likely to believe that obese male patients would follow recommendations compared to normal-weight male patients. With both male and female patients, students chose interventions related to weight reduction more frequently with obese patients. Students also selected strategies such as discussing the need for weight reduction and recommending reduced calorie intake for normal-weight patients 20% and 35% of the

time. Although the students demonstrated bias toward obese male and female patients, the bias was more pronounced with females (Obara et al., 2018), which may suggest that gender intersects with obesity in weight bias and patient care. Additionally, weight bias impacted care for normal-weight patients, reinforcing that sizeism affects people of all body sizes.

Puhl et al. (2009) found similar results among 182 dietetics students from multiple colleges in the United States. Participants' scores on the Fat Phobia Scale indicated moderate levels of fatphobia and were likely to impact treatment recommendations (Puhl et al., 2009). Despite identical scenarios other than weight, students were more likely to assess health and diet quality as worse for obese versus non-obese patients and to rate obese patients as less likely to comply with recommendations (Puhl et al., 2009). Also, a significant percentage of participants agreed with negative adjectives from the Fat Phobia Scale to describe obese patients, adjectives such as insecure, poor self-control, inactive, no willpower, self-indulgent, overeats, and unattractive (Puhl et al., 2009). Puhl et al. (2009) noted that health professionals, including dietetics students, may make negative assumptions about health and lifestyle based on BMI, despite evidence to the contrary.

Moreover, adults experience many healthcare messages about weight, exercise, and nutrition as stigmatizing and de-motivating (Puhl et al., 2013b). Puhl et al. (2013a) surveyed adults in the United States to systematically understand their preferences for terminology regarding weight and linkages to weight loss motivation, with terms presented as being used in a favorable healthcare relationship scenario. Participants rated 10 terms on levels of stigmatization, weight blaming, and motivational power for weight

loss, and they also responded to questions about their weight attitudes using the Fat Phobia Scale. Results indicated terms such as obese, morbidly obese, and fat were perceived as the most stigmatizing and blaming. Participants were more likely to respond to high BMI and weight as less stigmatizing and blaming, but still not without stigma and blame, with a few exceptions. The term overweight was slightly less desirable among racial and ethnic minorities than among White participants, and participants ages 56-88 rated high BMI less favorably than participants aged 30 and under (Puhl et al., 2013a).

Equally important to the perception of language is how participants indicated they would act after hearing stigmatizing speech from their provider. A significant percentage of participants indicated they would internalize negative feelings or feel embarrassed, and 41% of those in a normal weight category and 30% labeled as obese stated they would assume a strict diet for weight loss (Puhl et al., 2013a). Almost one-fourth of patients in both normal and overweight categories indicated they would find new providers, and 19% reported they would avoid appointments with doctors who stigmatized them due to body weight. Also, 13% of participants described as normal weight and 18% in the overweight category reported weight stigmatization by their doctor would lead to depression and increased eating (Puhl et al., 2013a). These results provide valuable information about how adults might behave toward providers and themselves when they feel stigmatized. They are consistent with other studies documenting the mental health and behavioral impacts of weight stigmatization on adolescents and adults. The Puhl et al. (2013a) study results also suggested there is no one preferred term to describe body weight and that all terms regarding body weight hold at least some level of stigmatization.

Considering bias and language can also be necessary for mental health providers. Counselors can be sensitive to the impact of language and clients' experiences. It could be important for counselors to allow clients to broach the topic of weight rather than counselors, and when clients do broach, counselors can inquire about their preferred terminology. Counselors can also focus on supporting behaviors that may positively impact client wellness and avoid direct messages about weight. When counselors need to refer clients to other health providers, they can refer to providers that take similar weight-neutral or body-positive approaches.

Intersectionality and Sizeism

Thin standards of beauty have roots in racism, classism, ageism, and ableism (Smith, 2019). Additionally, beauty and weight standards are included in the multidimensional determinants of social status, such as income, education, accent, appearance, gender, location, and affinities, just to name a few. McLaren's work (2007) highlighted multiple factors that may influence the negative association of larger body size among women with higher SES. Some evidence exists of differences in diet or access to particular types of food in the United States based on groups' SES, and education and occupation may also play a role in the valuation of thinness (McLaren, 2007). Women with higher SES tend to experience higher body dissatisfaction than women with lower SES status (McLaren & Kuh, 2004), but the same is not valid for men. Women are also more likely to experience weight/height discrimination than men (Puhl et al., 2008). Western beauty ideals emphasize middle and upper-class thin, young, non-disabled White women (Smith, 2019). Therefore, it is essential to consider multiple forms of discrimination simultaneously through the lens of intersectionality.

Race and gender are two other dimensions that can intersect with weight. Puhl et al. (2008) emphasized the high and growing prevalence of weight/height discrimination in the United States and suggested it is comparable to the pervasiveness of race-based discrimination. Between racial groups, there may be less stigma and more acceptance around larger bodies among Blacks and African Americans than Non-Hispanic White counterparts (Hart et al., 2016). However, an anti-fat bias still exists among African Americans (Hart et al., 2016). In a study examining implicit weight bias and ethnic identity among 207 African American and 310 White adults, Hart et al. (2016) observed anti-fat bias among all participants and greater ethnic identity among non-Hispanic Whites correlated with stronger anti-fat bias. The researchers also found anti-fat bias among African Americans, but in this group, anti-fat bias was inversely related to ethnic identity (Hart et al., 2016). The results suggest that a stronger sense of affiliation as African American could be a protective factor against size bias. However, in the limited research on African Americans' beliefs about weight, there is an indication of both anti-fat bias and the hegemonic belief in weight mutability.

Allison et al. (1995) examined weight-related beliefs of African American women with obesity who were interested in losing weight. When presented with silhouettes to choose their desired body shapes, participants chose thin silhouettes, those that were three or four on a scale of one to nine, with one being the thinnest, nine the fattest, and five as neutral (Allison et al., 1995). The participants overwhelmingly agreed with a statement that body weight is within a person's control (98.9%), and 90.6% attributed having overweight to poor health (Allison et al., 1995). The findings suggest that internalized weight bias and notions of healthism could exist among some African American women.

White, non-obese identifying persons have been historically overrepresented in research, and the intersectionality of living in a larger body, race, age, and gender is understudied (Puhl et al., 2008). In particular, women of color may experience unique issues of sizeism (Smith, 2019). African American women are caught between the White body ideal of size and shape and Black standards of attractiveness and health, which emphasize personality traits (Ristovski-Slijepcevic et al., 2010; Wilfred & Lundgren, 2021). African-American women may exhibit more body acceptance than White women, but a drive for thinness is still present (Kashubeck-West & Huang, 2013). Additionally, Black women have reported less negative talk about their bodies than White and Asian women (Fiery et al., 2016).

A significant limitation in body image research is the research has been conducted primarily by White researchers using measures normed on White populations (Capodilupo & Forsyth, 2014; Wilfred & Lundgren, 2021). For example, when some of the measures used in body image research (e.g., Eating Disorder Inventory-3 Body Dissatisfaction subscale(EDI-BD), Multidimensional Body-Self Relations Questionnaire – Appearance Scales (MBSRQ-AS), Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ-3)) were evaluated for reliability and validity with Black women in a midwestern college, the researchers noted mixed results and limitations in using these measures (Kashubeck-West et al., 2013). One critique is that these measures did not consider the experiences of Black women encumbered by White and Black body ideals in the White dominant culture, labeled *double consciousness* (Wilfred & Lundgren, 2021). Wilfred and Lundgren (2021) assessed the Double Consciousness Body Image Scale (DCBIS) and reported that higher scores of double consciousness, navigation between

ideals, positively corresponded to disordered eating behavior. Many nuances and intersectional considerations exist around body satisfaction, race, ethnicity, and internalization of the White beauty ideal (Capodilupo & Forsyth, 2014). In summary, a combination of qualitative and quantitative research studies has pointed to a complex conceptualization of body size and shape for Black women, which is influenced by historical stereotypes of curvy Black female bodies, racism, racial identity, healthism, and White body ideals (Capodilupo & Kim, 2014; Hughes, 2021; Ristovski-Slijepcevic et al., 2010; Schuler et al., 2008; Wilfred & Lundgren, 2021).

Gender identity, sexual orientation, ability status, and religious minorities are also typically missing in the literature on sizeism. Where sexual orientation is studied with obesity, myths about sexual minorities may contribute to misattributions of obesity, particularly among those who identify as lesbian, further compounding discrimination against those who hold multiple marginalized identities (McPhail & Bombak, 2015). In a study of oppression in adolescents, Bucchianeri et al. (2013) noted that adolescents at higher body weights experienced increased harassment versus lower-weight peers in not only weight but also other areas. This cross-harassment occurred across all measurements, including race, SES, and sexual (Bucchianeri et al., 2013). Additional research is needed to understand better the intersectionality of sizeism and other forms of oppression.

Scholars do not comprehensively understand the theoretical factors of body-based stigmatization (Puhl & Brownell, 2001) or the psychological, physical, health, and economic impacts. Persons in larger bodies tend to be underrepresented in research other than obesity studies, and there is a gap in understanding attitudes of sizeism and how they

may translate to discriminatory behaviors (Puhl & Brownell, 2001). It is vital for counselors to understand how they may be affected by sizeism and marginalized status and simultaneously become aware of how they may be complicit in this intersectional system of oppression that includes body weight and shape. This study will explore novice counselors' attitudes and beliefs about weight and shape to begin filling the knowledge gap in the counseling field.

Effects of Weight Bias

The adverse effects of weight bias are far-reaching. Weight-related bullying, such as being labeled as “too fat” as a pre-adolescent or early adolescent, is correlated with disordered eating cognitions and behaviors and additional weight gain by adulthood (Brochu, 2018). Additionally, youth encountering weight bias may experience physical and psychological effects “including increased risk of depression, anxiety, social isolation, substance use, suicidal thoughts, poor body image, low self-esteem, unhealthy eating behaviors, binge eating, decreased physical activity, and worsening of obesity” (Nutter et al., 2019, p. 186).

In adults, experiencing weight bias is associated with psychological distress, internalization of stigma, and increased emotional and uncontrolled eating (O’Brien et al., 2016). Tomiyama (2014) characterized some of the effects in a model termed cyclic obesity/weight-based stigma (COBWEBS), where weight stigma is a psychological stressor that may lead to weight gain. Media reports of an obesity epidemic and focus on thin bodies as the ideal are linked to feelings of shame and guilt and maladaptive coping mechanisms (Brochu, 2018; Puhl & Brownell, 2001; Puhl et al., 2008). In addition, social pressure to lose weight and stigmatization can lead to poorer health outcomes.

Individuals are less likely to exercise when they encounter weight stigma, and those who suffer weight-based discrimination are 2.5 times more likely to be diagnosed with anxiety. mood disorders, or depression (Tomiyama et al., 2018).

The harmful effects of sizeism are not limited to those in larger bodies. When slender bodies are idealized and fat bodies are ostracized in a dualistic environment, those with smaller bodies may continually strive to avoid fatness (van Amsterdam, 2013). Internalization of the thin ideal may lead to externalized harmful behaviors and effects. For example, in one related study, Rukavina and Pokrajac-Bulian (2006) noted the impact of societal pressure to achieve a thin ideal on increased body dissatisfaction and symptoms of eating disorders in Croatian adolescent girls. In particular, the researchers reported social pressure and body shape/weight-related criticism was significantly linked to the development of eating disturbances (Rukavina & Pokrajac-Bulian, 2006). Both internalization of the thin ideal and higher BMI or perception of being overweight correlated with body dissatisfaction and eating pathology (Rukavina & Pokrajac-Bulian, 2006). Even persons in normal weight categories are more likely to exhibit unfavorable health markers when they perceive themselves as overweight (Tomiyama et al., 2018).

Cultural messages holding thin, fit bodies in high esteem and criticizing those in larger bodies as obese and unhealthy are pervasive in US culture. Although many Americans believe that thinness is synonymous with physical health, multiple studies have delinked weight from health and mortality. For example, Flegal et al. (2005) analyzed National Health and Nutrition Examination Survey (NHANES) data gathered by the National Center for Health Statistics and year 2000 mortality data from US vital statistics to determine BMI-related deaths by category, adjusting for confounding

variables. All data were measured data rather than self-reported. The researchers found significant deaths attributable to BMI in the lowest (<18.5) and highest BMI categories, while overweight (BMI 25 - <30) had a reduced death rate compared to the normal category (BMI 18.5 - <25). Most of the excess deaths in the underweight category (<18.5) were in persons aged 70 years and older, and the majority of excess deaths in the obesity category were in persons younger than 70 years old. There was a slightly increased mortality risk in the category of Obese 1 (BMI 30 - <35), but still less than the mortality risk of being underweight. For those who never smoked, the mortality risk in the Obese I category was below the normal weight group. The most significant mortality risk was in the Obese II group with BMI>=35, but for those who never smoked, the risk in Obese II was equal to the underweight group (Flegal et al., 2005). Orpana et al. (2009) found similar results using Canadian data, but with the highest mortality risk at BMI < 18.5 and a slightly elevated risk at BMI >= 35. Likewise, these findings were supported substantially in a Japanese study (Tamakoshi et al., 2010).

Researchers have also examined biomarkers by BMI status and found no significant correlation between cardio health risk factors and overweight or obesity, whereby a considerable number of persons with normal BMI exhibited cardiometabolic risk factors, and a majority of those in overweight and obese categories displayed an absence of those markers (Wildman et al., 2008). Persons may have obesity without metabolic disorders or early signs of those disorders (Sims, 2001; Wildman et al., 2008), so it is essential to decouple health ideas from body size and shape and not assign causation of health factors to weight. Additionally, no known weight loss interventions, including surgery, provide significant, sustained weight reduction and adiposity

reduction. So, where health markers are poor, it may be more important to consider the following rather than focus on individual weight loss interventions: lifestyle factors other than food and size acceptance (Bacon et al., 2005), genetics (Friedman, 2009), dieting history (Dulloo & Montani, 2015; Outland, 2018), and social determinants of health, such as social policies, SES, and systems of oppression (Marmot & Wilkinson, 2005), including sizeism.

So, although studies have delinked weight from health and mortality (Flegal et al., 2005; Orpana et al., 2009; Wildman et al., 2008), obesity is classified as a disease in the healthcare community (CDC, n. d.; Chrisler & Barney, 2017; Nuttall, 2015) with diets as the cure. However, diets usually only produce short-term benefits. Dieting for weight loss is linked to reduced energy output, increased appetite, and decreased thyroid function, all leading to weight gain (Dulloo & Montani, 2015; Outland, 2018). Researchers have deemed diets ineffective long-term (Lowe & Timko, 2004; Mann et al., 2007). In fact, diets typically result in regaining weight, leading to weight cycling or yo-yo dieting, which can be more harmful physically and mentally than higher body weights (Mann et al., 2007; National Task Force on the Prevention and Treatment of Obesity [NTFPTO], 2000). Weight cycling is associated with cardiac and metabolic diseases and hypertension in women (Dulloo & Montani, 2015; Guagnano et al., 2000). Weight-based discrimination itself has also been correlated to declines in health and increased mortality (Sutin et al., 2015). Therefore, it is imperative to adopt, at minimum, a weight-neutral stance to avoid harm in providing psychological and medical care. Within counseling, this requires the counselor to develop self-awareness and analyze personal attitudes and beliefs where biases may exist (Ratts et al., 2016).

Weight Bias in Mental Health

Mental health professionals also may exhibit weight bias in treatment, including over-pathologizing, misdiagnosing clients, and compromising treatments (Pratt et al., 2016; Veillette et al., 2018). There is a link between sizeism and eating disorder pathology (Vartanian & Porter, 2016), and counselors are not exempt from cultural sizeism. DeLucia-Waack (1999) discussed countertransference as counselors treat clients with eating disorders, where counselors' own body image concerns may be triggered by their clients' body image issues. Moreover, Drell (1988) noted a typical pattern where clients enlist therapists in blaming their problems on their weight. Kinavey and Cool (2019) made the case that anti-fat bias among therapists can harm clients, and it is reasonable to believe that counselors may be subject to the same cultural biases as the clients they serve. Counselors' self-examination and normal relationships with food and their bodies are critical for effectively working with clients on these topics (DeLucia-Waack, 1999). So, mental health professionals' roles must include challenging weight bias through a weight-inclusive approach to support mental health and overall well-being (Calogero et al., 2019; Rothblum & Gartrell, 2019; Tylka et al., 2014).

Challenging weight bias, or what some scholars call a weight-normative approach (Calogero et al., 2019; Tylka et al., 2014), is an emerging topic in counseling and counseling-adjacent fields. Scholars have disseminated calls to action, but there is minimal evidence of changes within mental health fields based on reviews of textbooks and published studies. For example, scholars have advocated across mental health disciplines, and specifically for psychologists, to develop greater awareness and understanding of how they may be participating in weight bias and to incorporate anti-fat

bias into education (Bergen & Mollen, 2019; Brochu, 2019; McHugh, 2019; Romano, 2018) and therapeutic contexts (Matacin & Simone, 2019). Scholars continue to endorse the critical need to address sizeism on a larger scale in psychology training programs as a practice of diversity and multiculturalism (Brochu, 2019; McHugh, 2019). However, weight bias is missing from psychology's multicultural textbooks and code of ethics (Kasardo, 2019). Mental health professions other than psychology have also cited the need for anti-sizeist training.

Several studies have examined weight bias in marriage and family therapy (MFT). Pratt et al. (2014) surveyed 108 MFT faculty, students, and licensed clinicians to determine current practices regarding weight and related training and beliefs about working with clients regarding weight-related behaviors. Most participants had not received training to work with clients regarding weight but believed they needed training. Most participants also disagreed that family members should be included in weight-related goals (Pratt et al., 2014), which could indicate a departure from a systemic perspective or relate to a predominant cultural belief that body size and shape are individually malleable.

Cravens et al. (2016) further explored master's and doctoral MFT students' views on weight bias training using training modules and follow-up focus groups. Five doctoral and 30 master's students in MFT programs opted to receive the weight-bias training, which consisted of experiential activities developed by Pratt and Cravens (2014) for training and supervision. Through the study, the researchers identified gaps in four areas of MFT students: 1) knowledge about the systemic etiology of weight, 2) awareness of personal weight biases, 3) weight-related cultural sensitivity, and 3) MFTs'

understanding of their scope of practice related to weight (Cravens et al., 2016). These findings provided a qualitative perspective that corresponded to Pratt et al.'s (2016) findings of weight bias among MFT masters and doctoral students toward persons in larger bodies.

Since sizeism is documented within adjacent fields, it is important to consider the prevalence of sizeism within the counseling profession and the state of anti-fat activism. Within counseling, scholars such as Nutter et al. (2020) and Kinavey and Cool (2019) have advocated for the profession to address sizeism as a social justice concern. However, there does not appear to be evidence that weight bias is frequently taught in counseling programs or examined as an axis of inequality in training and supervision. There are also limited studies to date on sizeism within counseling specifically. Therefore, it is difficult to know whether practicing clinical mental health counselors (CMHC) have been trained to address weight bias as an axis of inequality.

In one of the only published empirical studies on weight bias in counseling, researchers documented evidence of weight bias among counselors. Forristal et al. (2021) conducted an independent measures experimental design study with 113 clinical mental health and community mental health counseling trainees from CACREP-accredited programs across the US. The study aimed to determine students' degree of sizeist beliefs using the Fat Phobia-Scale Short Form (FPS-SF) and whether personal and client body size and levels of fatmisia influenced how students assessed for major depressive disorder (MDD). Participants ranged in age from 23 to 56 years old. Seventy-five (66.4%) participants identified as White, and the remainder were split racially between Black (15.9%), Latinx (6.2%), multiracial (5.3%), Native American (.9%), Pacific Islander

(.9%) and non-identifying (4.4%). Participants were primarily female (Forristal et al., 2021).

The researchers found significant levels of fatmisia and that diagnostic impressions of MDD were influenced by the fictitious client's body size and students' weight bias levels (Forristal et al., 2021). In particular, the fattest clients were subject to the most severe MDD diagnosis. Counseling students' weight bias influences clinical judgment, which risks harming clients. Since counselors are charged to uphold ethical values of nonmaleficence and justice for all persons (ACA, 2014), it is vital to understand practicing counselors' views on body weight and shape. Unacknowledged sizeism in counseling may compromise client care.

Scholars across the counseling field (Kinavey & Cool, 2019; Nutter et al., 2020) are joined by psychologists (Brownell et al., 2005; Puhl et al., 2008; Veillette et al., 2018), MFTs (Pratt & Cravens, 2014; Pratt et al., 2014; Pratt et al., 2016), and professionals in adjacent fields in advocating for awareness, research, training and advocacy in sizeism. Scholars in women's studies (Rothblum & Gartrell, 2019), sociology (Hutson, 2017), medicine (Essel et al., 2022), dietetics (Berryman et al., 2006; Harvey et al., 2002; Oberrieder et al., 1995), and nursing (Oliver et al., 2020) have also advocated for weight-inclusive culturally sensitive care across teaching, supervision, mental health, and medical services. Forristal et al. (2021) noted the need for a deeper understanding of counselors' beliefs about fat clients and intersectionality regarding fatmisia. However, empirical data on practicing counselors' attitudes and perceptions regarding body weight and size has yet to be accrued. Thus, there is a critical need to

research weight attitudes and beliefs among clinical mental health and community counselors.

Study Purpose and Research Question

The counseling field is not exempt from the effects of sizeism, particularly in light of the lack of training and the influence of body size in diagnosis and treatment (Forristal et al., 2021; Kinavey & Cool, 2019; Nutter et al., 2020). Training on engaging overweight clients without imposing weight bias is limited in mental health fields (Cravens et al., 2016; Pratt et al., 2014; Forristal et al., 2021). There are calls for action in mental health disciplines, but sizeism has not yet been widely incorporated into the discourse (Matacin & Simone, 2019; Pratt et al., 2016; Rothblum & Gartrell, 2019). Moreover, several studies have shown mental health professionals exhibit explicit or implicit weight bias in treatment (Pratt et al., 2016; Puhl et al., 2014; Veillette et al., 2018). This bias can result in over-pathologizing clients, misattributing negative attributes to clients, or misdiagnosing and treating conditions, such as in eating disorders (Pratt et al., 2014; Veillette et al., 2018). It is crucial for all healthcare professionals, including counselors, to provide clinically competent, unbiased care and advocate for change, especially since counselors hold power in relationships with patients and clients.

In the literature, there are a few empirical studies that examined weight bias among healthcare providers and students in fields such as nursing (Oliver et al., 2020), nutrition and dietetics (Oberrieder et al., 1995; Puhl et al., 2009), medicine (Teachman & Brownell, 2001), and marriage and family therapy (Cravens et al., 2016; Pratt et al., 2014; Pratt et al., 2016). Some studies do not address bias, as is the case for Jang's (2020) study of obesity perceptions in nursing students. Jang (2020) studied the subjectivity of

nursing students' beliefs about obesity using Q methodology in Korea. The researcher identified two factors, one centered on the effects of obesity and the other on its causes. In the discussion, Jang (2020) did not address issues of discrimination and oppression based on weight and instead focused on recommendations to teach obesity management. This article may reinforce healthism and sizeism ideas rather than challenge them. Within other healthcare fields, Teachman and Brownell (2001) measured implicit and explicit weight bias among mostly male healthcare professionals at an obesity education event. Puhl et al. (2014) researched weight bias across cross-disciplinary providers treating eating disorders, which may have been the first study of its kind and has not been updated. All of these empirical studies were conducted outside the counseling profession, thus leaving a gap in research about weight and body beliefs among practicing counselors.

So, although ending sizeism seems to be an emerging social justice topic across the mental health field over the last few years, most of the literature is generated in professions adjacent to counseling, such as psychology (McHugh & Chrisler, 2019; McHugh & Kasardo, 2012; Puhl et al., 2014; Teachman & Brownell, 2001) and MFT (Cravens et al., 2016; Pratt & Cravens, 2014; Pratt et al., 2014). The counseling literature is conceptual in nature, with a single exception in Forristal et al.'s (2021) research. For example, Nutter et al. (2018a, 2018b, 2020) and Kinavey and Cool (2019) have written several conceptual articles in counseling calling for dialogue about sizeism as a social justice issue and ways to develop a size-inclusive approach in the therapeutic space. Only Forristal et al. (2021) published what appears to be the first and only empirical study on weight bias in counseling. In Forristal et al.'s (2021) investigation, the researchers

analyzed weight bias among counseling students in CACREP programs and the effect on client diagnosis (Forristal et al., 2021). This study builds on Forristal et al.'s (2021) research to understand the current landscape of body weight beliefs among novice clinical mental health counselors in practice.

In light of evidence that sizeism is prevalent in the US, that weight-based prejudice and discrimination results in physical and psychological harm (Cardinal et al., 2014; Dulloo & Montani, 2015; Guagnano et al., 2000; Puhl et al., 2008; Sutin et al., 2015; Tomiyama et al., 2018), and that counselors can be vulnerable to sizeism with clients (Forrestal et al., 2021), empirical research and education on body-weight beliefs and stigma within the counseling profession are critical. Empirical research among practicing counselors will progress the dialogue of sizeism as a social justice issue in counseling from theoretical to actionable. Since Forristal et al. (2021) focused on weight bias among counseling students, understanding novice counselors' attitudes and beliefs is a logical next step in the research. According to Ratts et al. (2016), awareness of "attitudes and beliefs is an important precursor to understanding social group identities, marginalized and privileged group statuses, power and privilege, limitations, strengths, assumptions, values, and biases" (p. 38). Systematically exploring the nature of counselors' perspectives about body shape and size, the commonality of beliefs, and who holds those beliefs (Baker & van Excel, 2022) will increase awareness among counselors, counselor educators, and counseling supervisors. The study results also highlight the need for additional knowledge and skills surrounding body size diversity, which can be incorporated into counselor education and supervision. Within the MSJCC framework, self-awareness is the first developmental domain that ultimately allows for multicultural

and social justice counseling and advocacy interventions (Ratts et al., 2016). Attitudes and beliefs span the developmental domains from self-awareness to interventions, and they connect to the other competencies of knowledge, skills, and action (Ratts et al., 2016). Thus, attitudes and beliefs are an ideal commencement of study.

Therefore, this study aims to fill the empirical literature gap by understanding the attitudes and beliefs of novice CMHC regarding body weight, including weight stigma, overweight and obesity, and body image. Q methodology was used to systematically discover a range of perspectives among CACREP-trained novice clinical mental health and community counselors. Using this methodology provides an opportunity to explore diverse perspectives without the limitations of pre-defined meanings in assessments and response biases in Likert scales. Q research is uniquely positioned to examine unconscious perceptions and has been used in counseling and psychotherapy research as a mixed-methods approach (Rost, 2020; Stickl et al., 2019). Q studies are ideal for gaining a broad understanding of the topic and individual differences in views. The methodology is also well-suited to exploring areas of inequality and intersectionality (Bailey et al., 2019).

Chapter Summary

Counselors and clients in the US live in a cultural system of weight-based stigma and oppression that privileges thin bodies (Brownell et al., 2005; Strings, 2019). Its origins are in racism, religion, and classism that define standards for beauty, behavior, and power, and the system is maintained by dominant power structures extolling modern-day healthism (Crawford, 1980; Strings, 2019). This oppression affects essentially every area of life – relationships (Akers & Harding, 2021; Rollero, 2022), education (Cardinal

et al., 2014; Tingstrom & Nagel, 2017), healthcare (Baker et al., 2017), media (Selensky & Carels, 2021), and employment – and it intersects with other areas of marginalization, such as race, gender, education, ability status, and SES, to name a few (Capodilupo & Kim, 2014; Himmelstein et al., 2017; Kasten, 2018; van Amsterdam, 2013). Weight bias is frequently internalized (Pearl et al., 2021), which contributes to the ill effects of stigmatization, both mental and physical (O'Brien et al., 2016; Pearl & Puhl, 2014; Selensky & Carels, 2021). Societal pressure to conform to the dominant ideal of a slender body frequently leads to weight loss attempts. In the vast majority of people, weight interventions are the beginning of weight-cycling, which can increase health and mortality risks beyond the risks of living in a larger body (Dulloo & Montani, 2015; Sutin et al., 2015). Understanding the long-term harm risks of weight interventions and weight cycling is vital for counselors since counselors are susceptible to systemic oppressive weight-based attitudes (Forristal et al., 2021; Kinavey & Cool, 2019) and are ethically responsible for culturally diverse, beneficent client care (ACA, 2014; Kinavey & Cool, 2019).

Per the literature review, several healthcare and mental health fields have advocated for weight-inclusive care through a social justice paradigm (Calogero et al., 2019; Teachman & Brownell, 2001). Although counselors have begun to issue similar calls to action (Kinavey & Cool, 2019; Nutter et al., 2020), empirical research in counseling is limited to one investigation of counselor trainees (Forristal et al., 2021). Forristal et al.'s (2021) research documented weight bias in counseling trainees and how the bias affected client diagnosis. This study builds on Forristal et al.'s (2021) work and fills the empirical research gap by exploring novice counselors' attitudes and beliefs

regarding body weight and obesity. Understanding counselors' perspectives systematically provides critical information for counselor educators in training and supervision needs and creates a foundation for developing training and education on the issue of sizeism as a multicultural competency.

CHAPTER 3

METHOD

The purpose of this study is to frame and describe novice counselors' social constructions about body size and weight. This chapter provides a summary of the need for this study, the research design with a brief introduction to Q methodology (Q) and details of the study design, data collection procedures, the process for analysis and interpretation, strengths, and limitations. Since Q methodology is inherently both quantitative and qualitative, this chapter also includes a statement of researcher subjectivity, in line with a feminist theoretical perspective that recognizes researchers and research are intertwined and that "our experiences of ourselves and the world are always grounded in context, and therefore forever shifting and multiple" (Wigginton & Lafrance, 2019, p. 8).

Feminist theory spans epistemologies, ontologies, and methods, and the core tenets of feminist research address power and oppression, all directed toward social change (Arinder, n.d.; Hesse-Biber, 2010; Ramazanoglu & Holland, 2002). Feminist theory has evolved from its origins in women's rights and incorporating women's experiences as a challenge to androcentrism (Smith, 1991) to inclusivity of all marginalized and oppressed groups (Arinder, n.d.; Hesse-Biber, 2008; Wigginton & Lafrance, 2019). It traverses Eurocentrism and colonial ideals through critical, postmodern thought (Ramazanoglu & Holland, 2002). A social constructionist feminist schema is appropriate for this study since weight bias and beauty standards of thinness

are embedded in dominant systems of privilege and power in the US (Smith, 2019). Women and those with marginalized intersectional identities have been particularly impacted by sizeism (Smith, 2019), so it seems appropriate this study would be guided by a theoretical frame that centers on women, intersectionality, and social change. Feminist research should be liberatory and transformative, creating knowledge aimed toward justice for disadvantaged groups (Harding & Norberg, 2005; hooks, 1994). This study was designed to expand understanding of body-based beliefs among novice counselors immersed in cultural sizeism, create dialogue through a critical lens, and advocate for change. So, feminist theory is well positioned as the guiding theoretical framework for this study as it is used to dismantle power structures (Crenshaw, 1991; Wigginton & Lafrance, 2019) like those in which sizeism is rooted.

Feminist theoretical tenets influenced this study throughout the research process according to Wigginton and Lafrance's (2019) methodological considerations for critical feminist research. These considerations comprise five categories: politics of the research question, language construction and sources of discourse, reflexivity, intersectionality and representation among participants and in data expression, and "mobilizing research for social change" (Wigginton & Lafrance, 2019, p. 13). The problem identification, literature review, and research question all flow from a feminist frame of reference. Furthermore, Q methodology has a historical basis as a suitable methodology for critical, postmodern epistemological frameworks such as feminist theory and social construction (Brown, 1993). This methodological approach allows researchers process and reflexive flexibility to align with feminist principles (Roper et al., 2015). Finally, the feminist framework and study purpose align with counselors' ethical values of justice,

beneficence, non-discrimination, and multicultural competence (ACA, 2014; Ratts et al., 2016).

Sizeism adversely affects persons of all body sizes, particularly those whose body size and shape deviate from the thin ideal associated with Western beauty standards, creating a marginalized position. Marginalization and oppression based on body size are associated with fat phobia and internalized stigma (O'Brien et al., 2016; Pearl & Puhl, 2014; Robinson et al, 1993; Selensky & Carels, 2021), mental health declines (Nutter et al., 2019), increased risk for eating disorders (Rukavina & Pokrajac-Bulian, 2006), weight cycling (Dulloo & Montani, 2015), and increased mortality risk (Sutin et al., 2015). Weight stigma has been found across a multitude of health disciplines (Puhl et al., 2009; Puhl et al., 2014), including psychology (Brochu, 2019; Veillette et al., 2018), MFTs, (Pratt et al., 2014; Pratt et al., 2016), and counseling (Forristal et al., 2021). This stigma can result in more severe and incorrect clinical diagnoses and misattribution of negative personal characteristics for persons in larger bodies (Davis-Coelho et al., 2000; Forristal et al., 2021; Pratt et al., 2014; Veillette et al., 2018; Young & Powell, 1985). So overall, mental health professionals with weight bias may risk harming clients. There has been only one empirical study in counseling addressing size bias among counseling trainees (Forristal et al., 2021). More research is needed to understand the topic of sizeism among counselors, particularly novice counselors. This investigation was intended to fill the empirical research gap by exploring social constructions of body shape and size among novice counselors.

Research Question

The research question that guided this study was:

RQ1: What are novice counselors' from CACREP-accredited mental health counseling programs attitudes and beliefs about body weight and shape?

Rather than deductive reasoning to analyze data in accordance with a hypothesis, Q relies on abductive logic to generate a hypothesis or theory (Watts & Stenner, 2012). Q methodology provides each person an environment to express their viewpoint, otherwise known in Q as their subjectivity (Watts, 2011). Since the viewpoint is a gestalt unique to each participant in the environment at a point in time (Watts, 2011), and hypotheses represent the researcher's viewpoint (Amin, 2000), Q does not rely on testing hypotheses with participants' responses. In studies that rely on deductive reasoning through hypothesis testing, *n* is the number of participants. However, Q is a method of inverted factor analysis whereby *n* is the number of Q statements that participants, the P set, use to express subjectivity through a sorting process (Watts & Stenner, 2005). Variables are the participants rather than "hypothesized traits" (p. 72), and factors are derived from participants' subjectivities (Watts & Stenner, 2005). In this way of capturing and analyzing participants' perspectives, Q research is quantitatively descriptive but more than an inductive exercise. Q generates insights and theories in the spirit of abductive logic (Watts & Stenner, 2012).

The research question guided the choice to use Q method to reveal unique and socially constructed perspectives. Indeed, "Q methodology is the systematic investigation of subjectivity, helping to quantify and provide depth on people's perspectives" (p. 191), and it is well suited to understanding diverse multicultural viewpoints (Wester et al., 2021). Q has proven valuable in exploring a range of topics in mental health, such as British therapists' attitudes towards persons with learning disabilities (Besika et al., 2018)

and social constructions of bulimia nervosa in Australia (Churruca et al., 2014). Q has also been applied in counseling to develop a more in-depth understanding "of the internal perspectives that shape human behavior" (Stickl et al., 2019, p. 106), such as clinical decision making (Fox et al., 2016), counselor development across the lifespan (Purswell et al., 2019), counselor educator teaching dispositions (Hurt-Avila et al., 2020), and supervisee roles (Baltrinic et al., 2021). Using Q in counseling research "complements the strengths of both quantitative and qualitative methods to explore subjectivity rigorously" (Stickl et al., 2019, p. 106).

Q Methodology and Research Design

William Stephenson developed Q methodology as an alternative to traditional factor analysis, which Stephenson called R methodology, to access subjective viewpoints through a combined qualitative and quantitative approach (Stephenson, 1953; Watts & Stenner, 2012). The relationship between the qualitative and quantitative data is unique, so much so that Watts and Stenner (2005) used the term qualiquantological to describe this mixed-methods approach. Q methodology bridges nomothetic and idiographic inquiry (Rost, 2020) to understand both shared perspectives and individual attitudes and beliefs in a systematic way. In R methodology, attention is given to the population and sample, and factors are derived from commonalities across variables. Q methodology flips the paradigm to focus on the breadth of the concourse and a representative Q set, which becomes the sample, and factors are built on the correlation between persons, the P-set, who become the variables (Watts & Stenner, 2012).

This unique mixed-methods approach may be used to gain a deeper understanding of a phenomenon or to explore the range of perspectives around a topic, exploring

personal viewpoints through a constructivist lens and constructionist social discourses (Watts & Stenner, 2012). Q methodology can be used across disciplines and may be valuable in psychotherapy research to uncover "more subtle psychological constructs, including unconscious, structural and dynamic ones" (Rost, 2020, p. 103). For example, in counseling, applying Q can increase understanding and enhance clinical practice (Stickl et al., 2019). Specifically, Fox et al. (2016) completed a Q methodology study to understand counselors' clinical decision-making better, and Baltrinic et al. (2021) explored how counseling supervisees understand their roles using Q methodology. Moreover, Q methodology was also employed to understand therapists' attitudes toward persons with learning disabilities (Besika et al., 2018).

When the subject matter does not have consensus, such as in the complexity of weight, bodies, and bias, Q methodology is ideal for deep inquiry to capture a story that is both holistic in nature and revealing of the interconnected themes (Watts & Stenner, 2012). The subject matter of body weight has a long and complex history in the US, and the topic is intertwined with marginalization, power, and privilege. Within Q methodology, those who may hold marginalized identities can express their positionality similarly to those who may hold privileged positions. All participants' perspectives are included as gestalt expressions of subjectivity (*Q sorts*) (Watts & Stenner, 2005). Q methodology "asks its participants to decide what is 'meaningful' and hence what does (and what does not) have value and significance from their perspective" (Watts & Stenner, 2005, p. 74). Factors are not pre-determined *a priori* but emerge from how the participants interact with the subject matter in the form of Q sorts, so marginalized

perspectives may be seen (Brown, 2006), and factors can be identified, quantified, and narrated.

Q Method

In this study, participants' viewpoints were sought as experts in counseling who hold personal beliefs, an acknowledgment of the person of the counselor as an agent of change in the therapeutic relationship (Courtois & Ford, 2016; Maine et al., 2010). Q methodology allows the researcher to explore diverse perspectives without being limited to a single assessment. Using only traditional assessments to measure beliefs could be limiting. Conventional assessments may not address the holistic viewpoints of practitioners. Additionally, assessments inherently contain pre-defined meanings (Watts & Stenner, 2012). Conversely, Q methodology challenges traditional testing and allows the participants to construct meaning through differential valuing (Watts & Stenner, 2005). The process results in gestalt configurations created by each participant (Watts & Stenner, 2005).

Stephenson's first use of Q methodology was a single-case design. In this tradition, influenced by constructivism, an individual sorts the prompts, typically in the form of statements, multiple times, exploring "segmentations of the self" (Rost, 2020, p. 101). Each sorting configuration is called a Q sort. More recent studies have followed the second-wave British Q methodology school, influenced by social constructionism (Rost, 2020; Watts & Stenner, 2012). In this second tradition, the Q methodology design engages multiple participants to explore subjectivity and shared viewpoints across a group (Rost, 2020; Watts & Stenner, 2012). In both traditions, participants express subjectivity operantly as they sort and rank Q statements in the Q sorting process (Rost,

2020; Stickl et al., 2019). Using the participants' Q sorts, the researcher identifies correlations between participants to create groupings, where *n* is the sample of statements and the variables are the participants in the study (Watts & Stenner, 2005; Watts & Stenner, 2012). Then factor analysis is conducted on the Q sorts; this factor analysis is frequently called inverted factor analysis to distinguish it from R factor analysis, where *n* is the number of participants (Stickl et al., 2019; Watts & Stenner, 2005).

Procedures

Q Methodology typically contains the following steps after designing the research question: 1) development of the concourse; 2) development of Q statements by identifying a sample from the concourse; 3) participant selection; 4) data collection through Q sorting; 5) post-Q collection of additional data; 6), data analysis; and 7) interpretation of results (Watts & Stenner, 2012). The following sections will explain each step of this Q methodology study. This study aligned with the second Q methodology tradition of engaging multiple participants to understand the phenomenon across the group (Rost, 2020; Watts & Stenner, 2012). Individual differences were also explored, particularly the participants' viewpoints that may not fit into a factor.

Concourse and Q-Set

Concourse Overview

After crafting the research question, the next steps in Q methodology are to develop the concourse and resulting Q statements for participants to sort. Developing the statements to which participants will react and sort begins with developing the concourse, a flow of communication around the topic of interest (Brown, 1993). According to Brown (1993), the concourse may be comprised of words and music, art, and other media. The

concourse is intended to capture all that could be expressed about a topic, so practically, it should broadly represent the topic and a range of opinions (Brown, 1993). The concourse is the source of the Q set, a sample group of statements that participants sort into a Q sort (Watts & Stenner, 2012). The research question shapes the direction of the concourse.

Concourse Development

The concourse for this study was developed from professional, academic, and social discourse. I used document analysis as an adjunctive qualitative method and helpful framework considering the documents' natures, contexts, and intended audiences (Bowen, 2009). Since weight bias and body image are social constructs, the concourse sources included social documents, such as social media, advertising, blogs, and other statements and images in the public domain. I noted messages about fat phobia and body weight in radio, television, and popular literature. I also searched Facebook and Instagram, two popular social media sites, and Google, using terms prevalent in the literature and popular culture, such as *diet*, *fat*, *weight*, *weight loss*, *exercise,* and *body positivity.* Relevant concepts were added to the concourse with the corresponding source.

The next step was mining information that counselors might use in the therapeutic context centered around body weight. Statements were extracted from research publications, literature, blogs, and assessments. Wood-Barcalow et al.'s (2021) body image workbook provided a partial library of body-related assessments that were reviewed. Statements were derived from the Fat Phobia Scale Short Form (Bacon et al., 2001), the Weight Bias Internalization Scale Modified (WBIS-M) (Pearl & Puhl, 2014), Antifat Attitudes Scale (ATAS) (Crandall, 1994), Multidimensional Body Self-relations

Questionnaire (MBSRQ) – Appearance Evaluation Subscale (Cash, 1990), Sociocultural Attitudes Towards Appearance Questionnaire - 4 SATAQ-4R (Schaefer et al., 2017)., Beliefs About Obese Persons Scale (Allison et al., 1991), Attitudes Toward Obese Persons Scale (Allison et al., 1991), Broad Conceptualization of Beauty Scale (BCBS): Gender Neutral Version (Tylka & Iannantouno, 2016), Health and Weight Attitudes Scale (Drake & Ogletree, 2018), the Attunement with Exercise Scale – Clinical (AWE-C) (Calogero & Tylka, 2021), and Attitudes about Treating Obese Patients (Puhl et al., 2014). Books and blogs were also used to build the concourse.

Including statements from multiple assessments normed on different populations would expand the diversity of the concourse. However, it appears there are no relevant assessments explicitly designed for non-White groups, and there are few eating disorder treatments and measures that include diverse samples in their validation process (Gilbert, 2003). Web pages written by people of color, all of whom were women, and those with disabilities were used to expand the concourse diversity and include marginalized voices.

Finally, I included statements and concepts from multi-disciplinary peer-reviewed literature with keywords such as weight, obesity, body image, fat, and diets and grammatical variations of these words. Additional keywords that emerged from the concourse development were also used as search terms in the academic literature to round out points of view. As sentiments began to be repeated, the concourse seemed to reach saturation for majority identities. So I sought more dialogue from those with marginalized identities, such as persons of color, religious minorities, and those with visible and invisible ability statuses. Throughout the concourse compilation, conjoined ideas were separated (Watts & Stenner, 2012), and ideas were shaped to fit the concourse

format. For example, where feasible, statements written in first person language were modified to the third person, and genders were removed unless they were germane to the substance of the statement.

Building the concourse was an interactive, non-linear process of investigating sources that led to new sources of information and ideas, so categories were revisited as new concepts emerged. When the information became repetitive, the concourse reached a saturation point (Stickl et al., 2019). As the concourse reached saturation, I engaged a research team member to review the concourse (Baltrinic et al., 2021). The research team member, a Black female, checked the concourse for sufficiency and diverse representation. She suggested resources for the theme of fat liberation and added several statements to the concourse. Having another research team member review the concourse helped ensure a diverse perspective in the initial pool of statements, which addressed the potential risk of a "skewed" sample (Wester et al., 2021, p. 192).

The first draft of the concourse was comprised of 554 statements. Statements were coded with a preliminary theme as they were recorded. As the concourse developed, an updated and expanded set of 15 themes emerged. So, each statement was re-coded according to one of the final 15 themes. Then the concourse was sorted by theme and reviewed for duplication and statement quality (Baltrinic et al., 2021; Paige & Morin, 2016) to ensure items contained singular ideas and were positively stated (Watts & Stenner, 2012). Duplicate statements and statements written in the first person that could not be reasonably converted to the third person were marked and eliminated (Paige & Morin, 2016). Also, mirror opposite statements were considered duplicates and removed, and statements unrelated to the theme were removed (Watts & Stenner, 2012). Paige and

Morin's (2016) summary of guidelines for selecting and editing statements was a reference for statement quality. The overall process also followed the work of Baltrinic et al. (2021), who used two research team members to eliminate duplicate items and those unrelated to the research question.

Considering there were many statements in the concourse, more than twice the number in Baltrinic et al.'s (2021) study, and the subsequent challenges in qualitatively identifying duplicate or closely similar items throughout a large data set, another round of review was completed. In this round, statements were arranged digitally as cards sorted in columns by themes to facilitate easy viewing across the data set. This process digitally mirrored Paige and Morin's (2016) "post-it notes" display (p. 107). Items that needed review as possible duplicates or needed revision according to criteria by Watts and Stenner (2012) were color-coded yellow for possible duplicates or purple for modification. Then once a final determination of duplication or statement revision was made, the statements were color coded as either red for removal or green to remain in the concourse. All items were ultimately color-coded red or green, and then all red items were removed. Each stage of the process was saved, creating an "audit trail" (Paige & Morin, 2016, p. 109) of decision points. The final concourse contained 386 statements across 15 themes.

Selecting the Q Set – Item Sampling

The next step was to select a sample of statements known as the Q set or Q sample from the concourse. According to Watts and Stenner (2012), the Q set must broadly represent the concourse (coverage) and, as closely as possible, capture the range of opinions and perspectives the research question seeks to answer (balance). I used a

structured approach to the Q set design that aligned with Watts and Stenner's (2012) suggestion of using themes to organize information. First, I created columns of themes and reviewed the themes for balance across the topic. Where themes were closely related, the themes were combined. Additionally, some themes were renamed to more closely reflect the content of the statements within. For example, the three themes of prejudice, bias, and weight stigmatization were merged since the statements within each theme were tangential. Fifteen themes were reduced to the nine themes shown in Table 1.

While selecting the Q set, items were recategorized or modified if clarification was needed, staying true to the original idea of the statement. Paige and Morin (2016) provided a summary of guidelines that I followed in editing statements. For example, negatively phrased statements were reversed into positive statements (Watts & Stenner, 2012), and in some cases, this shifted the theme or category of the statement. All themes were arranged digitally in a horizontal format for visibility, and I began the selection process by theme. I selected all eight statements within the theme of intersectionality, recategorized other related statements to this theme, and moved statements into different themes as appropriate, all to ensure statements regarding marginalized identities were prioritized in the Q set. When this was completed, there were nine statements in intersectionality, which became the upper limit of statements per theme.

Next, I selected items for themes with opposing views, such as health/medical and fat liberation, to strive for balance and avoid bias (Paige & Morin, 2016). In each category, I first chose unique items within the theme and represented distinctive ideas across the concourse. Then I began to fill in statements across all themes. I reviewed each category of statements, added statements where a broader perspective was needed, and

removed statements that communicated the same ideas. Throughout the selection process, I continually scanned each theme and the whole of the developing Q sample, exchanging items in and out of the concourse and across themes as needed to maintain unique ideas, coverage, and balance (Watts & Stenner, 2012). A second research team member reviewed the Q set to ensure trustworthiness. She identified unclear statements that needed modification or exchange with another statement in the theme. This process was similar to the process of Paige and Morin (2016) and Baltrinic et al. (2021), who used multiple researchers to provide input in the Q set selection process.

Brown (1993) described a method of determining the Q set by identifying dimensions in the concourse, further subdividing dimensions to create a cross-cell table or block structure, and choosing an equal number of statements from each cell. I accomplished a similar result by looking for coverage and balance across the themes and selecting an equal number of statements in each theme, resulting in 81 statements in the Q set. This set was further reduced to 60 final statements for a manageable size and estimated length of time to complete the sorting. Although there is no strict rule about the number of statements in the Q set, this final number is in accordance with Watts and Stenner's (2005) recommendation to narrow the list to 40 to 80 statements in the final Q set. The Q set does not need to be a complete set of information about the topic. It is sufficient that the Q set broadly represents the overall topic in the research question, and meaning is expanded as participants engage with the Q set through the Q sorting process (Watts & Stenner, 2005). Meaning is created by participants through their Q sort as a whole rather than an emphasis on each statement (Watts and Stenner, 2012; Wolf, 2022). The final Q set (Q sample) is included in Table 2.

Participants – The P Set

Participants in this study were novice counselors who graduated from CACREP-accredited clinical mental health programs within the last three years and are practicing in the southern US. Currently, Forristal et al.'s (2021) study on size bias is the only counseling research on this topic, and it was conducted with counseling trainees. By focusing on recent graduates, this research study traverses counselor preparation to praxis to better understand a new generation of counselors' attitudes and beliefs. Novice counselors are uniquely tasked to navigate unfamiliar clinical experiences as they simultaneously negotiate the developmental tasks of new counselors (Freading & Foss-Kelly, 2014). Given their limited practical experience, novice counselors are likely to be heavily influenced by clinical supervisors and their recent counselor graduate education (Gibson et al., 2011; Moss et al., 2014). Novice counselors may also have gaps between training, expectations, and practice (Freadling & Foss-Kelly, 2014) as they develop their counselor identities (Gibson et al., 2011; Moss et al., 2014). So, understanding the attitudes and beliefs of novice practicing counselors is a critical next step in filling the research gap within the counseling profession about weight and body issues.

No minimum number of participants is required for a Q study, nor is there a maximum. Instead, there are varying methods of determining the number of participants. Dieteren et al. (2023) conducted a systematic literature review of Q studies published between 2015 and 2019 and reported a wide variety of methods to determine the number of participants. Some articles referred to ranges found in the Q literature, such as 20 to 40 participants (Brown, 1980), other researchers determined the number of participants based on a ratio of participants to Q statements, and a smaller percentage reported

selecting the number of participants based on the number of factors they expected to uncover (Dieteren et al., 2023).

Watts and Stenner (2012) noted several benchmarks to consider when selecting the number of participants. For example, they noted studies completed in the UK tradition usually have 40-60 participants, and they observed "it may be sensible to stick to a number of participants that is less than the number of items in your Q set" (Watts & Stenner, 2012, p. 73) to avoid rejection by publications. In general, Q methodology can be completed with a small number of participants, and there is no set number to achieve since the participants are the variables. Frequently, Q researchers aim to have at least half as many participants as there are Q statements or, said another way, a sample size twice the number of variables, where the Q set is the sample, and the P set is the set of variables (Watts & Stenner, 2012). Based on 60 statements in the Q set, this study targeted a P set of 30 participants.

After obtaining study approval from the University of Georgia's institutional review board, I sought and selected study participants using purposive sampling, a technique employed in the qualitative research tradition and Q methodology (Dieteren et al., 2023; Palinkas et al., 2015; Watts & Stenner, 2012). A total of 24 participants (P = 40) were recruited from the population of counselors in the southern United States with an open call for novice professionals with three years of clinical experience or less who graduated from a CACREP-accredited master's in CMHC program within the last three years. According to Brown (1996), P sets as small as 15 are sufficient, and "P sets of 30 to 50 are generally more than adequate for most studies of public opinion" (p. 65). To participate, individuals must have been actively practicing in the clinical mental health

counseling field, including addictions, marriage, couples, and family counseling, career counseling, and college counseling, and have completed a master's degree in clinical mental health counseling or community counseling from a CACREP accredited program within the last three years. They had to be age 18 or older and could identify with any race, ethnicity, or gender. Participants must have been actively seeing clients as a counselor, which, for the purposes of this study, would entail conducting at least two individual, group, or family counseling sessions per week, including telehealth sessions, in any work setting in the southern US. For the purposes of this study, the southern US consisted of all fourteen states in the Southern region of the Association for Counselor Education and Supervision (SACES) as of December 31, 2021, plus Washington, District of Columbia. Southern states in the SACES region are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, West Virginia, and Virginia (CACREP, 2022). Individuals who indicated interest in the study were asked to complete a screening questionnaire. This questionnaire is located in Appendix A. Purposeful random sampling was used to maximize variation (Palinkas et al., 2015), and counselors who identified as members of marginalized groups were encouraged to participate.

I contacted counseling professional organizations and the CACREP-accredited master’s CMHC programs in the southern US with the recruitment email and flyer. SACES provides a way for researchers to recruit participants, and ACA permits recruitment in the Call for Study Participants community on ACA Connect, an online community for ACA. Some master’s CMHC programs will share research studies with alumni or allow posting on social media pages. For example, Mercer University forwards

research studies to their alumni database, and I also posted in the unofficial social media page for Mercer counseling program alumni. I also posted invitations in Georgia therapy listservs and regional and nationwide social media groups for mental health professionals. These are groups that novice counselors may join as they establish themselves in the profession. All invitations included written information about the study. Appendix B contains the recruiting materials I used. I will issue at least one specific call for counselors who identify as members of one or more marginalized groups to seek diverse participants actively. In the screening questionnaire, potential participants received a brief description of the research and informed consent regarding benefits and risks. The informed consent document is in Appendix C. All counselors who wished to participate in the study had to indicate they had received the informed consent document and they consented to participate before completing the Q sort. They could withdraw from the study at any time. Participants who completed the study, the online Q sort and the post-sort survey, could choose to be entered into a drawing to win one of four $25 gift cards.

Q Sort

Q sorting involves participants ranking statements into a distribution along a continuum of conditions, such as between agreement or preference. Although researchers may use a free-form distribution, allowing participants to rank statements without limits on how the statements are placed, many researchers use a forced quasi-normal distribution. According to Watts and Stenner (2005), there is no noticeable effect in results between each type of distribution, free form or a forced quasi-normal distribution. See Figure 1 for the quasi-normal distribution framework used in this study.

Participants were provided a web URL link to the study to sort the Q statements using EQ Web Sort (Banasick, 2022). This program was free for participants and did not require a registration or software download. I chose this tool for its flexibility and good user interface for someone with average web-based applications experience. Advanced computer skills were not required for participants.

When participants opened the study, they were asked to enter an identifier that I assigned to them. This identifier was entered instead of their name. I maintained the list of participants and their identifying numbers in an Excel spreadsheet separate from the software. Participants' identifying information, including the spreadsheet, were stored on my computer hard drive, which is password protected and only accessible to me as the researcher.

The instructions requestedd participants to sort the Q set statements from *most agree* to *most disagree* using a drag-and-drop feature in the software. First, they were directed to use a working area to move statements into three general piles: agree, disagree, and neutral. Then they were instructed to move the statements from the working area into a table of "prearranged frequency distribution" (Watts & Stenner, 2012, p. 16) shown in Figure 1, one statement at a time until all slots in the table were filled. The number of slots equaled the number of statements in the Q set, creating the forced ranking. Participants were also able to view all statements together. They could move statements in and out of the distribution and adjust the size of the statement cards and text for readability (Banasick, 2022). Once all the statements were ranked relative to each other in the distribution framework, participants submitted their responses and moved to

the post-sort survey to answer questions about their choices. This survey is located in Appendix D.

One advantage of using software for sorting, rather than sorting statements by hand, is the software prevents participants from putting more statements into each column than is allowed in the test design, thus forcing the distribution. Specifically, participants were only permitted to place one statement in each slot, and they were not able to move forward to the next section of data collection and submit results until all slots were filled. They were asked to verify responses, with an opportunity to make changes, and then each participant was asked several questions to collect data for additional analysis. This data is described below in the additional data collection section. After submitting their final answers, the participants' Q sort and additional data was saved in the software. I was able to view results by participant, including additional data collected, at any time during the study by downloading the file in JSON format, readable through Microsoft Word.

During the study period, I was available via email, telephone and Zoom to troubleshoot technical issues and answer procedural questions regarding the instructions. The Q sorting process, including answering demographic questions and explaining their overall Q sort, took approximately 25 minutes. Final data was exported to Ken-Q Analysis Desktop Edition (KADE; Banasick, 2019) for analysis. This process is explained below in the data analysis section. Risks to participants were minimal and included possible emotional discomfort as they explored body-based beliefs. The study may have benefitted participants as they gained insight into their attitudes and beliefs. Generating personal awareness is essential for counselors to understand their values and

beliefs and not impose them on their clients. This process of exploring cultural beliefs and bracketing is an ethical imperative in the counseling profession (ACA, 2014).

Additional Data Collection

After completing the Q sort, participants completed a post-sort survey. The post-sort survey contained questions asking participants to explain their thought processes in determining which statements received the most extreme and second most extreme placements, provide any other comments that help explain their decisions in sorting the statements, and share final thoughts about the process and experience of the Q sort (Wester et al., 2021). Additional questions in the survey were to ascertain demographic and background data. Each participant was asked to provide their years of counseling experience, explain training and experience treating clients with eating disorders, and describe their history of dieting and behaviors linked to eating disorders. Training and experience treating eating disorders were for demographic purposes only and were not screening criteria. Participants could optionally disclose if they had a prior diagnosis of an eating disorder or undiagnosed disordered behaviors regarding food and body. All data was linked by participant identifier to create a single item for each participant in the JSON file. Post-sort survey questions are included in Appendix D.

Some Q researchers have used questionnaires and post-sort interviews to aid in understanding individual Q sorts and interpreting factors (Dieteren et al., 2023; Gallagher & Porock, 2010; Wolf, 2014). All participants were asked to complete the post-sort survey in this study. At the end of the survey, they were asked if they would like to participate in a virtual follow-up interview and, if so, to provide an email address and phone number to be contacted regarding the interview. I conducted all interviews via

Zoom and recorded and transcribed them (Wester et al., 2021). Interviews lasted a maximum of one hour and took place up to one week post-Q sort, similar to how Gallagher and Porock (2010) used post-sort interviews to gain a deeper understanding of participants' Q sorts within a short time frame after completion. The interview aimed to understand the participants' rationale for sorting statements and provided an opportunity for them to comment on the Q sorting process (Gallagher & Porock, 2010; Wester et al., 2021). This interview was semi-structured, following the format of the written questions at the end of the Q sort, allowing participants to provide richer explanations and insights into their Q sorts (Wester et al., 2021). The interview protocol is in Appendix E. Allowing participants the chance to discuss their Q sorts can help the researcher "[avoid] bias and projection of researcher interpretations onto participants' sorting" (Wester et al., 2021, p. 192), thus increasing the trustworthiness of the study findings.

Participants had one to four week to complete the Q sort and follow-up questions, and I sent email reminders and offered technical and procedural assistance. Participants who opted-in to a post-sort interview were contacted via email to schedule the interview as soon as possible, ideally within one week after the Q sort. They self-selected interview times through the website Calendly, which also generated a unique Zoom link for each interview appointment. Participants engaged in the study voluntarily and could leave the study at any time. Participants who completed the study could choose to provide their name and contact information at the end of the survey to enter a drawing to win one of four $25 gift cards. Winners were randomly selected after all study data was collected, and gift cards were mailed to winners within 30 days of selection.

Data Analysis

The P-sort data was analyzed using the KADE v1.2.1 software for iOS operating systems. KADE is a free software used in Q Methodology analysis, and data can be input into KADE from several sources, including JSON files generated by EQ Web Sort (Banasick, 2019; Banasick, 2022). First, I exported data from EQ Web Sort into JSON format (Banasick, 2022) and saved it to my computer, which is password-protected and backed up. Then I input the saved data into KADE (Banasick, 2019). Once all data was entered and verified, I calculated the correlations in KADE (Banasick, 2019), creating a correlation table. Correlations were between participants and ranged from -1.0 to +1.0, expressed as -100 to 100.

Factor Analysis

The next step was to choose the method of factors, which can be centroid factor analysis (CFA) or principal component analysis (PCA), and then examine the factor loading. Scholars reported no significant outcome differences between PCA and CFA (Braswell, 2022; Watts & Stenner, 2012). I used principal component analysis (PCA), a well-known multivariate technique, to generate factors (Baltrinic et al., 2021; Stickl et al., 2019). The choice to use PCA was in line with current literature, whereby almost half of Q studies published from 2015 to 2019 reported PCA for factor extraction, and only 25% used centroid factor analysis (CFA) (Dieteren et al., 2023).

Next, I examined the factor loadings and determined how many factors to extract. This process included examining each factor's eigenvalue (EV), which is the sum of the squared factor loadings (loadings of all the Q sorts) for that factor, looking at the scree plot, and then applying other analytical approaches and expert guidelines before

finalizing the number of factors (Watts & Stenner, 2012). The goal in determining factors was to choose the number of factors that described the most variability in the data (Watts & Stenner, 2012).

In determining the number of factors to keep for rotation, first, I examined the EVs for each factor in the array, looking for factors greater than 1.0 as the Kaiser-Guttman cutoff (Watts & Stenner, 2012). Multiple factors were generated, but they were not all be significant (Brown, 1980). My starting point was the number of factors with EVs greater than 1.0. Then I examined the scree plot of factors to determine where the slope of the line changed and considered selecting factors before the slope change (visually, the factors to the left of the slope change) (Watts & Stenner, 2012). I considered factors with two or more loadings and calculated significance according to Humphrey's rule, which "states that a factor is significant if the cross-product of its two highest loadings (ignoring sign) exceeds twice the standard error (Brown, 1980, p. 223).

According to Watts and Stenner (2012), the scree test, two-factor loading test, and Humphrey's rule are conservative and thus may result in eliminating factors that contain valuable information. Based on the results and as a final litmus test, I considered experts' experience, such as starting with seven factors (Brown, 1980), depending on the number generated, and Watts and Stenner's (2012) recommendation to select one factor for every six to eight participants, which is a general rule rather than a statistical test. Although the Ken-Q-Analysis software is limited to a maximum of eight factors (Banasick, 2018), no more than eight factors were expected based on the statistical and judgmental recommendations described - seven factors per Brown (1980) and five to seven factors based on 40 participants, using a ratio of one factor to six or eight participants, according

to Watts and Stenner (2012). In summary, I started with EVs greater than 1.0, examined the factors according to statistical methods and expert recommendations (Watts & Stenner, 2012), and then applied judgment to ensure each factor chosen had at least two Q sorts loaded on the factor (Stickl et al., 2019).

After confirming the number of factors, I selected varimax rotation, an automated procedure to account for as much of the common variability as possible (Brown, 1980; Watts & Stenner, 2012). The Q Methodology expert assisted by reviewing the factor rotations and suggesting any by-hand rotations. Manually rotating factors "guided by the abductory principle" (Brown, 1993, p. 116) can add to the understanding of the data (Brown, 1980; Rieber, 2020) and may include more participants in the factor loadings (Watts & Stenner, 2012). Using varimax rotation with by-hand rotation adjustments minimizes any downsides to the rotation method (Watts & Stenner, 2012). The final result is captured in a table of rotated factor loadings.

KADE (Banasick, 2019) displays the loadings on each factor. I auto-flagged at the default significance level of $p < .05$ to identify participants loaded onto each factor. Some participants did not load onto a factor with this number of factors and significance level. Data can be re-analyzed with different factors, such as fewer factors, and then attributes would be combined into fewer groups. I examined the correlations and did not find any any outliers that did not fit the profile of the rest of a factor. For example, one or more participants could have a negative correlation where all other participants on the factor are positive, creating a bi-polar factor. Bi-polar factors may suggest a factor contains opposing viewpoints. These factors can be rotated differently to fully express each view (Watts & Stenner, 2012).

Watts and Stenner (2012) described various ways to determine how many factors to extract from the data and mathematical computations and judgment in factor rotation, noting there is no preferred way. The analysis process is often based on experience and what is revealed in the data. I ensured the analytical decisions were methodologically sound, grounded in theory, and made sense in the overall context of the study (Watts & Stenner, 2012). Inclusion was a guiding principle, which can result in more rather than fewer factors (Bailey et al., 2019; Watts & Stenner, 2012). The final set of factors should account for as much variance as possible, ideally more than 35-40% of the study variance (Watts & Stenner, 2012).

Once the aforementioned steps were completed, I sent the table data to output and select all rotated factors (Banasick, 2019). The factor visualization provided a composite Q sort for each factor. I saved the composites as digital images, and all the data was downloaded to an Excel file of KADE results (Banasick, 2019). This Excel file contains Q sort data by participant, a correlation matrix of participants' Q sorts, the unrotated factor matrix, and factor loadings.

The Excel download also contains a factor score correlation matrix, factor score ranks, additional views of each factor, and a consensus-disagreement table (Banasick, 2019) that was sorted to create a factor array by statement. The factor array shows raw scores by factor and z scores for each statement in the Q set. The factor array is the best representation of the Q sorts loaded on the factor, and the array will contain some error since it is unlikely individual Q sorts will exactly match the array (Watts & Stenner, 2012). Although factors are orthogonal, the arrays may be intercorrelated due to the inherent error (Watts & Stenner, 2012). So, I reviewed the factor score correlations

before moving to factor interpretation. Since factors one and two, one and three, and three and four were significantly correlated at p.<01, with correlation +/- .33, as shown in Table 3, I reassessed the number of factors (Watts & Stenner, 2012) as I reviewed the remainder of the data output. Even though highly correlated factors may represent different manifestations of a similar viewpoint (Watts & Stenner, 2012), I kept all four factors based on unique distinguishing statements that characterized each factor and to ensure that diverse voices loaded on factors were clearly represented in the final results. Then, after reviewing factor correlations, the factor array is a helpful starting point for factor interpretation since it provides a view of the factor in a simple format.

Interpretation

Although factor interpretation is a subjective process without stringent rules, Watts and Stenner (2012) advised applying a system of interpretation. First and foremost, researchers should bracket bias and focus on the viewpoints that emerge from the data (Watts & Stenner, 2012). I hold preconceived notions as a White, heterosexual female counselor, doctoral student, and researcher. I also have lived experience in my body in Western culture. This bias has guided me to the research topic and helped me build the concourse and Q set. My positionality can be valuable during the interpretation process as I consider different points of view to which I have been exposed or have experienced, and at the same time, it can unintentionally affect the findings. So, through a subjectivity statement, I reflected on my identity, privilege, values, and beliefs that I bring to the study design and interpretation of results. This statement was updated as appropriate during the research process. Reflexive positionality statements such as this are used in qualitative research "to clarify and contextualize one's position about the research

process for both the researcher, the research participants, and readers of research outputs" (Holmes, 2020, p. 4). Additionally, before interpretation was finalized, I sent the draft factor interpretations to the Q Methodology methodologist to verify that a holistic view of each was captured. Although other Q studies do not explicitly include this verification step in the process, this is one way that I could reduce bias that may negatively affect interpretation and ensure that I am staying true to the methodology. Watts and Stenner (2012) emphasized that "in keeping with [Q's] methodological holism, the final product must explain, or otherwise account for, the *entire configuration* captured in the relevant factor array" (p. 149).

Analysis and interpretation were made through the lens of abductive reasoning, staying true to the original Q Methodology philosophy of discovering the surprises in the data and letting the process unfold without preconceived notions to obtain a holistic and whole viewpoint (Watts & Stenner, 2012). Many clues awaited my discovery and examination as I looked at the story of each factor rather than analyzing specific differences between factors. Watts and Stenner (2012) proposed that it is the "interrelationship of the many items within the [factor] array that should ultimately drive our interpretation of [the] factor" (p. 149). These authors suggested using the crib sheet system as an interpretive guide, and I will use it in this study.

The interpretive method Watts and Stenner (2012) recommended is a crib sheet system that was used consistently for every factor to organize the process of interpretation. Even though the crib sheet method is systematic and begins with an examination of individual items within the factors, my ultimate focus wass on each factor as a "whole viewpoint…[that accounts] for the entire item configuration captured in the

relevant factor array" (Watts & Stenner, 2012, p. 149). Importantly, this mirrors the meaning of the Q sorts, that each is a gestalt. Therefore, there is less emphasis on the individual statements within a factor (and within a Q sort) than there is an emphasis on the meaning of the whole.

I used crib sheets to guide my focus on the individual items within the factor, to understand their place in the whole story of the factor (Watts & Stenner, 2012). I created a crib sheet in Microsoft Word with separate sections for each factor. Then I followed the same process to interpret each factor creating two drafts for each factor before finalizing the interpretation. According to the process outlined by Watts and Stenner (2012), I collected and examine four categories of data in the first draft - items ranked 1) highest, 2) lowest, 3) higher than in other factors, and 4) lower than in other factors. The resulting view demarcated the factor from other factors and illuminated the distinguishing features of the factor. Items in the middle of the distribution of the factor array were also reviewed, particularly compared to the ranking in other factors, to help determine the relevant importance of the statement in the factor. Although centrally placed statements may represent neutrality, they may also "act as a fulcrum for the whole viewpoint being expressed" (Watts & Stenner, 2012, p. 155). I noted ideas and hypotheses on the crib sheets as I looked at the top two (agree) and bottom two (disagree) statements, the statements in the factor that were sorted higher and lower than in other factors, and the middle distribution statements. After reviewing all of the items in the factor and noting hunches along the way on the crib sheet, I checked all the items and notations together to build the first draft of the story of the factor. The story of the factor is the narrative description of the factor developed through the interpretation of data.

Then I conducted a second review of each factor using the crib sheet process to note other items that may be relevant to the factor. I returned to the factor array, looking for surprises or clues to expand or elucidate my understanding of the factor's meaning. I also matched post-sort questionnaires and interview data to the Q sorts within the factor and overall factors, as Wolf (2014) did, all of which informed the emerging hypotheses. Watts and Stenner (2012) recommended waiting until the second draft of the crib sheet to include this data to minimize bias and preconceived notions.

At the top of each factor sheet, I described the factor – the EV, amount of variance explained in the unrotated factors, number of participants associated with the factor (Q sorts loaded onto the factor) – and the demographic data for the participants' whose Q sorts loaded onto the factor. Reviewing the demographic data and participants' written and verbal (interview) explanations of how they arrived at their final Q sorts provided additional insights to generate factor narratives and provided a more robust description of each factor. Through this qualitative data, I confirmed, rejected, and modified hunches and generated new insights to shape and finalize factor stories. During this round, I documented emerging hypotheses in the fashion of abductive reasoning and revised the narrative for each factor into a second draft.

Watts and Stenner (2012) encouraged Q Methodology researchers to use a first-person, human perspective. In the feminist qualitative tradition (O'Shaughnessy & Krogman, 2012), I highlighted participants' voices through the interpretive process. Interpretation took a narrative style, incorporating Q statements and qualitative comments, as Watts and Stenner (2012) suggested. The Q Methodology expert was

engaged throughout the interpretive process to review the factor arrays, crib sheets, and interpretations of each factor.

Limitations

This research may be subject to several limitations. This study aims to understand novice counselors' attitudes and beliefs about weight and body image to obtain a broad sample set of Q statements and a diverse group of participants. Diversity is particularly important since lack of diversity and attrition were limitations in a previous study of weight bias among professionals treating eating disorders (Puhl et al., 2014). Puhl et al. (2014) encountered high attrition rates during the investigation and possible resistance to revealing explicit weight bias, which could occur in this study. I plan to address this potential challenge through the forced ranking format of Q Methodology and by not inquiring about participants' personal histories and behaviors until after they have completed the Q sort. Conducting the study online will also provide a measure of privacy for participants. Since any counselor may encounter clients with weight bias, poor body image, or an eating disorder, it is valuable to capture various counselors' perspectives, not just those trained to treat these concerns. So, I recruited counselors broadly to diversify the participant set and resulting data.

There are also limitations within purposive sampling, the recruiting process, and the timing of collecting specific demographic data. Since the researcher determines where and whom to recruit and select as participants, bias may be introduced (Saumure & Given, 2008) in participant selection. With an invitation issued broadly through professional organizations and social media and demographic data, I was also unable to calculate a response rate or able to assess differences between those who participated and

those who chose not to participate or prematurely exited the study. Additionally, with a select group of participants, such as novice counselors from CACREP programs in the southern US, the sample demographics will be limited by the demographics of the selected population, and the results cannot generalize to groups with other characteristics (Saumure & Given, 2008) such as experience levels or geographic location.

By writing descriptive narratives of the data, "so that judgments about the degree of fit or similarity may be made by others who may wish to apply all or part of the findings elsewhere" (p. 77), I can increase transferability, a criterion of trustworthiness (Lincoln & Guba, 1986). Also, using random selection with the population of those who meet the study criterion could minimize bias and "selection effects" (Morgan, 2008, p. 725). Wisely choosing participants is a balance of strategically selecting participants according to the research question (Watts & Stenner, 2012) and including those with heterogenous views (Bailey et al., 2019; Palinkas et al., 2015; Watts & Stenner, 2012). Including all genders, races, and ethnicities in the selection criteria and allowing potential participants to define marginalization for themselves without overlaying socially constructed meaning (Bailey et al., 2019) is another way I minimized selection bias and encouraged participation, seeking to elevate all voices through research (Wigginton & Lafrance, 2019).

Finally, this study may be limited by my biases and experience level as a researcher. I have addressed this potential limitation by building experience in Q Methodology through doctoral level-coursework and practice and piloting relevant Q statements and methods. I have engaged a Q methodology expert on the project, as well as a contributor to the Q set who has diverse identities from mine. I believe this will

provide the best balance of using my position and knowledge as a counselor with lived experience who treats eating disorders with the objectivity and expertise of third parties without prior knowledge or history with the topic. I engaged in peer debriefing by having research team members review the study instrument and its development (concourse and Q set) and using an objective methodology expert to review the analysis and provide feedback on data interpretation. Peer debriefing is one way to increase credibility and, thus, trustworthiness (Lincoln & Guba, 1986). Additionally, the Q set was designed with fairness in mind (Lincoln & Guba, 1986), striving for balance and coverage (Watts & Stenner, 2012). I also kept an audit trail during instrument design that was reviewed by a research team member, which addressed the final elements of trustworthiness: dependability and confirmability (Lincoln & Guba, 1986).

Subjectivity Statement

This research was conducted from my position as a White, heterosexual female counselor education doctoral student researcher with lived experience of cultural sizeism. As a mixed methods researcher, I am an instrument in the research, and it is essential to recognize how my values and beliefs may affect the research process (Given, 2008; Wigginton & Lafrance, 2019). As a woman in the southern US, I have felt compelled by societal norms and beauty standards, relationships with family, friends, and romantic partners, employer wellness plans, and healthcare providers to lose weight to maintain a specific body size. This pressure resulted in my trying multiple weight loss techniques from early adolescence into adulthood. Each diet attempt resulted in initial weight loss and then, ultimately, frustration and weight gain. Rather than considering the diets as failures, I considered myself a failure.

When I entered the counseling profession as a practicum student working in eating disorder treatment, one condition of employment was to prepare and eat normal, non-restrictive meals with clients. I eschewed all weight loss plans and memberships, discarded all dieting paraphilia, and gave myself permission to eat, just as I recommended to clients. I learned and embraced the principles of *Intuitive Eating* (Resch & Tribole, 2020) and *Health at Every Size (HAES®)* (ASDAH, n.d.), and thus began my journey to sizeism recovery and advocacy for myself and my clients.

After completing one year of work in eating disorder treatment during my master's practicum and internship, I continued working in an eating disorder treatment center at multiple levels of care. I currently treat clients with eating disorders and body image concerns in an outpatient setting in private practice. I also have a clinical specialty treating trauma, which frequently co-occurs with disordered eating patterns, body image disturbance, and eating disorders. I received training and supervision in eating disorders during my master's practicum and internship year, and I participate in ongoing training in eating disorder treatment at least quarterly through national treatment centers and professional organizations. I research, write, and speak at conferences on cultural sizeism and mental health treatment for eating disorders. This ongoing experience and training shaped this research topic from inception and contributed to formulating the concourse from which the Q set will be selected.

Researcher Assumptions

As a woman with lived experience of sizeism in the US, a counselor attuned to clients' relationships with food, weight, and body image, and a consumer of varied social and scholarly literature on the topic, I anticipate that cultural weight bias will be inherent

in the findings. In this study, I am not seeking to determine the existence of bias or to measure it, but rather to understand counselors' diverse viewpoints on weight and body size and shape, which may exhibit elements of bias. I am equally interested in the exceptions and discerning the nuances of counselors' beliefs across identities as they relate to size and weight. In this study of subjectivity through a feminist lens, power is available to voices that might otherwise be suppressed or submerged. True to the nature of Q methodology and abduction, I expect surprises (Watts & Stenner, 2012). Elements of each theme represented in the Q statements are expected to emerge since the themes of the Q statements reflect the social discourse on weight and body. However, I cannot anticipate how the themes will emerge in configurations of Q sorts and factors and the meaning of the factors, and therein lies my curiosity and anticipation. With new awareness, I await the opportunity to connect insights to implications for counseling, counselor education, and supervision.

Ethical Considerations

This study will follow ACA's (2014) ethical research principles and university policies. One important ethical principle is respecting diversity and minimizing bias in the research process with contributors and participants (ACA, 2014). The university institutional review board will approve the study before commencing, and participants can ask questions through a clear, informed consent process. They may decline to participate, and if they do participate, they may withdraw consent and leave the study at any time. Participants' identities will be masked to the extent possible during data collection, analysis, interpretation, and reporting. I have no sponsors for the study or known conflicts of interest.

Potential Implications of the Findings

Findings from this study have implications for counselor education, supervision, and CMHC practice. Although some members of the counseling profession have advocated for attention to sizeism as a multicultural concern (Kinavey & Cool, 2019; Nutter et al., 2020), little empirical data about sizeism exists within the counseling field. So, this study will fill a knowledge gap. Counselor educators can use the findings from this research to develop awareness and knowledge of weight and body beliefs that may exist among students. Findings may support the case to include sizeism as an axis of inequality in the curriculum of CMHC programs and provide insights into current views and how they manifest among new counselors. Counselor educators could then design counseling curricula and supervision about weight and body using knowledge of the factors and insights from this study.

Additionally, understanding current beliefs and attitudes about weight and body among recent graduates of CMHC programs may highlight areas of privilege and marginalization within CMHC master's programs and in clinical practices. Findings can also benefit field supervisors and clinicians, as they examine sizeism as a multicultural issue and consider the ethical imperative to develop multiculturally competent counseling and supervision practice (ACA, 2014). Generating knowledge and awareness of statuses of privilege provide counselor educators, supervisors, and CMHC clinicians with opportunities for self-reflection, obtaining additional knowledge, developing new skills, and taking action in multicultural competency and social justice (Ratts et al., 2016).

Chapter Summary

This chapter provided a rationale for using Q methodology to answer the research question about novice counselors' beliefs regarding body weight and size. Since Q is a mixed-methods research method, employing it allows me to identify significant correlations and factors and explain these factors for a richer understanding of the data. This sample (Q-set) in this study was taken from the social concourse around weight and bodies, encompassing a broad range of themes and opinions. I targeted half as many participants (variables) as there are statements in the Q set (n) and finished the study with 24 participants. Participants sorted statements using a web-based program and provided additional data at the end of the sort. Correlations across Q sorts and factor extraction were conducted, with additional data used to aid interpretation and story-telling. Q methodology provides a quantitative approach to subjectivity. Findings may have implications for counselor education, supervision, and counseling practice.

Table 1

Final Concourse Themes

Health/Medical	Health at Every Size
Morality/Healthism	Body Positive/Diversity
Prejudice/Bias/Weight Stigmatization	Fat Liberation
Habits - Food and Exercise	Intersectionality
Beauty/Appearance Standards	

Table 2

Final Set of Q Statements (Q Set)

Stmt No.	Statement
1	Normal range Body Mass Index (BMI) is healthy
2	Weight loss is an appropriate treatment goal
3	For most people, their Body Mass Index (BMI) is a good assessment of health risk
4	Healthcare providers have an obligation to address weight with patients
5	Obesity is a chronic disease
6	Overeating is a sin (morally wrong)
7	People should love themselves enough to change their body
8	It's acceptable to call others fat
9	A body's "weight set point" can be unhealthy
10	People have a responsibility to maintain a fit body
11	Some people diet to get healthy
12	Overweight people are lazy
13	It's parents' fault when their children are at a heavier weight
14	Most obese people are dissatisfied with themselves.
15	Weighing more can be emotional protection
16	Fat people overeat
17	Obese clients are often noncompliant with treatment recommendations
18	It's uncomfortable to be around fat people
19	Obese clients lack motivation to make lifestyle changes
20	There are healthy foods and unhealthy foods
21	The purpose of exercise is to control weight
22	People can be addicted to food
23	It's important to watch what you eat to avoid weight gain
24	it's important to weigh yourself regularly
25	Diets can be done in a healthy way
26	Losing weight helps you feel better

Stmt No.	Statement
27	Diets don't work
28	Having a fit body is important in the role of counselor
29	People need to be thin to be liked
30	People should select clothes appropriate for their figure.
31	People should be complimented for weight loss
32	White women need to be thinner than Black women to be socially accepted
33	People who are lean are more beautiful than those who have other body types.
34	People feel social pressure to conform to the thin, fit appearance ideal
35	Weight regain is due to the body's "weight set point"
36	Dieting is unhealthy
37	Health is on a continuum
38	It's possible to be both fit and overweight/obese
39	Behaviors, not weight, make us healthy
40	Your ideal body weight is the weight that allows you to lead a healthy, normal life.
41	Exercise is for enjoyment
42	Our bodies should be celebrated for what they do
43	It's important to love our bodies just as they are
44	Counselors can hold space for clients without helping them lose weight
45	Beauty standards are unrealistic
46	There is no ideal body
47	Obese people are just as sexually attractive as nonobese people
48	People of all sizes should be encouraged to accept their bodies without changing them
49	If you aren't actively working on the liberation of fat people you are participating in their oppression
50	Weight-related microaggressions harm clients
51	If counselors are pursuing intentional weight loss they are harming clients of all body sizes
52	A counselor's role is to provide fat affirming therapy
53	Diet culture upholds white supremacy
54	Diet culture is a cult
55	Counselors can help clients heal their relationships with their bodies rather than try to lose weight
56	Black women are happy with their body shape and size
57	Sexual orientation affects body image
58	Eating concerns in people of color may be ignored by doctors
59	Race-based stress affects eating behaviors
60	Lesbians are heavier than other people

Note. Total Number of Statements N=60

Figure 1

Q Sorting Grid

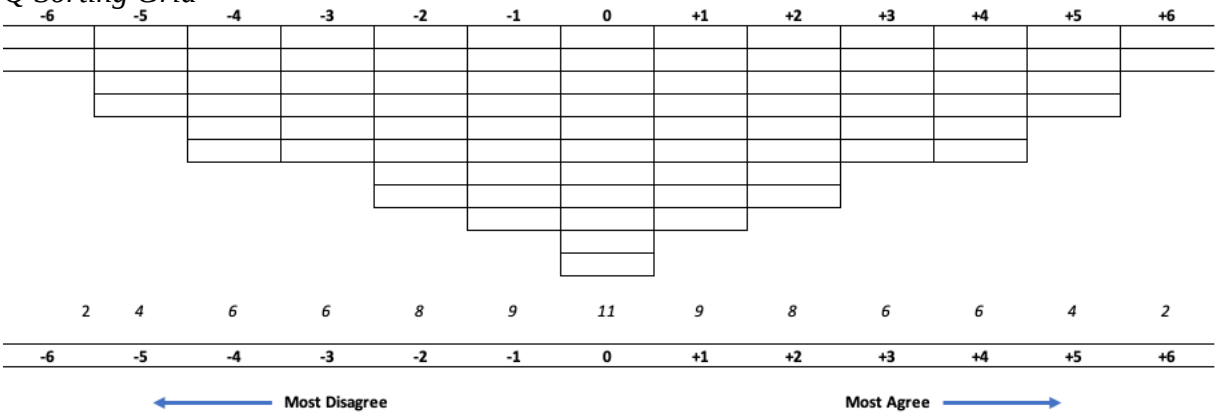

Table 3

Factor Score Correlations

	Factor 1	Factor 2	Factor 3	Factor 4
Factor 1	1	0.58	0.51	0.32
Factor 2	0.58	1	0.24	0.01
Factor 3	0.51	0.24	1	0.40
Factor 4	0.32	0.01	0.40	1

Note. All numbers were rounded to two decimal places.

CHAPTER 4

RESULTS

This study aimed to understand the attitudes and beliefs about body weight and shape among novice counselors from CACREP-accredited master's programs. Q methodology, an inherently mixed methods research technique, was chosen to explore subjectivities. Participants were recruited through social media groups, listservs, professional organizations, and CACREP-accredited masters programs, all within the SACES region. Initial recruiting emails and the final recruiting flyer are included in Appendix B. To be eligible for the study, individuals had to have been over the age of 18 years, have graduated from a CACREP-accredited master's program in clinical mental health counseling (CMHC) within the last three years, and be practicing within the Southern Association for Counselor Education and Supervision (SACES) region, conducting at least two counseling sessions per week on average. The SACES region consists of 14 states plus the District of Columbia.

After obtaining UGA IRB approval of the study, potentially eligible counselors were invited to complete a Qualtrics screening questionnaire, included in Appendix A. Those who met the study criteria were assigned a participant identification code and invited to complete the web-based Q sort, facilitated through EQ Web Configurator Version 2.0.0 (Banasick, 2022). The Q sort consisted of 60 statements, as shown in Table 2, and follow-up questions in a post-sort survey included in Appendix D. After the post-sort survey, participants could opt-in to a virtual interview conducted over Zoom, and

they could choose to have their name included in a drawing for one of four $25 gift cards. Quantitative data was analyzed using KADE v.1.2.1 (Banasick, 2019), a web-based Q analysis application. Then, using the crib-sheet method described by Watts and Stenner (2012), two rounds of qualitative analysis were conducted using the quantitative data output and participants' post-sort survey and interview responses. The research question that guided the study was:

RQ1: What are novice counselors' from CACREP-accredited mental health counseling programs attitudes and beliefs about body weight and shape?

Description of Participants

Potential participants were screened through a web-based survey hosted in Qualtrics. There were 88 screening survey attempts, and of those, 46 completed the screening survey and consented to participation. Two additional entrants declined participation, and they did not meet the study criteria. Excluding a duplicate entry, of the counselors who consented to participate, 40 unique individuals met the study criteria and were invited to participate via email and provided a participant identification (ID) to complete the online Q-sort. The targeted number of participants was 30, based on a ratio of half of the number of Q statements (Watts & Stenner, 2012), of which there were 60. The study was open to participants for four weeks, and three rounds of emails were sent, including the original invitation and two reminders. Participants who opted-in to an interview were invited to schedule the interview within one week of completing the Q sort using Calendly. UGA Zoom links were embedded in the Calendly scheduling software.

Twenty-four participants completed the Q-sort. An additional Q sort was submitted that was eliminated since it contained no data. A participant set of 24 was deemed acceptable since there is no requirement for the number of participants in Q research (Brown, 1980, 1996), and the focus is selecting participants who the researcher expects to have a viewpoint on the subject matter (Brown, 1980) rather than a particular number of participants. Most contemporary Q studies included 20 to 50 participants (Dieteren et al., 2023). Eight of the 24 participants opted-in to the virtual interview, and five scheduled and completed the interview. These interviews were recorded and transcribed.

Participants were selected through purposive sampling, the most common form of sampling (Dieteren et al., 2023; Watts & Stenner, 2012). Each of the 164 CACREP-accredited CMHC programs and state counseling associations in the SACES region was contacted via email and requested to send the study recruitment flyer and email to their program alumni and members, respectively. Two of the state counseling associations, representing South Carolina and Florida, emailed their members. How many CMHC programs forwarded the information to their program alumni is unknown. Participants were also recruited through listservs and social media groups where eligible members may have been active. Due to the nature of the sampling methods, a response rate could not be calculated. Of the 24 participants, 11 practiced counseling in Georgia (46%), and one participant who practiced in Georgia also practiced in a state outside the SACES region. Other participants practiced in Virginia (n = 5; 21%), Florida (n = 4; 17%), Tennessee (n = 2; 8%), South Carolina (n = 1; 4%), and Texas (n = 1; 4%).

As indicated in Table 4, the majority of respondents were White females. Nineteen participants identified as White, three as Black, one as African American, and one as multiple races. Fifty-four percent of the participants reported they are currently attempting to lose weight, and 79% have a history of past weight loss or weight loss attempts. For those participants who reported their birth year, the average age was approximately 32.8 years old, with the youngest participant at 24 years old and the oldest approximately aged 60 years. Half of the participants reported 12 months or less experience post-graduation, 25% reported 1-2 years experience, and 25% reported 2-3 years experience. Fifty-eight percent of those with a history of intentional weight loss also indicated either experiencing discrimination due to their body size, having an eating disorder, or both. Participants of all races expressed a history of deliberate weight loss and current attempts to lose weight. All genders reported a history of intentional weight loss; however, only the nonbinary respondents indicated no current weight concerns.

Factor Analysis

Q sorts were completed online using EQ Web Sort (Banasick, 2022), and data were collected in a Firebase database. This data was exported as a JSON file and imported into KADE (Banasick, 2019) for analysis. The first step was to analyze the correlations of the 24 Q sorts. This correlation table is shown in Table 5. Then using principal component analysis (PCA), factors were extracted and evaluated to determine how many factors to retain for rotation. Table 6 shows all unrotated factors with Eigenvalues (EVs) and the percentage of variance explained by the factor. Brown (1980) recommended starting with seven factors. When I rotated seven factors, only two had two or more participants loaded on the factor, with six significant loadings on two factors. I

reset the analysis and reran it using four factors since there were four factors with EV greater than one. Four factors met the tests of EV greater than one, at least two sorts loading on the factor, a guide of one factor for every six to eight participants, scree plot slope change (Watts & Stenner, 2012), and Humphrey's rule (Brown, 1980). The scree plot is depicted in Figure 2. These four factors were rotated using varimax rotation. Judgmental rotation did not result in additional factors, so factors one through four from varimax rotation were retained. All sorts loaded positively onto these factors, and none of the sorts on the four factors loaded significantly onto more than one factor. The four factors explained 69% of the variance. The function of factor analysis is to account for as much of the study variance as possible (Watts & Stenner, 2012; Brown, 1980) without a specific target. Table 7 shows the four rotated factors and participant loadings. In total, 17 participants loaded onto the four rotated factors at a significance level of $p < .05$ with the majority of the common variance on the factor. Seven participants loaded on Factor 1, four on Factor 2, four on Factor 3, and two on Factor 4.

Factor Interpretation

Factor 1 – Body Positivists

Factor 1 has an EV of 11.34 and explains 47% of the study variance. Seven of the twenty-four participants were significantly associated with this factor named *Body Positivists*. Background data for Factor 1 participants are in Table 9. All participants on Factor 1 identified as White, cis-gender females, and they ranged in age from 24 – 50 years old, with an average age of 34.8 years. One participant declined to provide her birth year. Experience ranged from one – six months to two – three years. Six of the seven participants reported a history of weight loss attempts. Three of those indicated prior

discrimination based on weight, and three reported past history with a suspected or diagnosed eating disorder. Two participants reported trying to maintain their weight, four were actively trying to lose weight, and one was not concerned about her current weight. Participant 4, who reported currently trying to maintain her weight, described her current weight behaviors as:

> I am not actively trying to gain or lose weight, but I am trying to work out more often to gain more muscle. I really just enjoy going to the gym and working out, so I'm trying to do that more often.

The participant unconcerned about her weight reported an eating disorder and weight loss history. One participant who loaded on this factor, Participant 17, reported no specialized training in eating disorder treatment, body image concerns, and Health at Every Size (HAES), as indicated in Table 10. However, in the post-sort survey comments, she stated:

> I have worked with Healthy At Every Size counselors and have done my own personal work to overcome my binge eating/restriction disorder and come to a place of peace with my body. I do work with clients that have eating disorders and we work more holistically on acceptance and changing narratives.

Key themes were identified from the quantitative data and explained with *Body Positivists'* qualitative data. Quantitative data for this factor is included in Table 10. This data includes distinguishing statements for the factor and statements ranked higher and lower in this factor than in other factors, based on the factor array shown in Table 8. Special consideration was given to distinguishing factors for *Body Positivists*. Statements referenced in narratives are denoted by the statement number and composite score, which ranges from -6 to +6. For example, Statement 37 ranked at +5 is denoted as (37: +5). A

visual representation of the factor is in Figure 3. This representation considers the weighting of each participant's Q sort noted in Table 9.

Body Positivists believe that health looks different for everyone (37: +5) and is not defined by BMI, which is outdated and inaccurate as a health measure (1: -2; 3: -3; 38: +5). For example, Participant 4 noted, "Every body is different so there isn't a one size fits all model to follow. If you are eating when you feel hungry and exercising when you want that's more important than a number on the scale." *Body Positivists* strongly believe that behaviors determine health rather than body shape and size (39: +4). There is no one-size-fits-all model of health, as human beings are all unique. Poor health and health are possible at any weight (9: +1), and bodies can be larger and still be considered fit (38: +5). Participant 17 discussed in her post-sort interview that she:

> would have liked a little bit more [in the Q sort] on how people in larger bodies are treated by the medical professionals… I'm very passionate about the topic about people that because of the way they're treated if they live in a larger body. They may deny health care or may not believed and that infuriates me…Sometimes doctors only see you as a number rather than the whole picture. A person can be in a larger body and have good test results like blood work and all those test results.

Since there is no ideal body (46: +3), according to *Body Positivists*, everyone should be encouraged to accept their bodies without changing them (48: +3; 7: -3). Participant 14 stated, "We are unique individuals and sometimes the celebration of that gets lost in American culture." *Body Positivists* believe counselors can affirm clients without participating in diet culture that promotes weight loss (44: +4). At the same time,

Body Positivists believe obesity is a chronic disease (5: +2) and that a body's weight set point may be unhealthy (9: +1). They also agreed that healthcare providers should address weight with patients (4: +1). *Body Positivists* support body acceptance as long as health is not compromised. For example, Participant 18 described, "Health is more important than weight by far." This group is not opposed to diet culture (54: 0) and believes dieting can be done healthily (25: +2), for example, by "increasing foods such as nutrient fruits and vegetables [to] help with an increase in consuming vitamins (Participant 11). So, in these ways, *Body Positivists*, on the one hand, promote body acceptance and celebrate bodies for what they do, and on the other hand, believe dieting and smaller bodies can be linked to good health. *Body Positivists* disagree that their weight loss desires and dieting practices harm clients (51: -2; 49: -1).

Body Positivists do not endorse the stereotype about how much fat people eat. They recognize that being fat does not mean that someone overeats (16: -4), and even if they did overeat, it is okay. Participant 3 said, "I like to reframe this as Fat individuals eat for their needs; however, some may have a negative relationship with food." Overeating is not inherently wrong (6: -6). *Body Positivists* notice that people's eating behaviors can be affected by race-based stress (59: +2), and they believe weighing more could act as emotional protection for those whose bodies have been violated (15: +3). They also acknowledge that medical professionals may ignore eating concerns in people of color (58: +1). *Body Positivists* overall disagree with labeling food healthy or unhealthy (20: -3). Two participants commented, "Portion control is key but some foods are definitely healthier than others" (Participant 18), and "foods are just more or less nutrient dense"

(Participant 17). Regarding food addiction (22: +3), Participant 17 described in her post-sort interview:

> I do believe people kind of can be addicted to food, strictly as kind of the same reason why they would be addicted to substances or whatever. It's a coping mechanism. It is a comfort. I know in my own personal thing, that when I was in my BED [Binge Eating Disorder] active, there were certain food that I would binge on that were addictive foods for me because of the way my body reacted and because the power behind those foods of having them been restricted in the past. So I really feel that they can, it can be like a drug of choice for some people.

According to *Body Positivists*, exercise is like punishment for some people trying to maintain their smaller bodies, but it really is for enjoyment (41: +3), a joyful movement. *Body Positivists* share a perspective that bodies should be celebrated for how amazing they are and all they do to sustain life (42: +6) without focusing on what they look like, especially since beauty standards are unrealistic (45: +5; 30: -2). Participant 18 stated, "Our bodies are amazing and the focus shouldn't be on weight." This group eschews the idea that beauty is limited to smaller bodies (33: -33) or that White women must be in smaller bodies than Black women for social acceptance (32: -5). Participant 3 noted about Statement 32 (White women need to be thinner than Black women to be socially accepted), "This is a social construct that many individuals believe; however we should not be setting standards for acceptance [of that construct]." There is some idea that Black women have more body acceptance in their racial community than White women, but *Body Positivists* believe "all women are under pressure to be thinner" (Participant 11).

Body Positivists reject the idea that body size is linked to sexual orientation (60: -4), and they do not accept body size as an indicator of likeability (29: -5) either.

As *Body Positivists*, counselors can help clients reject harmful societal notions and stereotypes about bodies and instead love themselves and their bodies through all seasons of changes, helping them reframe their body narrative. Participant 16 stated, "Why is change needed? Loving yourself to accept yourself is ideal." Participant 11 noted, "Not all clients are in therapy to lose weight. Counselors should encourage clients to love themselves through every stage, season, and size of life…[and this] can be helpful." Additionally, people can wear what they want regardless of their body size (30: -2). "All bodies are beautiful," said Participant 3. *Body Positivists* demonstrate a perspective regarding body size and shape that emphasizes body positivity and simultaneously includes medical views of higher body weight as problematic and some personal desire and support for weight loss. This factor accounted for 47% of the study variance.

Factor 2 – Body Liberators

Factor 2 has an EV of 3.00 and explains 12% of the study variance. Four of the twenty-four participants were significantly associated with this factor perspective named *Body Liberators*. Factor 2 participants' background data and Q sort weighting are described in Table 11. All participants loaded on this factor were White and reported female gender at birth. Two participants identified as female and two as non-binary. They ranged in age from 25 – 49, with an average age of 33.75. Participants loaded on this factor had either one – six months of experience or two – three years of experience. All participants who loaded on this factor reported a history of weight loss attempts and

either a history of a suspected or diagnosed eating disorder (*n* = 2), being discriminated against due to body weight (*n* = 1), or both an eating disorder and discrimination (*n* = 1). Three participants reported no current weight concerns, and one cis-gender female reported trying to maintain her weight. Two of the participants reported either specialized training in fat liberation (*n* = 1) or interest, reading, and research in the topics of fat liberation and Health at Every Size (HAES) (*n* = 1). This latter participant (Participant 9) commented:

> While I have not had specialized training, I have done a tremendous amount of reading around HAES, Fat liberation, etc. I have given several presentations on this throughout my time in graduate school and did a semester-long independent study class where I designed a curriculum for how to integrate fat affirmation with counseling.

Another participant who loaded on this factor has worked in eating disorder treatment, which included body image concerns, body positivity, HAES, and acceptance of all foods.

Statements rated highest and lowest and statements rated higher and lower than in other factors are shown in Table 12, along with distinguishing statements for the factor. This quantitative data provided the first view to explain the attitudes and beliefs of *Body Liberators*. Statements noted as distinguishing factors were examined first as standalone statements and then in the context of the entire factor. Participants' Q sort weighting was used to create a composite Q sort for *Body Liberators*, shown in Figure 4. The quantitative data with a composite view and participants' qualitative information provided the basis for the narrative of Factor 2, *Body Liberators*.

The perspective of *Body Liberators* is that counselors should provide identity-affirming, fat-affirming therapy (52: +5) and hold space for clients without participating in the diet culture of weight loss (44: +4), either for themselves (51: +4) or their clients (2: -6). Participant 9 described the counselor's role in providing fat-affirming therapy:

> It is trauma work… equivalent to working with a queer person with queer-affirming counseling rather than trying to use conversion therapy…Body size is such a salient identity and fat people face so much traumatic rejection and discrimination. Anti-fat oppression exists in our most intimate social spaces as well as our biggest most powerful institutions…If counselors are going to address the needs of their clients they are going to have to be able to contextualize their client's experiences through the lens of anti-fat oppression. They must recognize (at least start to recognize) just how ubiquitous and how deeply impactful to the psyche of fat people that oppression is. And in order to do that they have to know that fat people actually deserve to be treated better than they are. They have to be able to see the oppression.

Body Liberators believe in no way is supporting dieting appropriate for counselors to use with clients (2: -6), and not only are counselors not obligated to address higher weights in clients, but they should work to fight the prevalent culture that says people should be thin (29: +1). According to Participant 22, "Diet culture is absolutely a cult that profits on overpriced foods and people's insecurities, diet culture created via marketing and body shaming."

Body Liberators proclaim that diet culture upholds White supremacy (53: 5), healthism, ableism, and anti-fat bias. Participant 6 described the connection between diet culture and White supremacy in this way:

> Diet culture is a force of ableism and fatphobia which are closely tied to and uphold white supremacy. Being disabled is used as an excuse to disregard people as unworthy of care or even life and tying fatphobia to health facilitates easier discrimination of black people because it is used as an excuse for the violence black people face (i.e. medical neglect is disguised as telling someone to lose weight and that will solve their problem or denying care until someone loses weight).

Participant 9 also provided insight into the *Body Liberators'* view that diet culture upholds White supremacy:

> I see the way diet culture promotes white supremacist values such as the desire to discipline one's body rather than experience embodiment. There is a split between the body as object/project to be dominated and beaten into submission. That is seen as right and good. And the tendency to feel righteous in doing that to oneself normalizes the idea that it is okay to dominate and beat other (black and brown) bodies into submission using violent means…Diet culture pressures people to ignore their body's cues. Push through pain. Normalize deprivation. Neglect yourself. A (white) culture that sees those as normal will have a hard time being horrified at the deprivation neglect and pain of others (folx of color). Diet culture limits white people's capacity for empathy or solidarity. It also offers so many

> opportunities to marginalize folx of color without talking about race. (Using eating habits or body size as a proxy for other forms of discrimination.)

Body Liberators believe counselors should advocate for fat liberation rather than participate in the oppression of fat people (49: +3). Participant 6 expanded on this idea:

> Complacence is violence and harm especially in a field where we are given significant influence and power over individuals that needs to be regarded with care and we have a responsibility to be actively deconstructing the way in which forms of oppression are integrated into our education training and practice.

For *Body Liberators,* it is appropriate to use the word fat (8: +1), perhaps to reclaim the use of the word in the spirit of fat liberation and to remove its negative connotations. *Body Liberators* recognize weight-related microaggressions are harmful to clients (50: +6), and they think counselors pursuing weight loss for themselves are harming clients in all bodies (51: +4).

Body Liberators acknowledge people use diets in an attempt to improve health, but they believe diets are unhealthy (25: -1), do not make you feel better (26: -1) in the long run, and do not even work for weight loss (27: +3). For example, Participant 22 noted, "Cutting something out only makes the body and mind more scared that you will be unable to feed yourself leading to more unhelpful "crash diet" behaviors." For *Body Liberators*, diets reinforce the idea that larger bodies are not okay. *Body Liberators* affirmed that bodies would naturally grow larger again after dieting (35: +1) due to bodies' weight set points, and eating behaviors and body image are also affected by race-based stress (59: +2) and sexual orientation (37: +2). *Body Liberators* see much social pressure to conform to an unrealistic thin ideal (24: +5), resulting in an obsessive culture

of watching what one eats all the time (23: -3) and weighing oneself regularly to avoid gaining weight (24: -4), which is cultlike (54: 0).

In the *Body Liberator's* viewpoint, people have a right to live in the bodies they have (10: -3) without criticism as being lazy (12: -5), noncompliant (17: -4), unhealthy (9: -1), or addicted to food (22: -1), and that goes for counselors too (28: -3). Unfortunately, though, in American culture, thin bodies are prized. Those living in smaller bodies are deemed more likable (29: +1), and most larger-bodied persons are dissatisfied with themselves (14: +1) in this "culture that is ashamed of [fat bodies] and pathologizes [them]" (Participant 9).

Body Liberators believe it is harmful to those living in larger bodies to be pathologized as diseased (5: -4) or have their bodies commented on (31: -5). Obesity "is not a disease," stated Participant 6, and complimenting weight loss "reinforces the idea that they weren't okay or good before the weight loss," according to Participant 10. Participant 10 went on to state, "I think [complimenting weight loss] should be avoided unless it's a client's specific goal and the feedback is really more about praising them for reaching their goal." This mixed view about praising a client for reaching a weight loss goal may contradict other participants' perspectives. For example, Participant 9 wrote about complimenting weight loss, "This just simply reveals that the person complimenting rejects fatness. It reinforces the fundamental harms of anti-fat attitudes and oppression. Also triggers and reinforces eating disorders." Participant 22 also eschewed commenting on weight loss, stating, "No one needs to be commenting on anyone's bodies about anything. Unless it is something they can alter right then and there (i.e., something in their teeth)." Participant 10 described, "I do not believe it is my job at

all to focus on my client's weight. Unless their goal is to lose weight for mobility or health. Even then I'm going to encourage them to still love and accept themselves". So, *Body Liberators* can meet clients where they are while holding a fat-affirming view.

Body acceptance for all size bodies is a crucial message of *Body Liberators.* This group expressed BMI does not define health (1: -2), and weight is irrelevant (24: -4). There is no ideal body weight (40: 0) or singular definition of health (37: 0). For *Body Liberators*, all bodies are beautiful (47: +3) and worthy, regardless of what they can or cannot do (42: 0). *Body Liberators* believe counselors should stand against the cultural tide that promotes the thin, fit appearance ideal, healthism, and ableism, and as such marginalizes persons. For *Body Liberators*, counseling advocacy around weight and bodies is critical. According to *Body Liberators*, counselors should actively work toward fat liberation. This factor accounted for twelve percent of the study variance.

Factor 3 – Body Choosers

Factor 3 has an EV of 1.28 and explains 5% of the study variance. Four of the twenty-four participants were significantly associated with this factor. Table 13 depicts the demographic data and Q sort weights for Factor 3, called *Body Choosers*. Two participants were White, cis-gender females, one African American, cis-gender female, and one White, cis-gender male. Three participants reported birth years with an approximate age range of 25 – 60 years and average age of 38.7 years. One participant declined to provide her birth year. Counseling experience in this factor ranged from seven to twelve months to two to three years. All *Body Choosers* reported a history of weight loss attempts; one also reported a history of discrimination and a diagnosed or suspected eating disorder. The male participant reported trying to maintain his current weight, and

all females in this group are currently trying to lose weight. In the post-sort interview, Participant 15 described his history with weight loss as sports related. No participants indicated specialized training or work with eating disorders, body image concerns, HAES, body positivity, Intuitive Eating, or fat liberation.

Table 14 and Figure 5 provide Factor 3 quantitative data that defines this factor. The distinguishing statements and the statements ranked higher and lower than in other factors provided the structure for the interpretation. Then, reviewing participants' comments helped fill in the unique narrative and clarify the central theme around independence and choice for clients and counselors alike.

According to *Body Choosers*, beauty standards are unrealistic (45: +5), but there is a lot of social pressure to conform to the thin, fit appearance ideal: "As a society, we have always had pressure. 24 hour media/social media makes it even more pervasive," noted Participant 21. *Body Choosers* do not find obese people to be sexually attractive (47: -4), and they find leaner bodies are more beautiful (33: 0). *Body Choosers* believe fat people overeat (16: +3) and that people can be addicted to food (27: +4). *Body Choosers* acknowledge some people's eating can be affected by race-based stress. Participant 8 noted, "There are unique stressors that can lead to over or undereating in minority races." Otherwise, they believe food consumption is a choice, and people should not overeat (6: 0). *Body Choosers* believe people are responsible for their body size, and parents are responsible when their children are in larger bodies (13: +1).

For *Body Choosers,* exercise is multi-purposed, not just for enjoyment (41: -2) or solely to control weight (21: -3). They believe it is important for individuals to love their bodies as they are (43: +3) and, at the same time, love themselves enough to change their

bodies (7: +1). *Body Choosers'* perspective is that people can accept their bodies and still want to change them, and they reject the notion that people should be encouraged to accept their bodies without changing them (48: -4). Participant 15 commented on Statement 48 that people of all sizes should be encouraged to accept their bodies without changing them, "Without changing them is the problem here. You can accept your body and still desire healthy change." *Body Choosers'* opinions are that they should not just accept fat bodies (48: -4; 49: -4). Health is not necessarily determined by BMI or whether someone is overweight, but BMI is part of the picture (3: 0; 37: 0; 38: 0). Participant 1 commented:

> I was always stick thin until I started SSRIs which have put me at an "unhealthy" weight. It does appear to be my set weight, though - as in nothing I eat or no matter how much I exercise, seems to change that. So I'm certainly familiar with the struggle. But I don't *feel* healthy at this weight, which to me, means it should be fine that I try to lose weight. Study after study shows that increased weight, after a certain point, leads to all kinds of negative health outcomes. Granted, it's possible that some other health-related issue led to the increased weight in the first place, as is my concern for myself.

So, in the opinions of *Body Choosers*, diet culture serves a purpose (54: -1), but they do not support dieting to the extreme. They generally believe diets work (27: -1), are not inherently unhealthy (36: -1), and can be done healthily (25: +4). Participant 15 commented in the post-sort interview:

> Multi-marketing schemes with like get this green powder to detoxify…with vague promises…that stuff seems kind of extreme but just the sense of healthy foods

> could lead to better health like, if that's what we mean by diet, then that's not [cultlike] and there's plenty of diets that seem to be more reasonable.

Body Choosers believe counselors can help clients heal their relationships with their bodies and hold space for them without focusing on weight loss (55: +5; 44: +5) and do not believe it is appropriate for weight loss to be a treatment goal (2: -2) unless a client wants help with it, such as in motivation. *Body Choosers* do not set weight loss as a treatment goal but support weight loss for clients and themselves. Several participants commented on this idea. Participant 8 noted:

> It is not the counselors job to help the client to lose weight; clients should be under the care of a medical doctor for weight loss. However, we can help the client understand and if necessary change their relationship with body.

Participant 1 responded to Statement 44 (Counselors can hold space for clients without helping them lose weight):

> I set treatment goals collaboratively with clients. If they weigh 500 lbs but that's not impacting their life why would I focus on it in treatment? On the other hand if one of the reasons they're in my office has to do with body image issues we'd address what health looks like to them.

Body Choosers seem to hold a view that changing one's body is part of self-love (7: +1) and pursuing health, and also that body image and one's relationship with their body can be improved by or in parallel to weight loss.

Body Choosers think clients may live in larger bodies as emotional protection (15: +3). Additionally, this factor expressed an opinion that body image is not affected by sexual orientation (57: -1), and they do not assume Black women are necessarily happy

with their bodies (56: -3). This group does not endorse calling someone fat (8: -6), and *Body Choosers* believe clients are harmed by microaggressions about their weight (50: +6). They also reject the idea that people must be thin to be liked (29: -5), and they do not think being overweight means someone is lazy (12: -5). Participant 21 noted, "There are many causes to obesity. It is not a counselor's job to judge clients like this [as lazy]." Regarding Statement 18, that being around fat people is uncomfortable, Participant 8 responded, "This is absurd. "Fat" people are human beings; their size does not affect others."

Body Choosers believe counselors' body sizes and appearance (28: -3) and personal weight loss pursuits (51: -5) are irrelevant to their work with clients. From their perspective, they are not harming anyone with their own weight goals (51: -5) and certainly are not oppressing fat people (49: -4). In fact, *Body Choosers* may not either understand or align with the concept of fat liberation. Participant 1 responded to Statement 49 (If you aren't actively working on the liberation of fat people, you are participating in their oppression):

> I don't even know what this means. Are fat people in America somehow not liberated? Do I need to pay more for my plane ticket in order to allow a fat person to get two seats for the price of one to liberate them or does this question imply something different? Not to sound harsh but America is literally home of the free i.e. liberated.

Participant 15 discussed in the post-sort interview that he used to be more critical of persons in larger bodies and HAES than he is today. He attributed his former attitudes to the online media he was consuming and mirroring the beliefs of an online community,

but his perspective has changed. He described this change process occurring through maturity and the influence of his CMHC master's program:

> Racism, classism, and fat phobia, all that stuff kind of just went together where I was like, I basically was like, there are power structures…[and] now I'm like a lot more critical of these things in general. I like to think I've reformed my ways since my teenage years... It's a little different, because it's obviously the only difference is that weight is a little more changeable than something like race, right?

Body Choosers also expressed clear opinions about their own weight loss and desires to change their bodies. Participant 21 commented, "Counselors are also humans. They get to decide if their body is doing what they want to be able to do or if they want to pursue changes." Participant 1 expressed a similar sentiment, "If I'm discontent with my body weight I should be allowed to work to lose weight without somehow harming my clients. I can place my values on hold to work with my clients' values." For *Body Choosers* their weight goals are personal. In this factor, weight is conceptualized as the counselor's and client's choices. Factor 4 accounted for 5% of the study variance.

Factor 4 – Body Changers

Factor 4 has an EV of 1.11 and explains 5% of the study variance. Table 15 contains the demographic data and Q sort weighting in Factor 4. Two of the twenty-four participants were significantly associated with this factor perspective named *Body Changers*. Both participants loaded on the factor *Body Changers* identified as Black, cis-gender females with one – two years of counseling experience. One participant reported her birth year with an approximate age of 26, and the other declined to provide her birth

year. One participant loaded on this factor has a history of weight loss attempts, and both are currently trying to lose weight. Neither reported histories of weight-based discrimination, eating disorders, specialized training or work in eating disorder treatment, body image concerns, HAES, body positivity, Intuitive Eating, or fat liberation.

Quantitative data for Factor 4 *Body Changers* is shown in Table 14 (Q sort weighting by participant loaded on the factor) and Table 15, with the highest and lowest ranked statements. Table 1 also notes statements that distinguish this factor from other factors. Participants loaded on this factor provided minimal qualitative data for interpretation. The highest weighting Q sort, from Participant 24, included no comments, only demographic information. The weighting of Participant 24 was 16.91 as compared to 6.37 for Participant 13. Participant 13 only provided comments such as "I agree," "I do not think so," and "I know this is incorrect," specifically in response to Statement 8 that it is acceptable to call others fat. Neither participant opted in to an interview. Therefore, the interpretation of the factor is primarily based on the quantitative data.

Along with the data in Table 15, I used the compositive view of Factor 4, shown in Figure 6, to guide interpretation. I noted that Statement 50, "Weight-related microaggressions harm clients," is a distinguishing factor at $P < .01$ for this factor. Still, it is not rated higher or lower than in other factors, so it is not presented in Table 14. Additionally, I looked at the correlations of Q sorts between Factor 4 and other factors to provide more context for the interpretation. Participant 24, who weighted most heavily in this factor, negatively correlated with Participant 3, who loaded on Factor 1, *Body Positivists*, and Participants 6 and 9, who both loaded on Factor 2, *Body Liberators.* Reviewing Participant 24's Q sort alongside the quantitative and qualitative data of the

counter-perspectives of Participants 3, 6, and 9 information helped define the positioning of Participant 24 and the overall narrative for the *Body Changers* factor.

According to *Body Changers,* obesity is a chronic disease (5: +3) and should be addressed by healthcare providers (4: +3). *Body Changers* believe people should dress for their body shapes (30: +4) and love themselves enough to change their bodies (7: +1; 10: 0). They disagree that beauty standards are unrealistic (45: -1), believe weight loss should be complimented (31: +4), and it may be okay to use the word fat (8: +1) in some instances.

For *Body Changers,* there is not anything immoral about overeating (6: -6) or uncomfortable about being around fat people (18: -5). It is clear, though, that some foods are unhealthy (20: +6) according to this viewpoint. *Body Changers* believe losing weight helps people feel better (26: +2) and that people are healthier when they have a BMI in the normal range (1: +1). *Body Changers* agree that people's bodies should be celebrated for what they do (42: +5), and being at a weight to live a normal, healthy life is the ideal body weight (40: +5; 46: -2). While *Body Changers* believe it is possible to be in a larger body and be "fit" (38: +4), they also expressed some people may need to diet to be healthy (11: +3) since not all body weights are healthy (9: +1). It is vital for *Body Changers* to watch what they eat to avoid weight gain (23: +2). Since *Body Changers* do not believe weight regain is due to a body's weight set point (35: -4), and they believe in the power of diets (27: -3), it seems *Body Changers* ascribe to a view that individuals are in control of changing and maintaining their bodies. It is also interesting to note *Body Changers* disagree that diet culture is part of White supremacy (53: -3). Body Changers believes that dieting can be done healthily (25: +5), and it is not inherently unhealthy to

diet (36: -3). *Body Changers* view exercise as for enjoyment (41: +3) and also for weight control (21: 0).

According to *Body Changers,* body image and weight have nothing to do with sexual orientation (57: -1; 60: -4) or emotional protection (15: -1). They also do not blame parents for children with larger bodies (13: -3). *Body Changers* believe Black women are typically happy with their body size and shape and do not have to be as thin as White women to be socially accepted (56: +3; 32: 2). Race-based stress can affect eating behaviors (59: +2), and eating concerns in people of color may be ignored by doctors (59: +4) rather than addressed as they should be (4: +3).

In the view of *Body Changers,* obese clients are not necessarily dissatisfied with themselves (14: -4) or lack the motivation to make lifestyle changes (19: -5). They believe healthcare providers are obligated to address weight with clients (4: +3), and counselors can play a role in addressing concerns of being overweight (55: -1; 2: 0) rather than just holding space for clients (44: -1) and affirming fat bodies (52: -4). With positive views of dieting (54: 0), *Body Changers* support dieting for clients and themselves (51: -5) to change body shape and size. This factor accounted for five percent of the study variance.

Consensus Perspectives

Consensus statements are those statements that were not significantly differentiated across the factors. In this study, 10 statements listed in Table 17 had minimal Z-score variance or differentiation, indicating viewpoints that were shared by all of the participants loaded on these factors. All four factors placed Statement 59 (Race-based stress affects eating behaviors) in the same location at +2. All factors strongly

disagreed with the view that obese clients are noncompliant with treatment recommendations (Statement 17), that overweight people are lazy (Statement 12), and that obese clients lack motivation to make lifestyle changes (Statement 19). The latter statement was more positive in Factor 3 with a rating of -2 as compared to -4 and -5 in the other factors, but still with minimal variance. Three of the four factors rated Statement 54 (Diet culture is a cult) at zero, and it is positioned at -1 in Factor 3. Participants who commented or completed a post-sort interview across Factors 1, 2, and 3 noted that they generally placed items in the zero position when they could see both sides of the issue. So, although there may be similar expressions of viewpoints across factors in the form of the statement Z-score, it cannot be assumed precisely the same and may be more complex. For that reason, consensus statements were included in the interpretation of each factor and were taken in context as part of the gestalt.

Factor Analysis Summary

Through the process of factor analysis, four factors were extracted and rotated. These four factors accounted for 69% of the unrotated factor variance. Although the percentage variance of each factor was noted, the individual percentage is irrelevant to the importance of the factor (Brown, 1980). Neither can the percentage variance accounted for by a factor nor the number of participants who loaded onto a factor be extrapolated to the population of novice counselors. Instead, each factor represents a distinct viewpoint within the population of novice counselors from CACREP-accredited CMHC master's programs practicing counseling in the SACES region. It is also possible that additional viewpoints exist among this group.

Chapter Summary

This chapter presented the results of the mixed methods Q study exploring novice counselors' attitudes and beliefs about body weight and shape. All study participants graduated within the last three years from a CACREP-accredited master's program in clinical mental health counseling (or a similarly described program) and are currently practicing counseling within the SACES region. Twenty-four participants completed the study, and seventeen loaded onto four factors described as *Body Positivists, Body Liberators, Body Choosers,* and *Body Changers.* Each of the four factors was analyzed and interpreted using quantitative data. The quantitative data used for the first round of interpretation included differentiating statements, statements ranked higher or lower than in other factors, defining statements ranked highest and lowest, and consensus statements. Additionally, a composite view of each factor was presented. Participants' qualitative data gathered in post-sort surveys and interviews were used to deepen and expand the interpretation of each factor in the second and final rounds of interpretation. The findings from this study have provided an exploration of novice counselors' beliefs and contributed to the existing literature about sizeism in mental healthcare.

Table 4

Demographics of Participants

Gender	Counts	Percentage
Female	21	88%
Male	1	4%
Nonbinary	2	8%
Other	0	
Race/Ethnicity		
White	19	79%
African American	1	4%
Black	3	13%
Multiple	1	4%
Experience Level		
1-6 months	9	38%
7-12 months	3	13%
1-2 years	6	25%
2-3 years	6	25%
Current Weight Behavior		
Trying to lose weight	13	54%
Trying to maintain weight	5	21%
No weight concerns	6	25%
Trying to gain weight	0	
Weight History		
Weight loss/attempts only	8	33%
Weight loss and Discrimination	4	17%
Weight loss and eating disorder	4	17%
Weight loss, discrimination, and eating disorder	3	13%
None reported	5	21%
Discrimination only	0	
Eating disorder only	0	

Note. Total Number of Participants P=24

Table 5

Correlations Between Q-sorts

P No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1	100	33	-8	13	5	-30	21	45	-28	-12	24	5	31	21	43	24	13	32	3	28	42	-19	28	16
2	33	100	40	56	48	28	79	57	35	43	59	64	68	64	55	55	57	56	67	62	63	44	57	44
3	-8	40	100	65	49	48	52	10	64	58	40	58	24	39	16	51	56	41	58	41	29	66	49	-8
4	13	56	65	100	39	43	65	31	51	54	60	74	40	52	42	60	62	52	73	49	57	59	61	14
5	5	48	49	39	100	41	53	13	49	36	45	38	50	43	18	50	52	39	57	34	36	35	39	26
6	-30	28	48	43	41	100	49	22	86	64	24	57	21	34	26	30	45	13	63	38	32	61	29	-7
7	21	79	52	65	53	49	100	47	57	61	65	72	58	64	55	60	66	55	79	65	61	58	71	25
8	45	57	10	31	13	22	47	100	16	27	23	49	45	40	66	47	41	36	36	40	64	21	44	26
9	-28	35	64	51	49	86	57	16	100	71	37	58	18	34	26	38	47	17	70	37	34	67	35	-10
10	-12	43	58	54	36	64	61	27	71	100	46	61	29	44	30	49	48	20	71	44	32	49	48	6
11	24	59	40	60	45	24	65	23	37	46	100	50	58	39	31	44	49	42	64	49	56	30	57	23
12	5	64	58	74	38	57	72	49	58	61	50	100	53	57	51	49	56	49	73	53	55	66	56	17
13	31	68	24	40	50	21	58	45	18	29	58	53	100	54	45	49	40	40	49	52	45	18	53	34
14	21	64	39	52	43	34	64	40	34	44	39	57	54	100	45	62	56	50	55	51	46	36	47	19
15	43	55	16	42	18	26	55	66	26	30	31	51	45	45	100	45	37	41	50	50	54	22	47	26
16	24	55	51	60	50	30	60	47	38	49	44	49	49	62	45	100	59	42	52	44	49	50	58	14
17	13	57	56	62	52	45	66	41	47	48	49	56	40	56	37	59	100	50	60	54	56	54	50	16
18	32	56	41	52	39	13	55	36	17	20	42	49	40	50	41	42	50	100	54	39	42	34	47	25
19	3	67	58	73	57	63	79	36	70	71	64	73	49	55	50	52	60	54	100	59	52	59	55	25
20	28	62	41	49	34	38	65	40	37	44	49	53	52	51	50	44	54	39	59	100	48	28	54	27
21	42	63	29	57	36	32	61	64	34	32	56	55	45	46	54	49	56	42	52	48	100	41	50	15
22	-19	44	66	59	35	61	58	21	67	49	30	66	18	36	22	50	54	34	59	28	41	100	34	-9
23	28	57	49	61	39	29	71	44	35	48	57	56	53	47	47	58	50	47	55	54	50	34	100	37
24	16	44	-8	14	26	-7	25	26	-10	6	23	17	34	19	26	14	16	25	25	27	15	-9	37	100

Table 6

Unrotated Factor Matrix

Participant No.	Factor Number							
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Factor 8
1	0.2212	0.758	0.1765	-0.262	0.1704	-0.1855	0.002	0.0408
2	0.8194	0.2967	-0.0837	0.0981	-0.0862	0.0473	-0.1106	-0.0954
3	0.6653	-0.4422	-0.1258	-0.345	0.0316	0.072	0.1601	0.0365
4	0.802	-0.112	-0.0074	-0.2447	0.1924	0.2252	0.0332	0.0434
5	0.6149	-0.1133	-0.4693	0.0014	-0.2842	-0.352	-0.2077	0.1755
6	0.5894	-0.5909	0.2101	0.3223	-0.0787	-0.1161	-0.1062	-0.0116
7	0.8961	0.0318	-0.0362	0.0494	0.0629	0.0099	-0.0168	-0.0684
8	0.5642	0.4448	0.5079	0.1515	-0.1714	-0.0049	-0.0068	0.1838
9	0.6512	-0.6328	0.1122	0.186	0.034	-0.1136	-0.0884	0.0546
10	0.6869	-0.3951	0.0515	0.2225	0.167	-0.0474	0.3074	0.031
11	0.6943	0.1144	-0.3089	-0.0482	0.4904	-0.1429	-0.1447	0.004
12	0.8304	-0.126	0.148	0.0547	0.0125	0.2337	-0.0447	-0.1374
13	0.6532	0.3672	-0.232	0.1669	-0.039	-0.2595	0.0002	-0.1977
14	0.7162	0.1273	-0.0254	-0.0728	-0.3329	-0.1039	0.2105	-0.3417
15	0.6147	0.3827	0.417	0.1975	-0.0376	0.0765	0.0294	-0.0412
16	0.7313	0.0673	0.0204	-0.253	-0.2311	-0.1895	0.3449	0.2228
17	0.7646	-0.0561	-0.025	-0.1992	-0.1531	-0.0691	-0.0576	0.1113
18	0.6207	0.2542	-0.1481	-0.3428	-0.1668	0.3439	-0.2035	-0.1939
19	0.8685	-0.1861	-0.0778	0.1514	0.0894	0.0929	-0.124	-0.0755
20	0.7057	0.1677	-0.0037	0.1663	0.1639	-0.0741	0.1278	-0.2751
21	0.7092	0.2649	0.2855	-0.1039	0.1426	-0.1485	-0.3278	0.2052
22	0.6487	-0.4865	0.1616	-0.2144	-0.1356	0.183	-0.1381	0.0878
23	0.7414	0.1835	-0.1291	0.0021	0.1931	0.1303	0.3198	0.2302
24	0.2744	0.4553	-0.4336	0.4782	-0.152	0.3669	0.0069	0.2889
Eigenvalues	11.34	3.00	1.28	1.11	0.82	0.78	0.69	0.63
% Explained Variance	47	12	5	5	3	3	3	3
Cumulative % Explained Variance	47	59	64	69	72	75	78	81

Note. All numbers were rounded to two decimal places.

Figure 2

Scree Plot

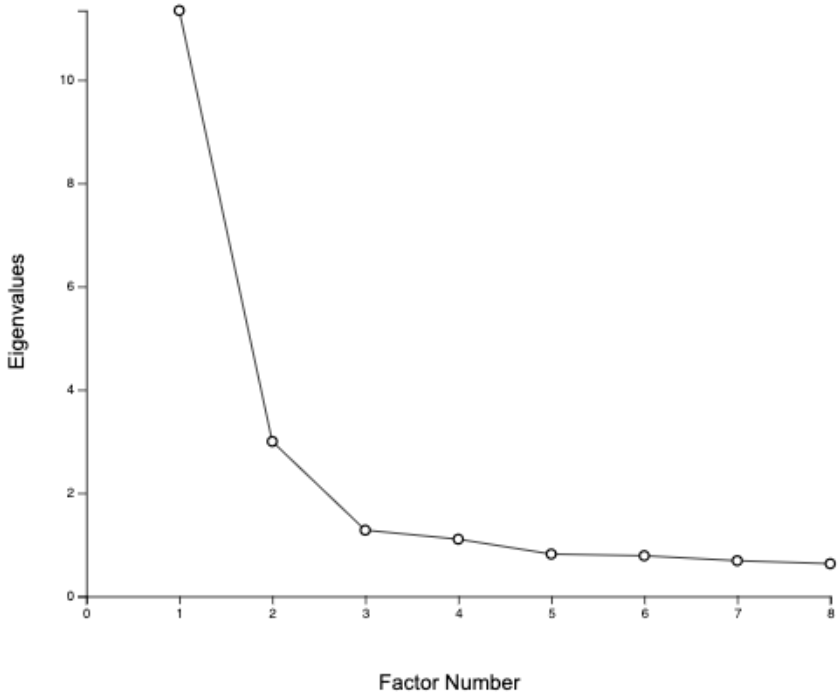

Table 7

Rotated Factor Loadings

Part. No.	Factor 1	Factor 2	Factor 3	Factor 4
3	**0.72**	0.50	-0.06	-0.07
4	**0.70**	0.38	0.27	0.08
18	**0.69**	-0.05	0.28	0.19
16	**0.65**	0.22	0.36	0.10
17	**0.65**	0.34	0.28	0.13
11	**0.59**	0.18	0.16	0.44
7	0.57	0.43	0.41	0.36
5	0.55	0.30	-0.10	0.46
14	**0.53**	0.23	0.37	0.26
23	0.52	0.21	0.35	0.40
2	0.50	0.21	0.50	0.49
6	0.10	**0.90**	0.13	0.04
9	0.27	**0.89**	0.05	0.02
10	0.28	**0.73**	0.16	0.18
22	0.52	**0.63**	0.12	-0.19
19	0.49	0.61	0.26	0.36
12	0.46	0.56	0.42	0.17
8	0.11	0.10	**0.87**	0.12
15	0.14	0.18	**0.80**	0.20
21	0.45	0.17	**0.66**	0.09
1	0.27	-0.53	**0.61**	0.09
20	0.35	0.29	0.44	0.40
24	-0.01	-0.10	0.14	**0.82**
13	0.39	0.07	0.36	**0.60**
% Explained Variance	23.00	20.00	16.00	11.00

Note. All numbers were rounded to two decimal places.
Participants flagged on each factor are bolded.

Table 8

Factor Array Sorted by Statement

Nm	Statement	Factor 1	Factor 2	Factor 3	Factor 4	Z-score variance
1	Normal range Body Mass Index (BMI) is healthy	-2	-2	-1	1	0.157
2	Weight loss is an appropriate treatment goal	-1	-6	-2	0	0.461
3	For most people, their Body Mass Index (BMI) is a good assessment of health risk	-3	-2	0	-1	0.197
4	Healthcare providers have an obligation to address weight with patients	1	-1	2	3	0.309
5	Obesity is a chronic disease	2	-4	2	3	1.066
6	Overeating is a sin (morally wrong)	-6	-5	0	-6	0.454
7	People should love themselves enough to change their body	-3	-2	1	1	0.364
8	It's acceptable to call others fat	-5	1	-6	1	1.078
9	A body's "weight set point" can be unhealthy	1	-1	0	1	0.116
10	People have a responsibility to maintain a fit body	-1	-3	-1	0	0.174
11	Some people diet to get healthy	1	2	2	3	0.066
12	Overweight people are lazy	-3	-5	-5	-2	0.116
13	It's parents' fault when their children are at a heavier weight	-1	-2	1	-3	0.396
14	Most obese people are dissatisfied with themselves.	0	1	0	-4	0.351
15	Weighing more can be emotional protection	3	0	3	-1	0.304
16	Fat people overeat	-4	-3	3	-2	0.847
17	Obese clients are often noncompliant with treatment recommendations	-3	-4	-3	-3	0.018
18	It's uncomfortable to be around fat people	-1	-3	-4	-5	0.225
19	Obese clients lack motivation to make lifestyle changes	-4	-4	-2	-5	0.156
20	There are healthy foods and unhealthy foods	-3	-1	4	6	1.642
21	The purpose of exercise is to control weight	-2	-2	-3	0	0.208
22	People can be addicted to food	3	-1	4	2	0.25
23	It's important to watch what you eat to avoid weight gain	-1	-3	1	2	0.469
24	it's important to weigh yourself regularly	-2	-4	-2	0	0.29
25	Diets can be done in a healthy way	2	-1	4	5	0.723
26	Losing weight helps you feel better	0	-1	1	2	0.045
27	Diets don't work	2	3	-1	-3	0.538
28	Having a fit body is important in the role of counselor	-1	-3	-3	-2	0.05
29	People need to be thin to be liked	-5	1	-5	-1	0.67
30	People should select clothes appropriate for their figure.	-2	0	3	4	0.73

Nm	Statement	Factor 1	Factor 2	Factor 3	Factor 4	Z-score variance
31	People should be complimented for weight loss	-2	-5	-2	4	1.131
32	White women need to be thinner than Black women to be socially accepted	-5	0	1	2	0.761
33	People who are lean are more beautiful than those who have other body types.	-4	-2	0	-2	0.305
34	People feel social pressure to conform to the thin, fit appearance ideal	1	5	5	0	0.363
35	Weight regain is due to the body's "weight set point"	0	1	0	-4	0.481
36	Dieting is unhealthy	0	2	-1	-3	0.56
37	Health is on a continuum	5	0	0	1	0.554
38	It's possible to be both fit and overweight/obese	5	3	0	4	0.368
39	Behaviors, not weight, make us healthy	4	1	1	1	0.183
40	Your ideal body weight is the weight that allows you to lead a healthy, normal life.	2	0	3	5	0.294
41	Exercise is for enjoyment	3	1	-2	3	0.474
42	Our bodies should be celebrated for what they do	6	0	2	5	0.758
43	It's important to love our bodies just as they are	2	1	3	2	0.081
44	Counselors can hold space for clients without helping them lose weight	4	4	4	-1	0.78
45	Beauty standards are unrealistic	5	4	5	-1	0.734
46	There is no ideal body	3	2	2	-2	0.486
47	Obese people are just as sexually attractive as nonobese people.	1	3	-4	0	0.678
48	People of all sizes should be encouraged to accept their bodies without changing them	3	2	-4	0	0.649
49	If you aren't actively working on the liberation of fat people you are participating in their oppression	-1	3	-4	-2	0.831
50	Weight-related microaggressions harm clients	4	6	6	1	0.423
51	If counselors are pursuing intentional weight loss they are harming clients of all body sizes	-2	4	-5	-5	1.468
52	A counselor's role is to provide fat affirming therapy	1	5	-1	-4	1.327
53	Diet culture upholds white supremacy	0	5	-2	-3	1.217
54	Diet culture is a cult	0	0	-1	0	0.063
55	Counselors can help clients heal their relationships with their bodies rather than try to lose weight	4	4	5	-1	0.548
56	Black women are happy with their body shape and size	0	0	-3	3	0.493
57	Sexual orientation affects body image	0	2	-1	-1	0.194
58	Eating concerns in people of color may be ignored by doctors	1	3	1	4	0.212
59	Race-based stress affects eating behaviors	2	2	2	2	0.017
60	Lesbians are heavier than other people	-4	-1	-3	-4	0.174

Table 9

Factor 1 Participants' Background Information

Part. No.	Gender	Approx Age	Race / Ethnicity	Experience	History	Current	Training	Sort Weighting within Factor	Follow-up Interview
3	Cisgender Female	27	White	1-2 years	Loss, ED	Maintain	ED Treatment, Body Image, HAES	10.00	No
4	Cisgender Female	24	White	1-6 months	None	Maintain	None Indicated	9.27	No
18	Cisgender Female	32	White	1-6 months	Loss, Discrimination	Lose	None Indicated	8.92	No
16	Cisgender Female	No Response	White	1-6 months	Loss, Discrimination	Lose	None Indicated	7.60	No
17	Cisgender Female	50	White	1-6 months	Loss, ED	No concern	None Indicated	7.60	Yes
11	Cisgender Female	49	White	2-3 years	Loss, Discrimination, ED	Lose	None Indicated	6.08	No
14	Cisgender Female	27	White	1-6 months	Loss	Lose	None Indicated	4.99	No

Note. All numbers were rounded to two decimal places

Table 10

Factor 1 Distinguishing Statements and High/Low Ranking Statements by Z score

Distinguishing Statements for Factor 1

Nm	Statement	Factor 1 Q-SV	Factor 1 Z-score	
37	Health is on a continuum	5	1.84	*
39	Behaviors, not weight, make us healthy	4	1.25	*
25	Diets can be done in a healthy way	2	0.55	**
52	A counselor's role is to provide fat affirming therapy	1	0.33	**
18	It's uncomfortable to be around fat people	-1	-0.54	**
30	People should select clothes appropriate for their figure.	-2	-0.71	**
51	If counselors are pursuing intentional weight loss they are harming clients of all body sizes	-2	-0.74	*
20	There are healthy foods and unhealthy foods	-3	-0.99	**
8	It's acceptable to call others fat	-5	-1.40	**
32	White women need to be thinner than Black women to be socially accepted	-5	-1.59	*

* Distinguishing statement at P<.01

**Distinguishing statement at P<.05

Stmt No.	Statement	Array Position
Highest Ranked Statements		
42	Our bodies should be celebrated for what they do	+6
Positive Statements Ranked Higher in Factor 1 Array than in Other Factor Arrays		
37	**Health is on a continuum***	**+5**
45	Beauty standards are unrealistic	+5
38	It's possible to be both fit and overweight/obese	+5
44	Counselors can hold space for clients without helping them lose weight	+4
39	**Behaviors, not weight, make us healthy***	**+4**
41	Exercise is for enjoyment	+3
48	People of all sizes should be encouraged to accept their bodies without changing them	+3
15	Weighing more can be emotional protection	+3
46	There is no ideal body	+3
59	*Race-based stress affects eating behaviors*	*+2*
9	A body's "weight set point" can be unhealthy	+1
54	*Diet culture is a cult*	*0*
Negative Statements Ranked Lower in Factor 1 Array than in Other Factor Arrays		
30	**People should select clothes appropriate for their figure****	**-2**
1	Normal range Body Mass Index (BMI) is healthy	-2
20	**There are healthy foods and unhealthy foods****	**-3**
7	People should love themselves enough to change their body	-3
3	For most people, their Body Mass Index (BMI) is a good assessment of health risk	-3
16	Fat people overeat	-4
60	Lesbians are heavier than other people	-4
33	People who are lean are more beautiful than those who have other body types.	-4
29	People need to be thin to be liked	-5
32	**White women need to be thinner than Black women to be socially accepted***	**-5**
Lowest Ranked Statements		
6	Overeating is a sin (morally wrong)	-6

Note. Distinguishing statements are indicated in bold. *P<.01. **P<.05. Consensus statements are indicated by italics.

Figure 3

Factor 1 Composite Q Sort

Table 11

Factor 2: Participants' Background Information

Part. No.	Gender	Approx Age	Race / Ethnicity	Experience	History	Current	Training	Sort Weighting within Factor	Follow-up Interview
6	Nonbinary	25	White	1-6 months	Loss, ED	No concern	Fat liberation	33.32	No
9	Nonbinary	32	White	1-6 months	Loss, Discrimination	No concern	None Indicated	29.95	Yes
10	Cisgender Female	49	White	2-3 years	Loss, Discrimination, ED	Maintain	None Indicated	10.88	No
22	Cisgender Female	29	White	2-3 years	Loss, ED	No concern	None Indicated	7.26	No

Note. All numbers were rounded to two decimal places

Table 12

Factor 2 Distinguishing Statements and High/Low Ranking Statements by Z score

Distinguishing Statements for Factor 2

Nm	Statement	Factor 2 Q-SV	Factor 2 Z-score	
53	Diet culture upholds white supremacy	5	1.77	*
52	A counselor's role is to provide fat affirming therapy	5	1.67	*
51	If counselors are pursuing intentional weight loss they are harming clients of all body sizes	4	1.24	*
49	If you aren't actively working on the liberation of fat people you are participating in their oppression	3	1.22	*
57	Sexual orientation affects body image	2	0.88	**
30	People should select clothes appropriate for their figure.	0	-0.05	**
20	There are healthy foods and unhealthy foods	-1	-0.27	**
60	Lesbians are heavier than other people	-1	-0.34	**
4	Healthcare providers have an obligation to address weight with patients	-1	-0.52	*
25	Diets can be done in a healthy way	-1	-0.58	*
5	Obesity is a chronic disease	-4	-1.51	*
31	People should be complimented for weight loss	-5	-1.58	**
2	Weight loss is an appropriate treatment goal	-6	-1.77	*

* Distinguishing statement at P<.01

**Distinguishing statement at P<.05

Stmt No.	Statement	Array Position
Highest Ranked Statements		
50	Weight-related microaggressions harm clients	+6
Positive Statements Ranked Higher in Factor 2 Array than in Other Factor Arrays		
53	**Diet culture upholds white supremacy***	**+5**
52	**A counselor's role is to provide fat affirming therapy***	**+5**
34	People feel social pressure to conform to the thin, fit appearance ideal	+5
44	Counselors can hold space for clients without helping them lose weight	+4
51	**If counselors are pursuing intentional weight loss they are harming clients of all body sizes***	**+4**
49	**If you aren't actively working on the liberation of fat people you are participating in their oppression***	**+3**
27	Diets don't work	+3
47	Obese people are just as sexually attractive as nonobese people.	+3
57	**Sexual orientation affects body image****	**+2**
59	*Race-based stress affects eating behaviors*	*+2*
36	Dieting is unhealthy	+2
35	Weight regain is due to the body's "weight set point"	+1
14	Most obese people are dissatisfied with themselves.	+1
29	People need to be thin to be liked	+1
8	It's acceptable to call others fat	+1
54	*Diet culture is a cult*	*0*
Negative Statements Ranked Lower in Factor 2 Array than in Other Factor Arrays		
40	Your ideal body weight is the weight that allows you to lead a healthy, normal life.	0
37	Health is on a continuum	0
42	Our bodies should be celebrated for what they do	0
22	People can be addicted to food	-1
26	*Losing weight helps you feel better*	*-1*
9	A body's "weight set point" can be unhealthy	-1
4	**Healthcare providers have an obligation to address weight with patients***	**-1**
25	**Diets can be done in a healthy way***	**-1**
1	Normal range Body Mass Index (BMI) is healthy	-2
10	People have a responsibility to maintain a fit body	-3
23	It's important to watch what you eat to avoid weight gain	-3
28	*Having a fit body is important in the role of counselor*	*-3*
17	*Obese clients are often noncompliant with treatment recommendations*	*-4*

Stmt No.	Statement	Array Position
24	It's important to weigh yourself regularly	-4
5	**Obesity is a chronic disease***	**-4**
31	**People should be complimented for weight loss****	**-5**
12	Overweight people are lazy	-5
Lowest Ranked Statements		
2	**Weight loss is an appropriate treatment goal***	**-6**

Note. Distinguishing statements are indicated in bold. *P<.01. **P<.05. Consensus statements are indicated by italics.

Figure 4

Factor 2 Composite Q Sort

Table 13

Factor 3: Participants' Background Information

Part. No.	Gender	Approx Age	Race / Ethnicity	Experience	History	Current	Training	Sort Weighting within Factor	Follow-up Interview
8	Cisgender Female	No response	African American	7-12 months	Loss	Lose	None Indicated	24.78	No
15	Cisgender Male	25	White	1-2 years	Loss	Maintain	None Indicated	15.55	Yes
21	Cisgender Female	60	White	7-12 months	Loss, Discrimination, ED	Lose	None Indicated	7.85	No
1	Cisgender Female	31	White	2-3 years	Loss	Lose	None Indicated	6.55	No

Note. All numbers were rounded to two decimal places

Table 14

Factor 3 Distinguishing Statements and High/Low Ranking Statements by Z score

Distinguishing Statements for Factor 3

Nm	Statement	Factor 3 Q-SV	Factor 3 Z-score	
20	There are healthy foods and unhealthy foods	4	1.26	**
16	Fat people overeat	3	1.03	*
13	It's parents' fault when their children are at a heavier weight	1	0.61	*
38	It's possible to be both fit and overweight/obese	0	-0.06	*
6	Overeating is a sin (morally wrong)	0	-0.15	*
52	A counselor's role is to provide fat affirming therapy	-1	-0.45	**
19	Obese clients lack motivation to make lifestyle changes	-2	-0.66	**
41	Exercise is for enjoyment	-2	-0.72	*
56	Black women are happy with their body shape and size	-3	-0.97	*
48	People of all sizes should be encouraged to accept their bodies without changing them	-4	-1.22	*
47	Obese people are just as sexually attractive as nonobese people.	-4	-1.24	*
8	It's acceptable to call others fat	-6	-2.17	**

* Distinguishing statement at P<.01

**Distinguishing statement at P<.05

Stmt No.	Statement	Array Position
Highest Ranked Statements		
50	Weight-related microaggressions harm clients	+6
Positive Statements Ranked Higher in Factor 3 Array than in Other Factor Arrays		
55	Counselors can help clients heal their relationships with their bodies rather than try to lose weight	+5
34	People feel social pressure to conform to the thin, fit appearance ideal	+5
45	Beauty standards are unrealistic	+5
44	Counselors can hold space for clients without helping them lose weight	+4

Stmt No.	Statement	Array Position
22	People can be addicted to food	+4
15	Weighing more can be emotional protection	+3
43	*It's important to love our bodies just as they are*	*+3*
16	**Fat people overeat***	**+3**
59	*Race-based stress affects eating behaviors*	*+2*
13	**It's parents' fault when their children are at a heavier weight***	**+1**
7	People should love themselves enough to change their body	+1
33	People who are lean are more beautiful than those who have other body types	0
3	For most people, their Body Mass Index (BMI) is a good assessment of health risk	0
6	**Overeating is a sin (morally wrong)***	**0**
Negative Statements Ranked Lower in Factor 3 Array than in Other Factor Arrays		
37	Health is on a continuum	0
38	**It's possible to be both fit and overweight/obese***	**0**
57	Sexual orientation affects body image	-1
54	*Diet culture is a cult*	*-1*
41	**Exercise is for enjoyment***	**-2**
21	The purpose of exercise is to control weight	-3
56	**Black women are happy with their body shape and size***	**-3**
28	*Having a fit body is important in the role of counselor*	*-3*
48	**People of all sizes should be encouraged to accept their bodies without changing them***	**-4**
47	**Obese people are just as sexually attractive as nonobese people***	**-4**
49	If you aren't actively working on the liberation of fat people you are participating in their oppression	-4
12	*Overweight people are lazy*	*-5*
29	People need to be thin to be liked	-5
51	If counselors are pursuing intentional weight loss they are harming clients of all body sizes	-5
Lowest Ranked Statements		
8	**It's acceptable to call others fat****	**-6**

Note. Distinguishing statements are indicated in bold. *P<.01. **P<.05. Consensus statements are indicated by italics.

Figure 5

Factor 3 Composite Q Sort

Table 15

Factor 4: Participants' Background Information

Part. No.	Gender	Approx Age	Race / Ethnicity	Experience	History	Current	Training	Sort Weighting within Factor	Follow-up Interview
24	Cisgender Female	26	Black	1-2 years	None	Lose	None Indicated	16.91	No
13	Cisgender Female	No Response	Black	1-2 years	Loss	Lose	None Indicated	6.37	No

Note. All numbers were rounded to two decimal places

Table 16

Factor 4 Distinguishing Statements and High/Low Ranking Statements by Z score

Distinguishing Statements for Factor 4

Nm	Statement	Factor 4 Q-SV	Factor 4 Z-score	
20	There are healthy foods and unhealthy foods	6	2.29	**
31	People should be complimented for weight loss	4	1.27	*
56	Black women are happy with their body shape and size	3	1.02	**
50	Weight-related microaggressions harm clients	1	0.33	*
2	Weight loss is an appropriate treatment goal	0	0.14	**
24	it's important to weigh yourself regularly	0	0.11	**
55	Counselors can help clients heal their relationships with their bodies rather than	-1	-0.07	*
45	Beauty standards are unrealistic	-1	-0.4	*
44	Counselors can hold space for clients without helping them lose weight	-1	-0.58	*
46	There is no ideal body	-2	-0.72	*
14	Most obese people are dissatisfied with themselves.	-4	-1.16	*
35	Weight regain is due to the body's "weight set point"	-4	-1.34	*
52	A counselor's role is to provide fat affirming therapy	-4	-1.49	**

* Distinguishing statement at P<.01

**Distinguishing statement at P<.05

Stmt No.	Statement	Array Position
Highest Ranked Statements		
20	**There are healthy foods and unhealthy foods****	**+6**
Positive Statements Ranked Higher in Factor 4 Array than in Other Factor Arrays		
40	Your ideal body weight is the weight that allows you to lead a healthy, normal life.	+5
25	Diets can be done in a healthy way	+5
58	Eating concerns in people of color may be ignored by doctors	+4
30	People should select clothes appropriate for their figure.	+4
31	**People should be complimented for weight loss***	**+4**
5	Obesity is a chronic disease	+3
11	*Some people diet to get healthy*	*+3*
56	**Black women are happy with their body shape and size****	**+3**
4	Healthcare providers have an obligation to address weight with patients	+3
41	Exercise is for enjoyment	+3
32	White women need to be thinner than Black women to be socially accepted	+2
59	*Race-based stress affects eating behaviors*	*+2*
23	It's important to watch what you eat to avoid weight gain	+2
26	*Losing weight helps you feel better*	*+2*
9	A body's "weight set point" can be unhealthy	+1
1	Normal range Body Mass Index (BMI) is healthy	+1

Stmt No.	Statement	Array Position
8	It's acceptable to call others fat	+1
7	People should love themselves enough to change their body	+1
21	The purpose of exercise is to control weight	0
2	**Weight loss is an appropriate treatment goal****	**0**
10	People have a responsibility to maintain a fit body	0
24	**it's important to weigh yourself regularly****	**0**
54	*Diet culture is a cult*	*0*
Negative Statements Ranked Lower in Factor 4 Array than in Other Factor Arrays		
34	People feel social pressure to conform to the thin, fit appearance ideal	0
55	**Counselors can help clients heal their relationships with their bodies rather than try to lose weight****	**-1**
57	Sexual orientation affects body image	-1
15	Weighing more can be emotional protection	-1
45	**Beauty standards are unrealistic***	**-1**
44	**Counselors can hold space for clients without helping them lose weight***	**-1**
46	**There is no ideal body***	**-2**
27	Diets don't work	-3
13	It's parents' fault when their children are at a heavier weight	-3
36	Dieting is unhealthy	-3
53	Diet culture upholds white supremacy	-3
14	**Most obese people are dissatisfied with themselves***	**-4**
35	**Weight regain is due to the body's "weight set point"***	**-4**
60	Lesbians are heavier than other people	-4
52	**A counselor's role is to provide fat affirming therapy****	**-4**
19	Obese clients lack motivation to make lifestyle changes	-5
51	If counselors are pursuing intentional weight loss they are harming clients of all body sizes	-5
18	It's uncomfortable to be around fat people	-5
Lowest Ranked Statements		
6	Overeating is a sin (morally wrong)	-6

Note. Distinguishing statements are indicated in bold. *P<.01. **P<.05. Consensus statements are indicated by italics.

Figure 6

Factor 4 Composite Q Sort

Composite Q sort for Factor 4

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
6. Overeating is a sin (morally wrong)	19. Obese clients lack motivation to make lifestyle changes	14. Most obese people are dissatisfied with themselves.	27. Diets don't work	49. If you aren't actively working on the liberation of fat people you	29. People need to be thin to be liked	21. The purpose of exercise is to control weight	37. Health is on a continuum	43. It's important to love our bodies just as they are	5. Obesity is a chronic disease	58. Eating concerns in people of color may be ignored by doctors	42. Our bodies should be celebrated for what they do	20. There are healthy foods and unhealthy foods
	51. If counselors are pursuing intentional weight loss	35. Weight regain is due to the body's "weight set point"	13. It's parents' fault when their children are at a heavier	33. People who are lean are more beautiful than those who have other body	55. Counselors can help clients heal their relationships	34. People feel social pressure to conform to the thin, fit appearance	50. Weight-related icroaggressions harm clients	32. White women need to be thinner than Black women to be socially	11. Some people diet to get healthy	30. People should select clothes appropriate for their figure.	40. Your ideal body weight is the weight that allows you to lead a healthy,	
	18. It's uncomfortable to be around fat people	60. Lesbians are heavier than other people	36. Dieting is unhealthy	46. There is no ideal body	57. Sexual orientation affects body image	2. Weight loss is an appropriate treatment goal	9. A body's "weight set point" can be unhealthy	22. People can be addicted to food	56. Black women are happy with their body shape and size	31. People should be complimented for weight loss	25. Diets can be done in a healthy way	
		52. A counselor's role is to provide fat affirming	53. Diet culture upholds white supremacy	16. Fat people overeat	15. Weighing more can be emotional protection	10. People have a responsibility to maintain a fit body	1. Normal range Body Mass Index (BMI) is healthy	59. Race-based stress affects eating behaviors	4. Healthcare providers have an obligation to address weight with	38. It's possible to be both fit and verweight/obese		
			17. Obese clients are often noncompliant with treatment	28. Having a fit body is important in the role of counselor	45. Beauty standards are unrealistic	24. it's important to weigh yourself regularly	39. Behaviors, not weight, make us healthy	26. Losing weight helps you feel better	41. Exercise is for enjoyment			
				12. Overweight people are lazy	3. For most people, their Body Mass Index (BMI) is a good assessment of	47. Obese people are just as sexually attractive as nonobese	8. It's acceptable to call others fat	23. It's important to watch what you eat to avoid weight gain				
					44. Counselors can hold space for clients without helping them lose	54. Diet culture is a cult	7. People should love themselves enough to change their					
						48. People of all sizes should be encouraged to accept their						

Legend

- Distinguishing statement at P< 0.05
- Distinguishing statement at P< 0.01
- ► z-Score for the statement is higher than in all other factors
- ◄ z-Score for the statement is lower than in all other factors
- Consensus Statements

Table 17

Consensus Statements – Do Not Distinguish Between Any Pair of Factors

Nm	Statement	Factor 1	Factor 2	Factor 3	Factor 4	Z-score variance
59	Race-based stress affects eating behaviors	2	2	2	2	0.02
17	Obese clients are often noncompliant with treatment recommendations	-3	-4	-3	-3	0.02
26	Losing weight helps you feel better	0	-1	1	2	0.05
28	Having a fit body is important in the role of counselor	-1	-3	-3	-2	0.05
54	Diet culture is a cult	0	0	-1	0	0.06
11	Some people diet to get healthy	1	2	2	3	0.07
43	It's important to love our bodies just as they are	2	1	3	2	0.08
9	A body's "weight set point" can be unhealthy	1	-1	0	1	0.12
12	Overweight people are lazy	-3	-5	-5	-2	0.12
19	Obese clients lack motivation to make lifestyle changes	-4	-4	-2	-5	0.16

Note. All numbers were rounded to two decimal places.

CHAPTER 5

DISCUSSION AND CONCLUSION

The purpose of this Q study was to explore the attitudes and beliefs of novice counselors toward body weight, shape, and size, including body image. This chapter summarizes the study findings and discusses the implications for the counseling field. Study limitations and suggestions for future research are also discussed in conclusion. The research question guiding the study was:

RQ1: What are novice counselors' from CACREP-accredited mental health counseling programs attitudes and beliefs about body weight and shape?

Summary of Results

Understanding counselors' attitudes and beliefs is vital as this is one of the four developmental competencies that span developmental domains in the Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts et al., 2016). Specifically, the developmental competencies are attitudes and beliefs, knowledge, skills, and action, and the developmental domains include counselor self-awareness, client worldview, the counseling relationship, and advocacy and interventions (Ratts et al., 2016). In particular, counselors' self-awareness of attitudes and beliefs is foundational for acknowledging personal limitations, defining their worldviews, attunement to clients' worldviews, and understanding how these views of self and the client impact the counselor-client relationships (Ratts et al., 2016). Since there is limited evidence of attitudes and beliefs about sizeism in counseling, this study aimed to establish a baseline exploratory study

with novice counselors who recently graduated from CACREP-accredited master's in CMHC programs and are practicing in the SACES region.

Feminist theory undergirded the study design, where particular attention was given to developing a robust concourse with diverse viewpoints around weight and body image. First, a feminist lens was used to challenge androcentric views (Wigginton & Lafrance, 2019) of health and body acceptance in the study design. Additionally, feminist social constructionism recognizes the power of language and purports that studying discourse "allows insight into the ways in which power manifests and is resisted" (Wigginton & Lafrance, 2019, p. 5). Thus, a social constructionist feminist view informed the development of the concourse from social discourse, balanced and representative Q statement selection, and abductive factor interpretation.

A specific example of how feminist theory guided the study is how the concourse was built using a broad perspective, including the voices of marginalized individuals. Then, a research team member with marginalized identity statuses as a Black female reviewed the concourse. From the concourse, 60 Q statements were chosen as the final Q set, and the final Q set was reviewed by another team member who is a White female. The post-sort survey included questions about identity statuses and personal and professional experiences with the topic. Participants were also invited to complete a virtual interview after completing the Q sort and survey, where they could expound upon their Q sorts in a semi-structured interview format. Factor interpretation included a comprehensive review of quantitative and qualitative data and included participants' voices in the narratives.

Twenty-four screened participants completed the Q sort, and five also completed virtual interviews via Zoom. The Q sorts were analyzed with KADE, a web-based software (Banasick, 2019), and post-sort survey data of demographics and comments were exported from the database of Q sorts to an Excel spreadsheet. Factors were extracted and selected for rotation primarily based on their EVs and the number of participants loading on the factor. Four significant factors emerged from the Q sorts. Seventeen of the 24 participants loaded onto one of the four factors, accounting for 69% of the study variance. These factors were interpreted through a series of review rounds, first using only quantitative data and then incorporating qualitative data. In the final interpretation, the four factors were named according to their distinctive viewpoints: Factor 1 – *Body Positivists*, Factor 2 – *Body Liberators*, Factor 3 – *Body Choosers*, and Factor 4 – *Body Changers*.

Discussion of Results

Consensus Statements

Four factors emerged from the Q study, each with a unique perspective. Additionally, 10 statements emerged as consensus statements with minimal variance across the factors. These consensus statements suggest some shared beliefs among participants, although with potentially different underlying motivations. In particular, two consensus statements point to similar perspectives that minority stress affects eating behaviors and a rejection of statements that negatively characterize people in larger bodies. This agreement is likely a result of participants' training in CACREP-accredited master's programs, where they would have learned about cultural diversity according to CACREP standards (2015) and unconditional positive regard.

Other consensus statements specific to weight loss, dieting, and body image represent topics that might not necessarily have been addressed in participants' counselor training. So the meaning of the consensus among factors is not as simply interpreted, especially disconnected from the overall composition of the factor. For example, statements affirming that losing weight helps people feel better, that it is important to love our bodies as they are, and that some people diet to get healthy were closely scored across the four factors. However, the motivation to rank statements similarly may differ across the factors (Brown, 1980), particularly given the diverse viewpoints of the factors around these topics. All of these statements, plus the consensus statement that diet culture is a cult, were interpreted in the context of each factor's composite Q sort and overall factor analysis. Hence, the consensus statement rankings have different meanings within different factors. As Watts and Stenner (2005) pointed out, Q method is a gestalt procedure, so we cannot break apart factors into individual statements. Instead, the factors point us to themes of interconnected ideas, and thus the consensus statements must be interpreted within the context of the factor.

Discussion of the Factors

Each factor expressed a distinctive viewpoint around weight, body size, and shape, with health, dieting, and oppression as fulcrums of their expression. Factor 1, named *Body Positivists*, expressed body acceptance, supporting loving bodies as they are, beauty in all bodies, and celebrating bodies for what they can do rather than how they look or what they weigh, aligning with their beliefs that societal beauty standards are unrealistic. Simultaneously, *Body Positivists* may endorse weight loss where they believe a higher body weight is linked to poor health. So, even as this group disagreed with Body

Mass Index (BMI) as a measure of health and weight loss as a treatment goal, they affirmed that healthcare providers should address weight with patients, that obesity is a chronic disease, and that a body's weight set point may be unhealthy. In these ways, *Body Positivists* may hold opinions aligned with the medicalization of fat (Farrell, 2011) and healthism (Crawford, 1980), along with elements of the body positivity movement.

Body Positivists' perspective is multidimensional and outside current definitions of body weight, body image, and fat studies. This factor does not fit in a purely weight normative model that aligns body weight with health since these participants eschew BMI as a measure of health and recognize persons in higher weight bodies can be healthy, but neither do they fit squarely in the camp of weight-neutrality (Calogero et al., 2019). Similarly, as much as *Body Positivists* demonstrate body positivity in their expressions of body acceptance and beauty standards, they do not clearly align with an expression of body positivity that seeks to change dominant narratives and promotes fat advocacy (Rothblum, 2012). Indeed, they believe counselors can pursue weight loss without harming clients and do not have to work on fat liberation. This expressed view is congruent with their current behavior, such that six of the seven participants who loaded onto this factor are either trying to lose weight ($n = 4$) or trying to maintain their weight ($n = 2$).

Given the overall viewpoint of *Body Positivists* and cultural norms, trying to maintain weight may be code for fatmisia (Forristal et al., 2021) aligned with healthism (Crawford, 1980) or fitnessism (Eriksson, 2022). Rupp and McCoy (2023) found that young women's participation in the body-positive movement was correlated with higher body dissatisfaction. Additionally, social media tagged as body positive on the social

media platform TikTok was found to be missing body-positive image themes more than 67% of the time (Harriger et al., 2023). Indeed, cultural influences to achieve and maintain thin privilege and so-called body-positive media focused on appearance (Rupp & McCoy, 2023) could partially explain this factor's current dieting practices. Altogether, this factor appears to be a unique viewpoint not described in the existing literature.

In contrast to Factor 1, Factor 2 clearly aligns with a social position of fat activism (Rothblum, 2012). Participants loaded on Factor 2, named *Body Liberators*, took a stronger position against diets and diet culture and supported counselors' roles in providing fat-affirming, liberatory care than did *Body Positivists*. *Body Liberators* acknowledged that people diet as a way to get healthy (a consensus statement), but clearly rejected diet culture and practice as well as commenting on others' bodies. *Body Liberators* disagreed that healthcare providers are obligated to address weight with patients, and their anchor of disagreement was with weight loss as an appropriate treatment goal. They voiced that sexual orientation affects body image and rejected the stereotype that it affects body weight. Like the other factors, *Body Liberators* affirmed that doctors may ignore eating concerns in people of color.

Body Liberators commented significantly about their Q sorts with a passion for supporting fat folks and rejecting a culture that promotes thinness as beautiful or a representation of health. Their view aligns with fat liberationists who recognize that the solution to fat oppression is not to change one's body to be accepted by society but to change the oppressive culture (Tovar, 2018). *Body Liberators* framed their position to denounce sizeism in the same vein as decrying other forms of marginalization, suggesting

they understand sizeism within a multicultural and social justice context. This factor rejected common myths and microaggressions about bodies and weight, demonstrating alignment with fat liberation (Rossignol, 2003) and the National Association to Advance Fat Acceptance's (NAAFA) recommendations for therapists (Bruno & Burgard, 2010). *Body Liberators'* position seems to contrast with the fatmisia beliefs Forristal et al. (2021) identified in counseling trainees from CACREP-accredited master's programs. Additionally, this factor connected their beliefs to their work as counselors, expressing that counselors cannot pursue weight loss or ignore fat liberation without harming clients. Moreover, unique among the factors is that none of the *Body Liberators* were currently trying to lose weight, demonstrating congruency between their expressed perspective and behaviors.

Additionally unique to this factor is that all *Body Liberators* had a history of discrimination due to body size, an eating disorder history, or both. It is also notable that of the 17 participants who loaded onto the four factors, the only two nonbinary participants both loaded onto this factor, which contained four participants in total. There may be a connection between participants' weight-based experiences as well as gender minority statuses and their liberatory positions. Indeed, *Body Liberators* seem to hold attitudes and beliefs consistent with body-related multicultural and social justice competencies (MSJCC) (Ratts et al., 2016). Further research may explore *Body Liberators'* development of this perspective and the corresponding role of counselor education and supervision. Additionally, it would be beneficial to investigate how this positionality of *Body Liberators* translates into knowledge, skills, and action, particularly

within the counseling relationship, advocacy, and interventions, according to Ratts et al.'s (2016) MSJCC model.

The overall viewpoint of Factor 3, named *Body Choosers*, starkly contrasted with *Body Liberators.* The *Body Choosers* group expressed a perspective that assigns individual responsibility for higher weights and obesity as a chronic disease that healthcare providers must address. *Body Choosers* believe counselors can hold space for clients and help them heal their relationships with their bodies without losing weight, particularly in light of pressure to conform to unrealistic beauty standards. At the same time though, this group holds a moralistic and stereotypical view of persons in larger bodies, believing fat people overeat and that overeating is morally wrong. The *Body Choosers'* perspective is reminiscent of the historical views of food and morality, rooted in morality and asceticism described by Strings (2019) and Griffith (1999).

Body *Choosers* rejected the idea that people of all sizes should be encouraged to accept their bodies without changing them. They also disagreed with the notion that counselors should provide fat-affirming care. So, while *Body Choosers* recognized that persons of size face stigma, they may be unaware they also hold views similar to other healthcare providers (Chrisler & Barney, 2017; Forristal et al., 2021; Miller et al., 2013; Pratt et al., 2014), that are also stigmatizing. For example, *Body Choosers* hold a popular but negative view that pathologizes obesity and conflates weight and health. Furthermore, *Body Choosers* rejected the idea of fat liberation and fat-affirming treatment for clients, which is salient since counselors are ethically charged with unconditional positive regard, beneficence, and social justice (ACA, 2014), especially because they hold power in the counseling relationship (Ratts et al., 2016).

Body Choosers clearly expressed that counselors should also be able to pursue their own weight loss, and they do not believe it affects their work with clients. This support for counselors losing weight without harming clients is congruent with their personal histories and professional education around body weight. All of the four female *Body Choosers* were currently trying to lose weight, and one male participant was trying to maintain his weight. Overall, *Body Choosers* endorse popular views of body weight and shape found in cultural sizeism and associated with weight bias. *Body Choosers* beliefs correspond with studies of implicit and explicit bias across medical (Miller et al., 2013; Puhl & Brownell, 2001; Sabin et al., 2012; Tomiyama et al., 2018), dietetics (Berryman et al., 2006; Harvey et al, 2002; Obara et al., 2018; Puhl et al., 2009), and mental health fields (Forristal et al., 2021; Pratt et al., 2014; Pratt et al., 2016; Veillette et al., 2018). Without developing body-based multicultural and social justice competencies, beginning with self-awareness and examining privileged and marginalized statuses as counselors and clients (Ratts et al., 2016), counselors who support this perspective may be at risk of reinforcing weight stigma and harming clients in counseling relationships.

Factor 4, named *Body Changers*, also expressed opinions that support obesity as a chronic disease, the need for healthcare providers to address weight, and pro-dieting behaviors. Unlike *Body Choosers*, however, *Body Changers* do not endorse the stereotype that fat people overeat or assign morality to overeating. The strongest agreement (+6) for *Body Changers* was that there are healthy and unhealthy foods (Statement 20), and this factor provided an overall view that is pro-dieting and avoiding weight gain. In contrast to the other three factors, *Body Changers* believe people should be complimented for weight loss, and they expressed a viewpoint that supports cultural

beauty standards and idealized bodies. *Body Changers* is the only factor that expressed disagreement with counselors holding space for clients and helping them heal relationships with their bodies without assisting them to lose weight. So, in the context of the overall viewpoint expressed by *Body Changers,* disagreement with that statement may include an idea that counselors should take an active role in helping clients change their body shape and size. These results suggest *Body Changers* hold weight bias and fatmisia, similar to Forristal et al.'s (2021) findings for counselor trainees. Weight bias and fatmisia are significant since weight bias is correlated with multiple adverse psychological and physical outcomes (Brochu, 2018; O'Brien et al., 2016; Vartanian & Porter, 2016; Tomiyama et al., 2018).

Uniquely, *Body Changers* also highlighted racial differences in social acceptance of Black women's bodies versus White women's, affirming that Black women can be in larger bodies than White women and still be accepted and that Black women experience satisfaction with body shape and size. Furthermore, *Body Changers* prioritized the statement that eating concerns in people of color may be ignored by doctors (Statement 58; +4). Both participants loaded on this factor were Black women currently trying to lose weight. Participants in other factors were primarily White, cis-gender females, and they may have been reluctant to agree with statements about identities outside of their own, such as statements referring to people of color or sexual orientation. For example, Participant 17 in *Body Positivists* commented in her interview about women of color, transgender persons, and how sexual orientation may affect body image, but she did not want to make "blanket statements" and described her comments as "secondhand experience, secondhand knowledge."

Factor Comparisons

Interestingly, *Body Positivists*, *Body Choosers*, and *Body Changers* all placed Statement 22 (People can be addicted to food) at similar levels of agreement. The agreement with the concept of food addiction within these factors is opposite the opinion of *Body Liberators,* who ranked this statement at -1. So, the idea of food addiction appears outside views of body-related liberatory consciousness among *Body Liberators.* Instead, it clusters with opinions of body weight as malleable and an individual choice, expressed among the other three factors. The belief that body weight is within individual control is found within healthism (Crawford, 1980) and fitnessism (Eriksson, 2022).

In three of the four factors, all except *Body Liberators*, there was some measure of support for clients' weight loss. In these three factors, nine of the 13 participants were actively attempting to lose weight, and three were trying to maintain weight, with only one participant across these factors reporting no weight concern. The prevalence of participants dieting is in contrast to *Body Liberators,* where three out of four expressed no weight concern, and one participant reported trying to maintain weight. The current behavior of weight management is significant given that in Puhl et al.'s (2014) study of weight bias among eating disorder treatment professionals, "those who reported currently trying to lose weight exhibited stronger weight bias and more negative attitudes and frustrations about treating obese patients compared to individuals not trying to lose weight" (p. 73). Furthermore, Swami et al. (2010) found in a study of weight bias among men and women that fear of becoming fat was a significant predictor of weight bias. Although this Q study did not ask participants specifically about their fears of becoming

fat, attempts to lose and maintain weight suggest some measure of avoiding fatness (Robinson, 1993). So, this is an area for further investigation among novice counselors.

In summary, the results of this study indicated that some novice counselors reject cultural sizeism and embrace fat liberation, and other groups endorse beliefs of cultural sizeism and weight bias that are connected with the medicalization of fat (Farrell, 2011; Strings, 2019), healthism (Crawford, 1980), and fitnessism (Eriksson, 2022). The effects of weight bias are psychological distress and internalized stigma (O'Brien et al., 2016), increased likelihood of anxiety, depressive and mood disorders (Tomiyama et al., 2018), weight cycling (Tomiyama, 2014), disordered eating behaviors (Brochu, 2018), poor health markers (Orpana et al., 2009; Wildman et al., 2008), and increased mortality risk (Flegal et al., 2005; Mann et al., 2007; Sutin et al., 2015). Given the inherent power imbalance of the counselor – client relationship, where the counselor holds power (Ratts et al., 2016), and the adverse effects of weight bias, novice counselors' expressing and upholding societal weight bias can be harmful to clients (Pratt et al., 2014; Pratt et al., 2016; Veillette et al., 2018). Therefore, incorporating anti-sizeist education, training, and supervision may help counselors work ethically with clients around topics of body image, shape, and size, as well as "honoring diversity…promoting social justice...and practicing in a competent and ethical manner" (ACA, 2014, p. 3). Indeed, the results of this study have implications for counseling practice, counselor education, and counselor supervision, in addition to implications for future research.

Implications

Implications for Counseling Practice

Counselors practice according to professional values and ethical principles for client welfare. The ACA *Code of Ethics* (2014) highlighted the significance of recognizing and respecting the "uniqueness of people within their social and cultural contexts" (p. 3). Additionally, counselors are called to promote equity and denounce injustices and oppression (ACA, 2014). A Key element for counselors to develop competence in these areas of multiculturalism and social justice is an ongoing investigation of their own identities and clients' worldviews (Ratts et al., 2016). However, issues of body weight and size discrimination may be new concepts for some counselors, as these topics are not typically included or discussed in depth in multicultural textbooks (Kasardo, 2019). So, novice counselors may not have been exposed to or have ever explored cultural sizeism. Ratts and Pedersen (2014) proposed a model of multicultural competence development in three stages: 1) counselor self-awareness, 2) knowledge, and 3) skills with application. Before applying this model, counselors need exposure to body size as a dimension of identity and sizeism as a realm of prejudice, discrimination, and marginalization. Results from this study demonstrated three distinctive points of view among novice counselors that contain aspects of sizeism, in addition to a perspective of fat liberation. Multiple viewpoints that endorse sizeist attitudes indicate a gap in the application of MSJCC to body weight and inclusivity. This finding aligns with the calls for sizeism to be taught as a component of multicultural counselor training (Bergen & Mollen, 2019; Calogero et al., 2019; McHugh & Chrisler, 2019; Rothblum & Gartrell, 2019).

Hence, this Q research provides an opportunity for education on sizeism, to discuss ongoing discrimination that persons of size in the US face across life domains (Brochu, 2018; Puhl & Brownell, 2001; Swami et al., 2010; Tomiyama et al., 2018), and to explore how practicing mental health counselors can hold biases that affect negatively affect clients (Forristal et al., 2021; Pratt et al., 2016; Puhl et al., 2014; Veillette et al., 2018). Notably, persons in the lowest weight bodies may also face discrimination (Swami et al., 2010), and those living in smaller bodies can display fat phobia as a fear of weight gain (van Amsterdam, 2013). This pressure to maintain a smaller body can manifest itself in shame and guilt, mental anguish, body dissatisfaction, and caloric restriction (Brochu, 2018; Puhl & Brownell, 2001; Puhl et al., 2008; Rukavina & Pokrajac-Bulian, 2006). The effects of sizeism on physical and psychological health are far reaching, and counselors are not immune to these ill effects. So, counselors examining the literature outlined in this study can bring sizeism to consciousness and spark the process of self-discovery.

Indeed, recognizing sizeism and its adverse effects in Western culture is just the beginning of the process for counselors. Next is making a personal connection, surveying one's own beliefs and potential biases on the topic. The results of this Q research advance this exploration by reporting counselors' attitudes and beliefs about critical components of sizeism and its antithesis. Indeed, the counselors in this Q study expressed four distinct views about weight and body image, one of liberatory consciousness and three others with distinct and varying attitudes about dieting behaviors, weight loss, body shape and size, and notions of health related to body weight that are all linked to sizeism and healthism. Novice counselors are likely to find their perspectives principally represented in one of the factors in this study, and counselors with experience beyond three years may

also identify with one or more factors that emerged in this research. Although this study did not quantitatively measure bias, it identified and described sizeist views along a spectrum that counselors can consider in the context of ethical imperatives (ACA, 2014) and their multicultural and social justice identity development.

Counselors can develop multicultural competence around body weight and image by continuing education, consultation, and supervision. A weight-inclusive approach can be developed by examining culture, evaluating data that includes weight-neutral health and wellness, and critical reflection on internal and external weight stigma (Calogero et al., 2019). Calogero et al. (2019) advised therapists to avoid repeating refrains of healthism, particularly reinforcing ideas of an obesity epidemic or praising weight loss. Alternatively, counselors may seek body-diverse media and spaces that reinforce the inclusivity of all bodies. Overall, counselors must continue to educate themselves with data on the harmful effects of sizeism and recognize, question, and challenge the forces of body-based oppression (Calogero et al., 2019).

Rothblum and Gartrell (2019) suggested training on appearance standards, weight terminology, and a weight-neutral stance that decouples weight from health to introduce sizeism in multicultural mental health training. Addressing cultural norms of appearance and their origins and decoupling weight from health cover the central topics of sizeism that arose in this research among novice counselors. Furthermore, Bergen and Mollen (2019) suggested those who train mental health providers should reflect on their own size privilege or marginalization as well as the size diversity in the audience. Counselors may seek trainers, supervisors, and consultants demonstrating fat advocacy and weight inclusivity. Trainers, consultants, and supervisors can broach size with counselors in a

way that invites reflection and dialogue around weight bias and simultaneously models an approach for counselors to use with clients. As counselors and supervisors strive for weight inclusivity, they must also curate environments in clinical settings that both accommodate all body sizes and affirm body diversity (Calogero et al., 2019; Rothblum & Gartrell, 2019).

Implications for Counselor Education

In addition to implications for practicing counselors, this research has implications for counselor education. Counseling theories and practice have evolved over the decades to include multiculturalism, often called the fourth force in counseling, and more recently, to a social justice paradigm, the fifth force (Ratts & Pedersen, 2014). However, the topics of body diversity, weight bias, and sizeism are typically missing from multicultural textbooks (Kasardo, 2019). For example, a search of Ratts and Pedersen's (2014) text on counseling for multiculturalism and social justice also revealed an absence of dialogue on weight bias, fat phobia, fatmisia, and sizeism. Counselors have an ethical imperative to provide culturally competent care to clients (ACA, 2014). Yet, they may be missing education regarding one of the most common forms of discrimination based on body size (Puhl et al., 2008). Weight bias has been documented among counseling students (Forristal et al., 2021). This study adds to the literature with the landscape of beliefs about weight and body among practicing counselors new to the field.

As the fourth and fifth forces of counseling advance, in concert with ethical standards inclusive of diversity and multicultural competency, it is critical to include body diversity and weight inclusivity. This Q study revealed some novice counselors

hold stereotypical beliefs, such as fat people eating more than other people and people being in larger bodies due to emotional issues or for protection (Bruno & Burgard, 2010), that may be harmful to clients. Counseling theory, education, and practice should include all areas of diversity and potential marginalization and address body size and shape similar to race, ethnicity, religion, and other identity elements. To train counselors to honor the "worth, dignity, potential, and uniqueness of people" and "[promote] social justice" (ACA, 2014, p. 3), counseling theories must be inclusive. This study provides a lens through which to view the current landscape of beliefs among novice counselors and how multicultural and social justice theory and education may need to shift further. Even critics of the social justice tradition who "argue that counseling should be a 'value-neutral' endeavor where counselors help clients achieve optimal health and well-being" (Ratts & Pedersen, 2014, p. 29) can benefit from understanding how some current beliefs are value laden and can harm clients and how more inclusive approaches support clients' physical and psychological health.

Counselor education is a multidimensional field encompassing teaching, supervision, advising and mentoring, research and scholarship, and service that often takes the form of leadership and advocacy within counselor education programs, higher education more generally, and the community (Atieno Okech & Rubel, 2019). Counselor educators are also responsible for gatekeeping, which begins in the admissions process (Ziomek-Daigle, 2019), and they may hold administrative positions with their programs or the institution at large (Hays, 2019). So, counselor educators are influential in developing the next generation of counselors and counselor educators, prioritization and publication of research and scholarship, the direction of the counseling field, and public

policy. As such, it is critical that counselor educators' professional identities and commitment to professional development are aligned with ethical codes and accreditation standards, including honoring diversity and promoting social justice and advocacy (Atieno Okech & Rubel, 2019; ACA, 2014).

This research explored attitudes and beliefs related to sizeism, an area of bias and discrimination often socially accepted, especially in the name of health. The medical model of care generally focuses on obesity as a disease and public health crisis (Centers for Disease Control [CDC], 2022b; Nuttall, 2015). This model promotes body shape and size as an individual choice and moral responsibility (healthism) and extols smaller bodies as healthier. Indeed, the wellness model of counseling, "rooted in a preventative perspective and values with connections to social justice and advocacy" (Kleist, 2019, p. 26), affords counselor educators a unique position to take a comprehensive view of health and wellness that accounts for the body-weight-based discrimination. Learning how sizeism negatively affects persons of all body sizes, particularly those in larger bodies, is important to recognizing weight bias and discrimination as areas for multicultural consideration and social justice.

Singh (2019) encouraged counseling faculty to "create a culture of shared accountability to diversity learning" (p. 74), continuing to identify opportunities for personal and collective growth. Counselor educators may consider their potential to hold weight bias, especially in light of studies that showed mental health professionals in other disciplines exhibited anti-fat bias (Brochu, 2019; Pratt et al., 2014; Pratt et al., 2016; Puhl et al., 2009; Veillette et al., 2018), as did counseling students (Forristal et al., 2021). In the process of ongoing development in MSJCC, counselor educators may consider their

own attitudes and beliefs (Ratts et al., 2016) as well as those of the students they teach, advise, and supervise. The results of this study provided four discrete, multidimensional perspectives of novice counselors who recently graduated from CMHC master's programs. Counselor educators can use these perspectives as a basis for considering their own attitudes and beliefs about weight and body image and how their perspectives may be similar to or different from students' views. Additionally, this study can provide insight into the need for additional student development in size diversity as a topic of MSJCC.

As counselor educators evaluate and build knowledge and skills around sizeism, they can address misconceptions and biases across domains of counselor education. In teaching and supervision, faculty can ensure future counselors and counselor educators are appropriately trained to work with clients and students of all body sizes. First, students can be educated in harm prevention, assuring nonmaleficence in approaches and interventions (ACA, 2014) to avoid contributing to the discrimination that persons of size face in seeking healthcare services (Amy et al., 2006; Balkhi et al., 2013; Giori et al., 2018; McPhail et al., 2016; Puhl & Brownell, 2001, Tomiyama et al., 2018). Students can also learn and apply size-inclusive screening, diagnosis, and treatment interventions. A helpful framework is Tylka et al.'s (2014) applied model of weight-inclusivity, which is appropriate for counselor educators and future and practicing counselors. The model is ethically and multiculturally grounded and spans personal life, clinical care, and public policy (Tylka et al., 2014). These domains, plus self-awareness and how a counselor's worldview can affect the client relationship and advocacy (Ratts et al., 2016), represent pertinent domains visible in the results of this study.

There are also online resources to support anti-sizeist counselor education. The Association for Size Diversity and Health (ASDAH) provides education and resources, including principles of Health at Every Size (HAES), that counselor educators and students may use in training and with clients. Additionally, the NAAFA is a resource to introduce students to social justice advocacy around size diversity and fat activism. Q pedagogy may be used as an activity to help students explore their positions around body size (Rieber, 2023) or even to generate and create a composite representation of weight-inclusive interventions as part of building knowledge and skills within the MSJCC model (Ratts et al., 2016). In assessment training, students can practice evaluating assessments according to HAES, and counselor educators can include size diversity as a dimension of how assessments were developed and validated. Students who endorse tenets of fat liberation, such as those expressed in the factor *Body Liberators,* can provide an anchor point in the classroom environment and contribute additional knowledge. Counselor educators can support and nurture all students' growth within a safe learning space, mirroring how future counselors can meet clients where they are in their attitudes about weight and body image.

Furthermore, as persons of size already face challenges across life domains, including in healthcare, and may have internalized fat phobia, future counselors must be able to provide non-judgmental and accepting spaces to explore the harmful effects of sizeism. Counselor educators can ensure that students develop the awareness, knowledge, and skills to consider their privileged and marginalized body identities and consider clients' worldviews around body shape and size (Ratts et al., 2016). MSJCC education

must address fatmisia so that counselors can treat clients in all bodies with weight-inclusive interventions and advocacy.

Counseling students may be unfamiliar with sizeism as discriminatory (Rothblum & Gartrell, 2019) and may resist exploring body-based beliefs and weight bias as problematic, especially given its widespread cultural acceptance. In fact, the factors that emerged in this study of novice counselors' attitudes share some features of Bergen and Mollen's (2019) observations of types of resistance they encounter while training on sizeism, such as reactions of benevolent sizeism, overt or hostile sizeism, healthism, and internalized sizeism. Understanding the potential resistance Bergen and Mollen (2019) described, combined with the multi-dimensional view of distinct perspectives that novice counselors expressed, can help counselor educators prepare for diverse and potentially entrenched positions of students. Counselor educators can introduce students to terminology, discuss cultural appearance standards, and share psychological and physiological health data regarding weight-normative versus weight-inclusive treatment (Rothblum & Gartrell, 2019). Experiential activities, such as privilege exercises (Bergen & Mollen, 2019), can help increase students' awareness of thin privilege and size discrimination and enhance empathy and compassion. These kinds of exercises are essential for students who endorse views similar to *Body Choosers* and *Body Changers* in this study, where negative stereotypes are attributed to larger-bodied persons and thinness is idealized. Additionally, students who affirm body positivity may be unaware of areas of privilege and oppression and how views of healthism contribute to discrimination and adverse effects on persons of size.

Since counseling research in sizeism is in its infancy, counseling faculty may borrow approaches used in other disciplines, such as Hutson's (2017) work teaching critical perspectives about body weight in sociology and current literature in fat studies. Additionally, counselor educators can use the factors from this Q study to generate critical classroom dialogue. They may also build on elements of this study to engage in anti-fat phobia Q pedagogy (Rieber, 2023) among students and faculty. Results from this study may also inform how counselor educators think about and approach MSJCC in leadership, administration, and research. Counselor educators are uniquely positioned to embrace and expand sizeism advocacy and scholarship as they train the next generation of counselors and counselor educators.

Implications for Supervision

This study also has implications for counseling supervisors of practicing counselors, who are responsible for counselor supervisee development and client care (ACA, 2014, F.). Practically speaking, transference may arise around any topic and within either dyad, namely, supervisor–supervisee or supervisee-client. Thus, beliefs about body weight and shape can affect these relationships and client well-being. Supervisors must be attuned to issues that may arise for supervisees working with clients of all body sizes. DeLucia-Waack (1999) described how supervision is needed "to help counselors…have a realistic sense of body image, food, and weight to that the unrealistic expectations and perceptions of women with eating disorders are not supported" (p. 380). I would also argue this is not only an imperative for supervisees specifically working with eating disorders but that attitudes and beliefs about weight and body image are essential to work with all clients who face cultural pressures of appearance and social

predominance of healthism. Furthermore, supervisees would benefit from sound, body-neutral, culturally competent beliefs and skills to appropriately screen for disordered food and body behaviors.

Currently available validated eating disorder assessments may be used cautiously, with an understanding of the groups they were normed on, typically White females (Gilbert, 2003). African American women may have internalized Euro-centric constructs of thin body ideals and are underrepresented in the eating disorder literature, as are Asian American and Latina women (Talleyrand, 2012). Men of color are also underrepresented in the literature (Stewardson et al., 2020). Problematic food and body-related beliefs and behaviors in persons of color may not fit Euro-centric risk factors or symptomology schemas. Thus, disordered patterns could be missed in screening. For resources that are fat-friendly and grounded in intersectional identities, supervisors may reference resources published by ASDAH. Additionally, NAAFA provides opportunities to learn more about the fat community and advocacy.

In addition to overseeing multicultural awareness of supervisees with clients, supervisors are also responsible for negotiating multicultural topics and diversity issues in the supervisor–supervisee relationship (Borders & Brown, 2005). However, sizeism and body diversity seem to be understudied in supervisor–supervisee and supervisee–client relationships since there is a paucity of counseling research altogether on these topics. Bernard and Luke (2015) surveyed 10 years of supervision literature without noting sizeism or related topics in the subject matter review, in multicultural and social justice topics or otherwise. The most closely related topic was eating disorders, for which they identified one empirical study (Bernard & Luke, 2015), and it was not indicated if

this study included topics of weight bias and a weight-inclusive versus weight-normative approach.

DeLucia-Waack (1999) developed supervision guidance targeted toward counselor supervisees working with eating disorders, and many of the concepts may be transferrable to counseling supervision across client presentations where concerns of food, weight, and body image manifest. Additionally, several calls to the mental health field, primarily from psychology, offer weight-inclusive education and principles for therapists (Calogero et al., 2019; Tylka et al., 2014) and strategies for incorporating the topic of sizeism in mental health education, training, and supervision (Bergen & Mollen, 2019; McHugh & Chrisler, 2019; McHugh & Kasardo, 2012; Rothblum & Gartrell, 2019). Bergen and Mollen (2019) presented suggestions for supervision, such as considering body size as an axis of diversity and inequality in case conceptualizations and exploring countertransference and bias. Likewise, supervisors are cautioned against overemphasizing body size in case conceptualization and "[conflating] fatness with mental illness or physical disease" (Bergen & Mollen, 2019, p. 176).

Furthermore, supervisors would need to examine their own attitudes and beliefs related to weight and body image in an ongoing process of developing self-awareness (Ratts et al., 2016). In fact, Ratts and Petersen (2014) and Ratts et al. (2016) described self-awareness and knowledge as a necessary, sequential foundation upon which to build multicultural skills before trying to put skills into practice. Bergen and Mollen (2019) also encouraged supervisors to consider their beliefs about body weight and the ethical concerns of supporting clients in weight loss, likening the latter to conversion therapy. Indeed, Meulman (2019) wrote a first-hand account of sizeism in supervision from the

point of view of the supervisee, which offers an opportunity for supervisors and supervisees to reflect on their beliefs about body size and shape. This article could also be used as a tool for supervisors to broach the topics of sizeism with supervisees. Broaching may occur within the supervisor relationship, case conceptualization, and the supervisee's relationship with the client (Fickling et al., 2019). Self-awareness is an essential factor that may determine a supervisor's ability and willingness to broach multicultural and social justice topics (Fickling et al., 2019), such as sizeism.

Supervisors may also use this Q study as an entry point "to first take inventory of their own values, beliefs, and biases" (Ratts et al., 2016, p. 38). For example, they could begin by studying the research premise and explore the factor(s) with which they most identify. Moreover, since the participants in this research were novice counselors, many of whom are likely to be in supervision, examining the results of this Q study can give supervisors an emic perspective of novice counselors' beliefs and attitudes. Considering the MSJCC model (Ratts et al., 2016) in the supervisor–supervisee relationship context, understanding supervisees' worldviews is the next developmental domain after supervisor self-awareness. So then, combining self-awareness, knowledge, and a sense of supervisees' worldviews lays the groundwork for broaching body diversity and sizeism with supervisees. This framework and broaching also provide a model for supervisees to use with their clients.

This research highlights the need for some novice counselors to expand multicultural and social justice competencies to include sizeism, body diversity, and weight inclusivity. Supervisors can use the factors of this research as a frame of reference for beliefs about body weight and shape within novice counselors and develop

appropriate interventions according to their supervision model. So, in summary, employing the results of this Q research to aid in multicultural competency can benefit supervisors, supervisees/novice counselors, and clients.

Implications for Q Studies

This Q study was designed and conducted according to best practices from Q scholars and evidence in Q literature. It also may be unique in several ways, which can contribute to the Q literature of Q study design and implementation. For example, Baltrinic et al. (2021) outlined the concourse and Q set development process and the use of research team members in the review process. Paige and Morin (2016) also provided insight into their concourse and Q set development process, expressly how they used Microsoft Excel to record statements and share them among the research team. In this Q study on weight and body image beliefs of novice counselors, using components of Baltrinic et al.'s (2021) and Paige and Morin's (2016) processes, I detailed the technique of concourse development and Q set creation using Microsoft Excel spreadsheets. Using multiple sheets and color coding the review, editing, and selection process created an audit trail which can be important to establish credibility. Additionally, I used Microsoft Excel to digitally create statement sticky notes (Paige & Morin, 2016), and from those produced a digital visual array of final Q statements in a gestalt, organized and color-coded by theme. Creating the board in Excel, a file that could be easily shared with the research team, addressed a limitation noted by Paige and Morin (2016). So, having a record of the process with digital tools and techniques can provide a sequence for the novice Q researcher to follow or modify.

This study also provides a way of collecting data that can serve as a reference in future Q research. The entire study was conducted online, which could reduce the administrative and time burden on the research team and participants compared to in-person and paper-based data collection. Also, most recent Q studies that reported which software they used (Dieteren et al., 2023) employed software that researchers may find unavailable or prohibitively costly. I used Qualtrics for screening and informed consent, EQ Web Configurator (Banasick, 2022) to host the Q sort, Firebase and Zoom to collect quantitative and qualitative data, and KADE (Banasick, 2019) for quantitative analysis. All of these platforms offer free services to users. Although using online software a-la-carte in this manner may not be feasible for all researchers, Banasick (2019, 2022) provided clear instructions to set up data collection and analyze the quantitative data. The mainstream software, such as Qualtrics and Microsoft products, included user-friendly help functions. It was also simple to export JSON files from Firebase and load the post-sort survey data into Microsoft Word or Microsoft Excel, which I did, for further analysis. Finally, I collected qualitative and descriptive data using a post-sort survey and an optional online interview via Zoom. I linked Calendly, an online scheduling tool, with Zoom to allow participants to schedule interviews and connect directly to the Zoom interview. I also enabled transcription in Zoom to have a written reference for use in the crib sheet process of factor interpretation. Dieteren et al. (2023) noted more than 37% of the articles they reviewed did not report how the researchers collected qualitative data. The remaining studies reviewed collected qualitative data through individual and focus group interviews. This Q study with novice counselors demonstrated a way to capture qualitative and descriptive data using a combination of online methods. As such, it

provides a roadmap for an efficient and effective way to allow participants to expand on and share their opinions and for scholars to conduct a Q research project entirely online.

Limitations of the Study

This study has several limitations, the first being the lack of racial and ethnic diversity among participants. This lack of diversity may mirror the target population of novice counselors in the SACES region who graduated from CACREP-accredited CMHC programs. There also may be other reasons for the lack of participation, such as distrust of research from predominantly White institutions (PWI), such as the author's university, or reluctance to discuss this particular topic, a form of sampling bias (Sheperis et al., 2017). Additionally, racial diversity may be lacking in the listservs, social media groups, and state counseling associations where the study was advertised, and response rates could not be measured. It is unknown if there are different views among those who responded and those who did not, so sampling bias can exist across all demographic categories. Demographic data for those who enrolled in but did not complete the study is unknown.

Most of the 24 participants and 17 who loaded on factors were White, cis-gender females. Only three people of color loaded onto the four factors analyzed. The two other participants of color, Participant 2 and Participant 20, did not load onto a factor, so their perspectives were not represented in the final analysis. Persons of color may have different attitudes and beliefs about body weight and shape that were not characterized in this research.

Furthermore, in this study, participants were not asked to disclose BMI or how they and others perceive their body size and shape. So, it is unknown if this research

includes body diversity. Future studies could explore the beliefs of people with specific identities and experiences such as race and ethnicity, sexual orientation, body size and shape, and body weight-related experiences such as acceptance, rejection, and discrimination.

This Q study was also limited by geography, recruitment strategies, and the time the study was available. In this study, I used strategic sampling as described by Watts and Stenner (2012) to elicit responses from novice clinical mental health counselors who are currently practicing in the field without limiting the study by age, race, or other demographic variables "to ensure a sufficiently varied participant group" (Watts & Stenner, 2012, p. 71). Participants must have been practicing within the SACES region, which is limited to 14 states plus the District of Columbia and have graduated from any CACREP-accredited CMHC program within the last three years. Recruitment emails were sent to CACREP-accredited CMHC master's programs and state counseling associations within the SACES region. Only two states contacted, South Carolina and Florida, sent the recruitment email and flyer to their constituents. It is undetermined how many CMHC master's program contacts sent the recruitment email and flyer to alumni, as requested. Therefore, I cannot measure the response rate using these recruiting strategies with an unknown number of impressions. Study participants practiced in six of the SACES region states. Given the study recruitment and the nature of Q studies, if there are geographical differences in attitudes and beliefs about weight and body, these would not be evident in the analysis and interpretation.

Participants were also recruited through both listservs and social media groups with a combination of affiliations by state, region, and professional interest. Listservs and

social media are valuable ways to broadcast messages widely, and at the same time, many will not see posts due to social media algorithms and email filters. Email was also both beneficial and limiting in communicating with those who indicated an interest in the study and met the study criteria. For these individuals, I emailed the study link to complete the Q sort after reviewing their screening questionnaire responses. The nature of email communication, with spam filters and potentially high volumes, may have limited the number of enrollees who read the email and subsequently completed the study. Additionally, this may have limited the number of interviews conducted, as out of the eight participants who opted-in to interview, only five scheduled and completed the interview. Finally, the study was open for a limited time. Individuals who enrolled near the end of the study received fewer reminders and had less time to complete the Q sort than earlier enrollees, which may have affected the participation rate for the Q study overall and the optional interview.

Participant bias is another potential limitation of this study. Similar to Mulherin et al.'s (2013) and Puhl et al.'s (2014) research limitations, participants may have responded in socially desirable ways or attempted to do so in this study. There exist different ideas of what is socially desirable around weight and bodies, such as healthism on the one hand and anti-discrimination on the other hand, that would have challenged participants' ideas about social desirability, mainly since they had limited opportunity to rank multiple items at strong agreement or disagreement. The forced ranking format of the Q sort would have made it more challenging to sort along the lines of social desirability or researcher expectancy compared to research using Likert scales. Additionally, completing the Q-sort online, unobserved, minimizes participant bias. However, it is possible and could account

for some of the seemingly mixed perspectives in the factors, which would have confounded factor interpretation.

Q methodology uses quantitative and qualitative data in analysis and interpretation. Factors and their composite Q-sorts were derived through quantitative analysis. Factor interpretation relied on quantitative data for each factor and the qualitative data collected in the post-sort survey and optional interview. Since interviews were optional and not all participants who interviewed loaded onto a factor, data from only three interviews were included in the factor interpretation. There was one interview each for Factors 1, 2, and 3, and no interview for Factor 4 participants. Additionally, the participants who loaded onto Factor 4 provided minimal responses to the post-sort survey questions about why they chose the statements with which they most agreed and most disagreed. Minimal qualitative data for Factor 4 necessitated the researcher relying more heavily on quantitative data and, undoubtedly, her personal knowledge and experiences, which could include researcher bias.

The interviews were also conducted days after the participants completed the study, so a here-and-now post-sort perspective was missed. To compensate for any Q-sort recall deficits, the researcher gave visual and verbal reminders to interviewees of their Q-sorts and conducted the interviews as soon as possible, within one week after each Q sort was completed. The interviews took place via Zoom, so the researcher observed non-verbal clues in addition to the spoken word and used interview transcripts as a reference during the interpretation process. Although Stephenson (1953) did not include post-sort interviews in his Q techniques and methods, contemporary Q scholars have frequently used interviews to collect data. Dieteren et al. (2023) noted that more than half of the

articles they reviewed referenced individual interviews, mostly conducted face-to-face, and more than one-third of the studies they examined did not reference a qualitative data collection method.

Choices in the study configuration and analysis process are at the discretion of the researcher, which can introduce researcher bias (Sheperis et al., 2017). From a qualitative perspective, the researcher is an instrument in interpreting the data. So, this study was limited by my knowledge and influenced by my personal views. I sought to increase researcher trustworthiness through reflexive practice and additional steps to increase internal validity (Sheperis et al., 2017). Bias was mitigated and trustworthiness was supported by including research team members with different strengths and perspectives in triangulation and peer debriefing, as described by Lincoln and Guba (1986). Indeed, as a qualitative researcher, I acknowledge my interpretation and description of the data are unique to my position and identity. Others may draw different conclusions from the data and would likely narrate it differently based on their unique perspectives. I sought to provide transparency by including a thorough description of and rationale for the decisions in the study, such as in concourse development, Q statement selection, recruitment, analysis, and interpretation. Using rich, descriptive narratives also increases transferability (Lincoln & Guba, 1986).

Recommendations for Further Study

This Q study explored the attitudes and beliefs of practicing CMHC new to the field within three years post-graduation and thus built on the work of Forristal et al. (2021), who studied weight bias among counseling students. This study was a baseline study for novice counselors' perspectives on weight and body image. Now, there is an

opportunity to explore adjacent groups' attitudes and beliefs to build a more comprehensive picture of the counseling field. For example, counselor educators and more experienced counselors may also be studied. Additionally, future research can expand geography, recruitment, study timing, and other efforts to generate a more diverse participant set. There is also an opportunity to investigate contributing factors to novice counselors' beliefs and how body size and internalization of fat phobia amid the population may influence body weight and size views.

Since this study explored attitudes and beliefs, the next steps would be to connect these beliefs to knowledge and skills and counselor self-awareness, a research path aligned with Ratts et al. (2016) MSJCC developmental domains. Ratts et al. (2016) also highlighted the need to understand intersectionality and privileged and marginalized statuses. Further research may also measure weight bias, similar to Forristal et al.'s (2021) study with counseling students and studies of other healthcare providers' implicit and explicit weight bias (Puhl et al., 2014; Teachman & Brownell, 2001). It is perhaps even more important than investigating weight bias to examine its impact on clients and supervisees. This data can expand our understanding of multiculturally competent counseling and supervision and highlight opportunities for change.

Finally, additional research can be conducted that is specific to supervisors and counselor educators, particularly since they significantly influence client welfare and the profession's future. Inquiry into sizeism and transference in the dyads of supervisor–supervisee and counselor-client can have implications for supervisor and supervisee development and client welfare. Supervisory and client interventions may also be investigated to build an evidence base for culturally competent counseling and

supervision with larger-bodied persons and clients of all sizes and shapes who may be affected by cultural sizeism. Additionally, the next steps in counselor education could include a comprehensive review of the curriculum and creating and testing Q pedagogy sizeism instruction (Rieber, 2023).

Conclusion

The prevailing societal preference for smaller bodies and views of health and body size as individually controllable provide an environment for sizeism to flourish. Weight stigma and societal pressure to achieve and maintain thinness negatively affect physical and mental health (O'Brien et al., 2016; Rukavina & Pokrajac-Bulian, 2006; Tomiyama, 2014; Tomiyama et al., 2018) and counselors may be both victims of this phenomenon and unknowingly perpetuate harmful beliefs and behaviors, particularly without training in sizeism as an area to development multicultural competency and advocacy. In this research, studying novice counselors provided a view into recent counselor education and practicing counselors' beliefs entering the field as the next generation of counselors. The results of this Q study revealed four distinct perspectives, called factors, with only one factor being a clear expression of a socially conscious view of weight and body image. The other three factors included a range of attitudes and beliefs about weight and body aligned with cultural sizeism, suggesting an opportunity exists to develop multicultural competency in this area further. So, this Q study added to the small literature base of calls to the counseling field (Kinavey & Cool, 2019; Nutter et al., 2020) and empirical research of fatmisia among counseling students (Forristal et al., 2021) by investigating attitudes and beliefs of novice counselors. More counseling

research is needed to identify and address size discrimination and marginalization in counseling and counselor education.

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APPENDICES

Appendix A - Online Screening Questionnaire

Online questionnaire using Qualtrics

Thank you for your interest in our research study. My name is Lisa Hedden, and I am a doctoral candidate at the University of Georgia completing my dissertation research.

The purpose of this research study is to explore novice counselors' attitudes and beliefs about weight and body. This research is designed to better understand new counselors' perspectives on the topic.

Are you interested in participating in the study?

☐ Yes
☐ No
If no, survey closes.

If yes, Thank you for your interest. Before enrolling you in the study, we need to ask you some questions to determine if you are eligible for the study. This should take less than 10 minutes of your time. There are no anticipated risks to answering these questions.

All information received from this questionnaire, including your name and any other information that can possibly identify you will be strictly confidential and will be password protected. Remember, your participation is voluntary; you can refuse to answer any questions or stop completing the questionnaire at any time without penalty.

Thank you. If you have any questions about this research project, please feel free to call me at 770-824-6707 or email me at lisa.hedden@uga.edu. You may also contact my faculty advisor, Dr. Amanda Giordano at amanda.giordano@uga.edu. Questions or concerns about your rights as a research participant should be directed to the Institutional Review Board (IRB) Chairperson at 706-542-3199 or irb@uga.edu.

Are you age 18 or older?
☐ Yes
☐ No
If no, survey closes.

Did you graduate from a CACREP-accredited master's program in clinical mental health counseling (CMHC) within the last three years? (including addiction counseling, community counseling, college counseling, and other specialty areas; excludes school counseling)

☐ Yes
☐ No
If no, survey closes.

Please indicate the month and year of your graduation from the CACPREP-accredited master's in CMHC program (MM/YYYY)
__/____

What degree did you receive (be specific with degree and title or specialty area)?
_____

From which institution (school/university) did you receive this degree?
_____

Please select your current counseling role:
☐ Clinical mental health counseling
☐ Addiction counseling
☐ Community counseling
☐ Marriage, couples, and family counseling
☐ College counseling
☐ Other
If Other, please specify: _____
☐ Not currently working in the counseling field
If not working in the counseling field, You do not meet the criteria for this study. Thank you for your time.

In this role, do you conduct two or more counseling sessions per week (including individual, group, or family)?
☐ Yes
☐ No
If no, You do not meet the criteria for this study. Thank you for your time.

In this role, please select the state(s) in which you are currently working:
☐ Alabama
☐ Arkansas
☐ Florida
☐ Georgia
☐ Kentucky
☐ Louisiana
☐ Maryland
☐ Mississippi
☐ North Carolina
☐ South Carolina
☐ Tennessee
☐ Texas
☐ West Virginia

☐ Virginia
☐ Other
If Other, please specify: _____

Thank you for your responses. We will review the information provided and contact you regarding your eligibility. Please provide your name, email address, and phone number below so that we may contact you regarding the study. We will only contact you by phone if we are unable to reach you via email.

Appendix B - Research Study Recruitment Materials

Recruitment Flyer

Email

Subject Line: New Counselors Needed for an Online Research Study

Hi everyone! My name is Lisa Hedden, and I am a counselor in Atlanta, GA, and a doctoral candidate at the University of Georgia (UGA). To complete my doctoral research, I am looking for new counselors (graduated from CACREP-accredited master's program in clinical mental health within last 3 years) currently practicing in the clinical

mental health field. This includes community mental health, addictions work, treatment centers, college campuses, and more!

Please check out the attached flyer for more information and to access the screening questionnaire. You may also go to the screening questionnaire using the QR code below. Contact me with any questions at lisa.hedden@uga.edu. This study is being conducted under the direction of Dr. Amanda Giordano at the University of Georgia (amanda.giordano@uga.edu).

Please also share the flyer with counselors in your work setting who may fit the criteria. Thank you all!

Sincerely,
Lisa Hedden, LPC, NCC
Lisa.hedden@uga.edu
770-824-6707

Appendix C - Participant Informed Consent

UNIVERSITY OF GEORGIA
CONSENT FORM
Novice Counselors' Weight and Body Image Beliefs: An Exploratory Q Study

My name is Lisa Hedden, and I am a doctoral candidate in Counselor Education and Supervision at the University of Georgia (UGA), working under the direction of Dr. Amanda Giordano, Associate Professor in the Department of Counseling and Human Development Services at UGA. You are being asked to take part in a research study. The information in this form will help you decide if you want to be in the study. Please ask the researchers below if there is anything that is not clear or if you need more information.

Principal Investigator: *Dr. Amanda Giordano*
Associate Professor
Counseling and Human Development Services
amanda.giordano@uga.edu

Co-Investigator: *Lisa Hedden*
Doctoral Candidate
Counselor Education and Supervision
770-824-6707
lisa.hedden@uga.edu

The purpose of this study is to learn more about novice counselors' perspectives on weight and body size and shape. You are being asked to be in the study because you are a counselor who graduated from a CACREP-accredited master's program in clinical mental health counseling within the last three years and are currently working as a counselor in the mental health field in the southern United States. Participation in this research is completely voluntary and you can refuse to participate before the study begins or stop taking part at any point.

If you decide to participate in this study, we will ask you to complete an online card sorting activity and a series of questions dealing with the following topics: weight, body size, body shape, eating and exercise. We estimate that it will take roughly 40 minutes to complete.

After you complete the activity and follow-up questions, you may choose to opt-in to a one-on-one online interview with Lisa Hedden via Zoom to further explain your responses. If you choose to complete the interview, it will be audio or video recorded

with your permission. You may choose to remove your name from Zoom to complete the interview. This interview is not required to be part of the study, and you may still participate in the interview even if you are not willing to have the interview recorded.

Completing the research study could bring up feelings of stress or discomfort.

We hope that learning more about novice counselors' beliefs about weight and body will help improve training and education for counselors and counseling supervisors.

For your participation in the research study, you can choose to be entered into a drawing for one of four $25 gift cards. You do not have to be in the study to enter the drawing. Send an email to lisa.hedden@uga.edu to enter the drawing if you do not want to be in the study. Your name will be provided to the investigator's departmental business office for tracking purposes if you win.

Data will be handled and processed only by the persons who are responsible for the necessary activities for the purposes above. Research records will be labeled with participant IDs that are linked to you by a separate list that includes your email address. This list will be destroyed once we have finished collecting information from all participants. The information collected in this project will be shared only after identifiers have been removed, thus never connecting your identity to your responses. The information will be shared with other researchers after identifiers have been removed, and the research may result in publications and presentations of the study findings.

The data will be stored for a period of five (5) years.

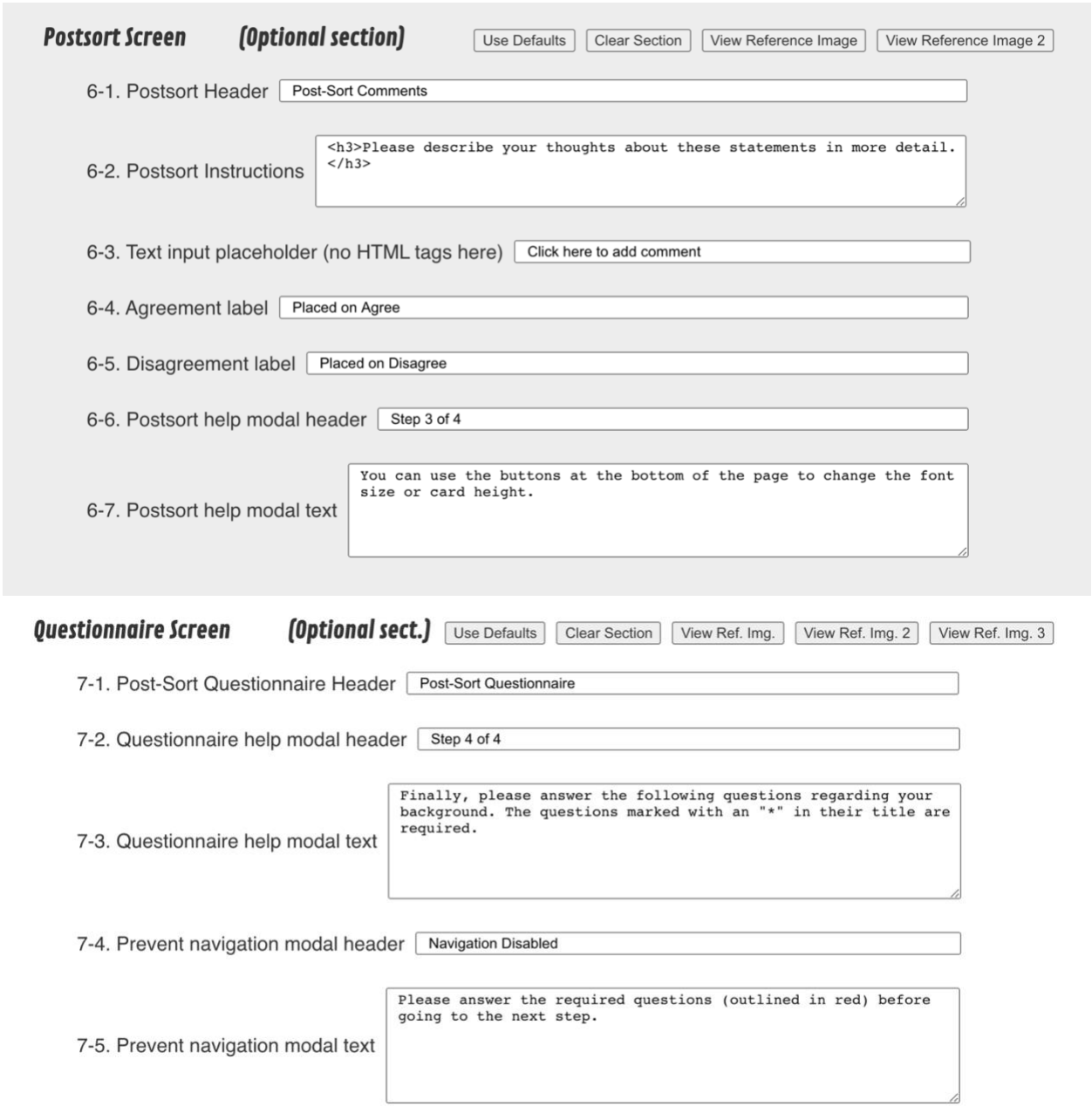
No automated decision making will be performed, including profiling, and the collected Data will not be further processed other than the purpose for which it was collected.

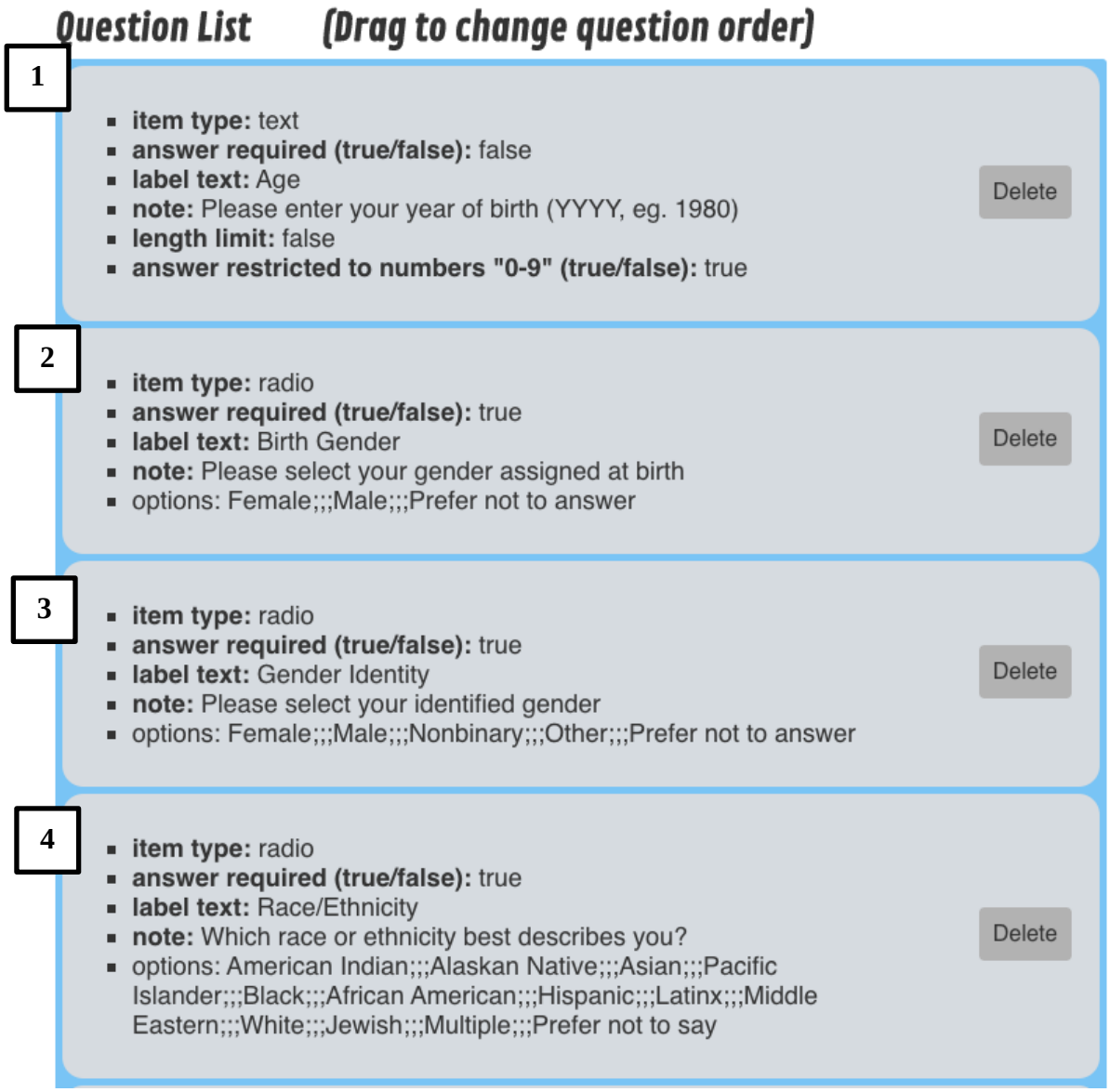
This research involves the transmission of data over the Internet. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

If you have any further questions about the research project please contact Lisa Hedden (lisa.hedden@uga.edu); phone 770-824-6707 or Dr. Amanda Giordano (amanda.giordano@uga.edu).

Any questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board; 706-542-3199; irb@uga.edu.

Appendix D - Additional Data Collection Questions – Post-Sort Survey




Question List (Drag to change question order)
1
item type: text
answer required (true/false): false
label text: Age
note: Please enter your year of birth (YYYY, eg. 1980)
length limit: false
answer restricted to numbers "0-9" (true/false): true
Delete
2
item type: radio
answer required (true/false): true
label text: Birth Gender
note: Please select your gender assigned at birth
options: Female;;;Male;;;Prefer not to answer
Delete
3
item type: radio
answer required (true/false): true
label text: Gender Identity
note: Please select your identified gender
options: Female;;;Male;;;Nonbinary;;;Other;;;Prefer not to answer
Delete
4
item type: radio
answer required (true/false): true
label text: Race/Ethnicity
note: Which race or ethnicity best describes you?
options: American Indian;;;Alaskan Native;;;Asian;;;Pacific Islander;;;Black;;;African American;;;Hispanic;;;Latinx;;;Middle Eastern;;;White;;;Jewish;;;Multiple;;;Prefer not to say
Delete


5
item type: radio
answer required (true/false): true
label text: Experience
note: How long have you been working in the counseling field since you graduated with your master's degree? (experience post-graduation)
options: 1-6 months;;;7-12 months;;;1-2 years;;;2-3 years;;;More than 3 years
Delete
6
item type: checkbox
answer required (true/false): false
label text: Pease indicate if you have had specialized training in the following areas:
options: Eating disorder treatment;;;Body image concerns;;;Health at Every Size;;;Intuitive Eating;;;Body positivity;;;Fat liberation
Delete
7
item type: radio
answer required (true/false): true
label text: Weight
note: Please choose the answer below that best describes you now
options: I am trying to stay the same weight;;;I am trying to lose/reduce weight;;;I am trying to gain weight;;;I am not concerned about my weight
Delete
8
item type: checkbox
answer required (true/false): true
label text: History
options: I have a past history of intentional weight loss or attempts to lose weight;;;I have been discriminated against because of my body size;;;I have had a suspected or diagnosed eating disorder;;;None of the above
Delete

9

- **item type:** textarea
- **answer required (true/false):** true
- **label text:** Additional comments
- **placeholder:** Please provide any additional comments that help explain your sorting decisions or other information you would like us to know.

Delete

10

- **item type:** radio
- **answer required (true/false):** true
- **label text:** Interview
- **note:** Would you like to participate in a virtual interview to discuss your responses? Interviews will take place within one week and will last no more than one hour.
- **options:** Yes;;;No

Delete

11

- **item type:** textarea
- **answer required (true/false):** false
- **label text:** Interview contact
- **placeholder:** If you indicated you would like to participate in an interview, please provide your email address and best contact phone number

Delete

12

- **item type:** textarea
- **answer required (true/false):** false
- **label text:** Would you like to be entered into a drawing for one of four $25 gift cards:
- **placeholder:** If so, please provide your email address. All winners will be selected at random and notified via email.

Delete

Appendix E - Semi-Structured Interview Protocol

1. Tell me about the experience of the card sorting activity. What was this process like for you?
2. When you think about the overall activity and what you created at the end, what does it say?
3. Considering the statements you placed in or near the middle – what were your thoughts and reasons for doing so?
4. Considering the statements you placed to the right – how did you decide to place the statements there?
5. Considering the statements you placed to the left – how did you decide to place statements there?
6. Were there any statements you were unsure what to do with? What did you decide and how did you come to that conclusion?
7. Is there anything you would have liked to find in the statements that you didn't find? If so, where you have placed this/these statements and what would you have moved or have been different?
8. You mentioned _____ in the post-sort survey. Would you talk more about that? (Ask clarifying questions and probe choices that appear to be contradictory or incongruent with other choices.)
9. I'm curious about your thoughts on the topic of weight and body now that you have completed this activity. What has changed or is different now?