FACTORS RELATED TO WEIGHT-BIAS AMONG COUNSELORS

by

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ABSTRACT

KATIE NICOLE CHRISTENSEN. Factors Related to Weight-Bias Among Counselors.
(Under the direction of DR. SEJAL PARIKH FOXX)

More than two-thirds of adults and one-sixth of children and adolescents in the United States experience higher levels of body fat and/or obesity (Hales et al., 2020). Individuals with higher levels of body fat often experience weight-bias, prejudice, and discrimination from various sources including mental health professionals in the fields of psychology, social work, and marriage and family therapy (Cravens, et al., 2016; Davis-Coelho, et al., 2000; Pratt, et al., 2015; Young & Powell, 1985). However, little is known about the presence of weight-bias within the counseling field. Literature shows that weight-bias can negatively impact physical and mental health (Friedman & Puhl, 2012; Himmelstein et al., 2017; Puhl et al., 2017). Counselors may be exhibiting weight-bias towards clients, thus causing harm (Feister, 2012). The counseling profession has committed to developing multiculturally competent counselors, yet body weight is not included in discussions of bias, prejudice, oppression, and power (Bergen & Mollen, 2019). This study used a correlational, non-experimental research design and a standard multiple regression to explore relationships between weight-bias and race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias among licensed counselors (*N*= 587). Results indicated there were statistically significant relationships between weight-bias and gender, weight-bias education, and multicultural competence. The group of predictor variables explained a significant portion of the variance in weight-bias among counselors ($F(5,572)=10.101$, $p<.001$, $R^2=.081$, *adjusted* $R^2=.073$) which accounted for 8.1% of the variance.

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I also want to thank my stepdad, Paul, and siblings, Aimee and Andy, for your love and support throughout my life and throughout my ongoing academic pursuits. To my nieces and nephew, Jillian, Jason, and Kayla, you can achieve your dreams! Dream big, work hard, and utilize the supports around you. You will never be alone. I hope I will continue to inspire you and I pledge to support you as you find your own passions and dedicate your lives to loving yourselves and others.

To my cohort, thank you for challenging me, allowing me to lean on you, and growing together as counselors, counselor educators, and human beings. I cannot wait to see where each of our journeys take us and how we will continue to support one another throughout our careers and lives.

Finally, to my best friends, Mónica, Erin, Shanna, Sharon, and Tashlie, thank you for all your love and support throughout my life and through my journey of becoming a counselor and now a counselor educator. May we continue to laugh, dance, and explore the world together.

DEDICATION

This dissertation was written in dedication to my mom, Sam Christensen. My mom has inspired me throughout my life to dream big and achieve big. Throughout my life, she has been an example of how to be a fierce advocate, by speaking up about injustice and working to improve the lives of both loved ones and strangers. Her career led her to open her own medical practice and provide compassionate and highly skilled medical weight management to individuals with higher body weights. She has shown such passion in advocating within the medical profession for medical providers to better understand obesity and insist on more humane medical care for individuals with obesity. Her dedication to her patients and to eliminating weight-bias and stigma within the medical profession inspired me to explore weight-bias in the counseling field through this dissertation. Her unwavering support throughout my academic career has anchored me in difficult times and assured me of my own strengths and passions. Her knowledge in communication and writing helped me organize my thoughts and ideas and transfer these into this paper. Mom, thank you for all you have given me these last few years while I completed my doctoral studies and throughout my life. Together, we are helping to eliminate weight-related biases and improve the quality of life for individuals of all body shapes and sizes.

This dissertation is also dedicated to my late father, Brad Christensen. Dad, your unwavering support and love helped me learn how to dedicate myself to achieving my goals. As a child, you taught me how to work hard and shoot for the moon. Your journey with obesity led to an early separation from this world, and from my life. But, your journey and my loss has inspired me to help others live long and healthy lives with their loved ones. This dissertation was

inspired by my continuing love for you. Though you may not be physically here, I know you were with me as I thought, felt, and believed in this project.

Finally, this dissertation is dedicated to individuals of all body weights and sizes. I see the disenfranchisement our society has created for individuals of higher body weight and size, and I stand ready to fight it. I am dedicated to passionately advocating for individuals, communities, and systems to eliminate weight-bias and stigma and replace negative attitudes, beliefs, and behaviors with ones rooted in size-inclusivity and size-affirmation.

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CHAPTER I: INTRODUCTION

Overview

Counselors are held to ethical and legal standards to provide quality care to diverse clients (American Counseling Association [ACA], 2014). In the past 30 years, the counseling profession has increased its attention and effort to incorporate cultural understanding into clinical work, counselor education, and research (Arredondo et al., 1996; Ratts et al., 2015; Sue et al., 1992). While many cultural elements, such as gender, race, and sexuality are now included in counselor education curriculum and attended to within the counseling process, less attention has been paid to the relationship between body weight and size and counseling (Kasardo, 2019; McHugh & Chrisler, 2019; McHugh & Kasardo, 2012).

According to the Center for Disease Control and Prevention [CDC], more than two-thirds of adults in the United States (US) are overweight or have obesity and more than one-sixth of children and adolescents in the US have obesity (Hales et al., 2020). Obesity is a medical diagnosis for individuals with a body mass index (BMI) of 30.0 or higher (Center for Disease Control [CDC], 2020). An individual is considered overweight when BMI is between 25.0 and 29.9 (CDC, 2020). BMI is calculated by dividing a person's weight in kilograms by the square of height in meters and can be an indicator of body fatness (CDC, 2020). Obesity has come to be understood as a complex condition, with several contributing factors including genetics, culture, lifestyle, physical activity, nutritional intake, and various psychological factors (Wang et al., 2012). Those with obesity may be at higher risk for serious physical diseases and mental health conditions (Friedman, & Puhl, 2012). Higher body fat is correlated with higher risk of type 2 diabetes, heart disease, stroke, cancer, and other diseases which are leading causes of

preventable, premature death (Hales et al., 2020). Overweight and obesity also contribute to lower quality of life and mental health issues, such as depression and anxiety (CDC, 2020).

Individuals with higher body fat often experience weight-bias, prejudice, stereotyping, and discrimination in employment, education, healthcare, media, and interpersonal relationships, which research shows can negatively impact physical and mental health (Lee et al., 2014; Puhl et al, 2008). Overt and covert discrimination due to weight can also lead to weight-bias internalization within the individual (Kahan & Puhl, 2017), thus contributing to both immediate and long-term consequences on emotional and psychological health (Pearl & Puhl, 2018). Studies have shown that weight-bias and obesity may have a bidirectional relationship, in which each contribute to development and/or continuation of the other (Kahan & Puhl, 2017). Individuals often seek counseling to heal emotional and psychological wounds, which may include wounds resulting from weight-bias from others and self. The presence of weight-bias in our society and within counseling further jeopardizes public health, mental health, and quality of life. Thus, counselors must be prepared to address weight-related concerns with clients and attend to their own weight-biases to avoid harming clients (Kinavey & Cool, 2019).

Preference for weight-related terminology varies across demographic characteristics such as race/ethnicity, gender, and weight status (Puhl, 2020). Terms such as obesity, overweight, and fat are all used throughout published research and recommendations within the study of weight-bias (Agell & Rothblum, 1991; Brochu & Esses, 2011; Calogero et al., 2019; Crandall, 1994; Davis-Coelho et al., 2000; Gudzune et al., 2011). Evaluations and judgements of weight-related concerns are also presented using various terms such as weight-bias, weight-stigma, weightism, sizeism, fat oppression, anti-fat, and fat phobia (Bacon et al., 2001; Brown, 1989; Bucchianeri et al., 2013; Crandall & Martinez, 1996; Cravens et al., 2016; Friedman & Puhl, 2012; Hayward et

al., 2018; McHugh & Chrisler, 2019). Conflicting preferences exist throughout the literature, making it difficult to develop and use consistent terminology that is weight-inclusive and minimizes shaming (Kinavey & Cool, 2019; Puhl, 2020).

A recent shift in terminology has been to reclaim "fat" as part of the weight-inclusive and fat acceptance movement (Kinavey & Cool, 2019). Those who prefer the term fat believe fat to be a natural descriptor of a body, and by reclaiming it, removes the stigma which had and continues to be assigned to fatness from the medical field and society (Bergen & Mollen, 2019; Kinavey & Cool, 2019). "Obesity" is a medical term which has been found to be stigmatizing and less preferred by individuals experiencing fatness (Puhl, 2020). For consistency and clarity this author will use the term fat, in effort to align with evolving preferences and efforts to reclaim this term, promote size-affirming language, and de-pathologize fatness. Despite efforts to move away from using "obesity", this term will also be used due to its pervasive use throughout the literature and discussions of weight-bias. However, use of the word "obesity" will be used when referring to the medical condition of obesity. Weight-bias and stigma will be used as terms to describe the prejudice, stereotyping, and discrimination due to weight from both individual perspectives and societal perspectives.

The counseling profession has adopted person-first language, in effort to remove or reduce the stigma associated with certain terms, conditions, or diagnoses from the person (Kinavey & Cool, 2019). Debate exists as to whether person-first language reinforces stigma when discussing weight-related concerns (Kinavey & Cool, 2019). To stay consistent with the counseling field, this author will use first-person language and refer to a person or individual with fat or obesity, rather than "a fat person" or an "obese person".

Counseling and Weight-Bias

In society, the medical field, and the mental health field, fatness is portrayed as a negative medical condition in need of repair because of the perceived health risks associated with higher levels of fat (Bergen & Mollen, 2019; Kasardo, 2019; Tischner, 2013). Countless advertisements and public health campaigns in print, television, and social media send an overwhelming message to all that fat is bad and thin is good while offering solutions to this problem (Alberga et al., 2016; Grabe et al., 2008). Diet and exercise plans focus on the individual to fix their "bad" habits and teach them how to be better (Kinavey & Cool, 2019). The message this sends to individuals of all shapes and sizes is to not love or accept themselves because of their body weight, size, or shape, and to blame or shame those who do not fit the societal ideals of body weight, size, or shape (Alberga et al., 2016; Grabe et al., 2008; McHugh & Kasardo, 2012).

Obesity and Counseling Profession. Though "obesity" was rejected as a disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5), "overweight/obesity" was listed as a focus on clinical attention that can be diagnosed as a factor that influences functioning (American Psychiatric Association [APA], 2013, p. 726). This indicates that the mental health field recognizes the impact body weight and size can have on mental health. The DSM-5 also included "target of perceived adverse discrimination or persecution" as a v-code, with weight and physical appearance listed as examples (APA, 2013). The DSM-5 includes other weight-related pathology such as anorexia nervosa disorder, bulimia nervosa disorder, and binge-eating disorder (APA, 2013). With the DSM-5 as a guide, the counseling field primarily focuses on the pathology of body weight and size and how counselors can help clients be a "healthy" weight (Kasardo, 2019). When weight is discussed, it is typically viewed as a diagnosable

condition which requires treatment to either gain or lose weight (Brown-Bowers et al., 2017; Kasardo, 2019; Tischner, 2013).

Published research does not provide evidence that counselors are likely to look beyond pathology and consider how an individual views their body weight and size or what forms of discrimination they may have experienced due to their weight. In 2012, the *Journal of Counseling & Development* published a special section in one issue that focused on cultural considerations of the assessment and treatment of eating disorders (Chaote, 2012). While many of these articles acknowledged societal expectations, including variations within different racial and ethnic cultures, none named or discussed the culture of weight-bias that others exhibit towards individuals (Chaote, 2012). These articles, while discussing weight within a counseling context, primarily focused on the pathology of disordered eating- not on understanding and addressing weight or obesity as a cultural element within a client's life (Chaote, 2012). While disordered eating may be a diagnosable condition for many clients, the counseling profession has yet to widely consider how body weight and weight-bias impact the individual and the counseling process (Bergen & Mollen, 2019). Studies show that while obesity and fat can negatively impact health, studies also show that bias, discrimination, and judgement from others significantly impacts physical and mental health (Friedman, & Puhl, 2012; Kahan & Puhl, 2017; Pearl & Puhl, 2018). If counselors are not aware of, and thus not attending to their own weight-related biases, they may be contributing to clients' psychological distress instead of alleviating it, which violates the code of ethics set forth by the American Counseling Association (ACA) (ACA, 2014).

Weight-Inclusive Approach

Although research shows that higher fat can pose physical and mental health risks (Friedman, & Puhl, 2012; Pearl & Puhl, 2018), it is not necessarily true for all individuals, nor is obesity or fatness an accurate measurement of health (Calogero et al., 2019). An alternative movement, Health at Every Size (HAES), challenges the scientific and cultural assumptions about weight, celebrates body diversity, and encourages compassionate self-care regarding eating and body movement (Bacon, 2020). HAES is an example of a weight normative approach, which opposes the harmful societal messages about body weight and size pervasive in western cultures. Calogero et al. (2019) explores the "fundamental right to be fat" by positioning fatness as a normal part of human diversity and proposing that weight-inclusive approaches can combat societal messages that fat is "wrong". Counselors have an opportunity and responsibility to support clients who are in need of letting go of societal pressures and untrue beliefs that their body must be a "correct" size to be lovable or valued (McHugh & Kasardo, 2012). If counselors are aware of how weight-bias impacts clients' self-esteem, self-worth, and relationships with others, they can help clients to heal from the harm caused by these biases, instead of focusing on "fixing" the person's weight to better align with societal ideals. Therefore, this study focused on variables that may contribute to weight-bias among counselors: race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias.

Variables of Interest

The variables of interest in this study were weight-bias, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias. The dependent variable was weight-bias. The independent variables were race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias. These variables are

introduced below, and then relevant literature related to each variable are presented in the following chapter.

Weight-Bias

Weight-bias refers to the negative attitudes, beliefs, and stereotypes directed toward individuals who are perceived to have excess body weight (Bacon et al., 2001; Pearl & Puhl, 2018). Weight-bias can be experienced in a variety of relationships and situations including from family members, friends, strangers, medical professionals, media, in workplace or education settings, and society in general (Andreyeva et al., 2008). These biases are harmful and increase the risk for psychological consequences including depression, anxiety, low self-esteem, poor body image, substance abuse, and suicidal thoughts and actions, which are common presenting issues in counseling (Friedman & Puhl, 2012; Pearl & Puhl, 2018). Weight-bias has been found among medical and various mental health professionals, such as psychologists, social workers, and marriage and family therapists (Cravens, et al., 2016; Davis-Coelho, et al., 2000; Pratt, et al., 2015; Young & Powell, 1985). While weight-based biases and stigma are prevalent throughout society and healthcare systems, they are rarely discussed or addressed within counseling and counselor education. Research has shown that young, white, female, and less-experienced mental health professionals exhibit more weight-related bias than other demographics (Davis-Coelho et al., 2000). As 62% of working counselors are white and 73% are female (DataUSA, 2017) it seems likely that many licensed counselors have weight-biases. This study aimed to research contributing factors to weight-bias of counselors as a starting point for recognizing and addressing weight-bias in counseling.

Demographic Variables

Race and gender have both been found to be related to weight-bias in the general population and among mental health providers. Literature related to weight-bias and race indicate varying levels of weight-bias across racial/ethnic identities. Weight-bias has shown to be stronger among White, Hispanic, and Asian individuals compared to Black individuals (Barnes et al., 2014; Dorsey et al., 2009; Grabe & Hyde, 2006; Hebl & Turchin, 2005; Himmelstein et al., 2017). Studies focusing on healthcare professionals also found higher levels of weight-bias among White, Hispanic, and Asian participants compared to Black individuals (Phelan et al., 2014; Sabin et al., 2012). However, the relationship between race and weight-bias has yet to explored among counselors.

Studies have also shown that women are more likely than men to be the target of weight-bias (Bucchianeri et al., 2016; Hebl & Turchin, 2005; Puhl et al., 2015). In the general population, men tend to exhibit more weight-bias than women (Flint et al., 2015; O'Brien et al., 2007; Puhl et al., 2015), but in mental health care, women have shown higher levels of weight-bias than men (Davis-Coelho et al., 2000; Young & Powell, 1985). This study explored the relationship between weight-bias and race and gender to better understand how these variables relate to weight-bias among counselors.

Weight-Bias Education

Counselors may be unaware of their biases, feel uncomfortable bringing up weight-related concerns with clients, or may lack the skills to discuss those concerns when they arise (Abreu, 1999; Boysen & Vogel, 2008). Beginning in undergraduate psychology education, courses and textbooks portray body weight and size from a medical perspective, with no mention of viewing weight through a social justice lens (McHugh & Kasardo, 2012; Kasardo, 2019; Watkins & Gerber, 2016). This foundation of weight as a medical problem needing to be fixed

continues into graduate-level counselor education and rarely expands into considering the cultural and social justice components of body weight and size (Kasardo, 2019). With limited or no education regarding body weight and size, counseling students have limited awareness of how body weight impacts their own views of clients. The lack of formal training in recognizing and reducing weight-related biases and conducting weight-related conversations may lead counselors to mistakenly demonstrate explicit or implicit weight-bias with clients (Boysen, 2010), potentially damaging the therapeutic alliance and deterring clients from seeking services.

Currently, there is minimal education regarding weight-bias despite the Council for Accreditation of Counseling & Related Educational Programs (CACREP) instructions for the foundation of counselor education programs to "reflect current knowledge and projected needs concerning counseling in a multicultural and pluralistic society," (CACREP, 2016, 2.A). CACREP recognizes social and cultural diversity as one of the eight core areas of counseling curriculum (CACREP, 2016, F.2.a-h). Following CACREP standards, many counseling programs put forth substantial effort to educate students about diversity related to race, ethnicity, gender, sexual orientation, age, religion, able-bodiedness, language, and country-of-origin. Yet there is a lack of education regarding weight and fat biases.

Beyond counselor education, professional conferences offer education sessions and workshops to increase awareness and skills regarding various counseling concerns. As weight-bias is an emerging topic within counseling, little is known about the prevalence of post-graduate weight-bias education via conferences and workshops. The Association for Counselor Education and Supervision (ACES) bi-annual 2017 Conference offered one session focused on fat phobia within counselor education (ACES, 2017). In 2019, the same conference offered four sessions

that focused on fat phobia, weight-bias in counselor education, and sizeism in counselor education (ACES, 2019), indicating a recent and emerging interest in weight-bias education.

Given the harm weight-bias can have on individuals, weight-bias education has been developed and implemented to reduce weight-bias. Weight-bias education has shown to be an effective method for reducing weight-bias among professionals in a variety of disciplines within the medical and mental health fields (Burmeister et al., 2016; Cravens et al., 2016; Hague & White, 2005). Weight-bias education interventions typically explore participants self-awareness of weight-bias, frame fatness and obesity as complex medical conditions with many causes, provide strategies for reducing weight-bias (Burmeister et al., 2016; Cravens et al., 2016; Hague & White, 2005), and have been shown to be effective at reducing weight-bias (Ciao & Latner, 2011; Davis-Coelho, et al., 2000).

Given that the counseling profession, and specifically counselor education, is responsible for training culturally competent counselors, it is vital that weight-related biases are recognized and reduced. Therefore, this study examined the relationship between weight-bias and weight-bias education among counselors. While weight-bias education interventions may be helpful in reducing weight-bias, multicultural competence may also play in a role in the weight-bias of counselors.

Multicultural Competence

Multicultural competence refers to an individual's level of attitudes/beliefs, knowledge, skills related to culture within counseling (Gamst et al., 2004; Ratts et al., 2015; Sue et al., 1992). The counseling profession recognizes that counselors hold biases regarding many cultural elements such as gender, race, sexual orientation, religion, able-bodiedness, socio-economic status (SES), immigration status, etc. and that these biases can damage the therapeutic

relationship and inflict harm on clients (Abreu, 1999; Arredondo et al., 1996; Boysen & Vogel, 2008). The ACA code of ethics state “counselors are aware of -and avoid imposing- their own values, attitudes, beliefs, and behaviors” within the counseling relationship (ACA, 2014, p.5). Weight-related biases are no different. Studies show that weight-based discrimination is comparable to discrimination based on race and age (Andreyeva et al., 2008; Lee et al., 2014). Systemic oppression functions to discriminate against fatness and perpetuate inequality in similar ways as race and gender (Bergen & Mollen, 2019). Media influence, personal experiences, scientific communities, and societal pressures influence how weight and body size are viewed and valued (Lee et al., 2014; Puhl et al, 2008).

Framing weight as a cultural consideration within counseling requires an exploration of the multicultural counseling competencies used within the counseling profession. In an effort to recognize and reduce cultural bias in counseling, the counseling profession adopted and embraces the Multicultural Counseling Competencies (MCC) (Sue et al., 1992) and the Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts et al., 2015) which outline the attitudes and beliefs, knowledge, and skills that counselors need to develop multicultural competence and advocate for social justice and marginalized groups. Framing body weight as a multicultural consideration means applying these multicultural competencies to counselors’ ability to counsel and advocate for individuals of all body sizes. Research is not available to report how counselors apply multicultural education and multicultural competencies to issues related to body weight and size. Research indicates that even recently, psychologists continue to have weight-bias despite inclusion of multicultural education in graduate programs and continuing education (Bergen & Mollen, 2019). Research is scarce on the prevalence of weight-bias among counselors, so little is known how multicultural competence is related to

weight-bias among counselors. Therefore, this study explored the relationship between multicultural competence and weight-bias among counselors. In addition to race, gender, counselor education, and multicultural competence, personal experiences with weight-bias may impact weight-bias among counselors.

Personal Experiences with Weight-Bias

40% of adults report they have experienced discrimination, prejudice, or unfair treatment due to other's perceptions of their body weight and size (Himmelstein et al., 2017). Examples include being singled out by another person because of weight, being stared at in public, overhearing rude remarks about body weight or size, not being hired because of body weight, or receiving unsolicited advice on how to lose weight (Vartarian, 2015). Weight-bias can be experienced from many sources, including comments or discriminatory actions from family members, strangers, children, healthcare providers, employers, and co-workers (Pearl et al., 2018; Vartarian, 2015). Distress from experiencing weight-bias can lead to self-blame, which can contribute to internalized personal beliefs regarding body weight and size (Lewis et al. 2011; Pudney et al., 2020). Those with higher levels of internalized weight-bias have incorporated societal weight-stigma into their perception and value of self (Pearl & Puhl, 2018). Weight bias internalization (WBI) has shown to have negative impact on mental and physical health, including additional weight gain and development of eating disorders and obesity (Kahan & Puhl, 2017). WBI has most commonly been studied with individuals experiencing higher levels of fat, and often with those seeking weight-loss.

While studies have shown that experiencing weight-bias can lead to development of internalized weight-bias, no studies were found by this author that link personal experiences with weight-bias to one's own weight-bias about others. Weight-bias internalization (WBI) refers to

the internalization of societal stigma about body weight and size and applying these values to oneself (Kahan & Puhl, 2017) but does not refer to how an individual applies these values to others. This study is unique in assessing to what extent personally experiencing weight-bias impacts one's weight-bias about others. Will individuals who have experienced weight-bias be more likely to apply these same beliefs to others, or will their personal experiences protect them from applying these harmful beliefs to others? Given the gaps in the literature, this study examined how race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias impact weight-bias among counselors. These constructs will be explored in more depth in chapter two of this paper.

Significance of the Study

Previous research has highlighted the existence of weight-bias among medical and mental health care providers (Gudzune et al., 2011; Phelan et al., 2015; Pratt et al., 2015; Young & Powell, 1985) but little research is focused on counselors. Much of the current literature focuses on psychologists, social workers, and marriage and family therapists (Cravens, et al., 2016; Davis-Coelho, et al., 2000; Pratt, et al., 2015; Young & Powell, 1985). While there are many commonalities between these mental health disciplines, counseling is a unique profession based not on a medical model but instead on the wellness and empowerment of diverse individuals, families, groups, and communities (American Counseling Association (ACA), 2019). The lack of research and subsequent limited awareness and knowledge of the impact of weight-bias on the counseling profession is concerning given the severe consequences introduced above. Based on the results from studies in other mental health disciplines, it is extremely likely that weight-bias exists in counseling too. This study helps improve understanding about the relationship between weight-bias and race, gender, weight-bias education, multicultural competence, and personal

experiences with weight-bias, which may help the counseling profession address and reduce weight-bias among counselors.

Purpose of the Study

The purpose of this study was to examine factors that may contribute to weight-bias among licensed counselors who earned a master's degree in counseling. This study intended to show whether and to what extent a relationship exists between weight-bias and race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias.

Research Question

Given the presence of weight-bias in society this study aimed to answer the following question.

Question 1: To what extent, if any, does race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias impact weight-bias among licensed counselors who earned a master's degree in counseling?

Limitations

The following limitations, which were outside of the researcher's control, are associated with this study:

- This study consisted of a sample of licensed counselors, some of whom were members in professional counseling organizations. The researcher did not have control over the membership of these counseling organizations or how well these counselors represent the counseling population in general.
- The self-report surveys in this study may not protect against social desirability. It is possible that participants responded to the questions in the survey in a way they believed

will be viewed as positive by others, rather than expressing their true attitudes and beliefs. Data was collected via online survey, which may limit social desirability.

- Due to the correlational research design, no causal inferences could be made.

Delimitations

The following delimitations, which are within the researcher's control, were associated with this study:

- The sample in this study were self-identified counselors within the United States who may be members of professional counseling organizations.
- Counselors were defined as an individual licensed as a counselor within the United States and earned a master's degree in counseling.
- Data was collected via Qualtrics.

Assumptions

The following assumptions were made in this study:

- Participants were able to read, understand, and respond to the questions in English.
- Participants responded honestly and accurately to the items on the instruments.
    - Participants did not alter their answers to achieve social desirability.
- Weight-bias was present in participants.
- The instruments used were valid and reliable in measuring elements of weight bias, race, gender, weight-bias education, multicultural competence, and personal experience with weight-bias.

Threats to Validity

Threats to Internal Validity

This study, as any study, was subject to threats to internal validity, some of which are discussed below. Threats to internal validity compromise credit to the dependent variables for changes of the independent variable (Johnson & Christensen, 2004). This non-experimental survey research design utilized strategies to minimize threats to instrumentation and history. First, the instruments may not truly measure what they intend to measure. To minimize this risk, only instruments with acceptable alphas (> .7 or higher) were included in this study. A second risk was that the participants were completing the instruments at a single point in time. Responses may have been subjective to historical or environmental events occurring in society or participants personal lives which were outside of the control of this study. This study occurred during a worldwide pandemic, which was considered in the interpretation of results.

Threats to External Validity

This study was also at risk for threats to external validity, or the researcher's ability to generalize findings beyond the study (Johnson & Christensen, 2004) including the following. First, the sampling of the counseling population in this study was not random. Participants were self-selected based on their affiliation with a state-level counselor licensure board or a professional counseling association. Due to the sample not being randomly selected, the researcher was not able to control for demographic characteristics of the sample. Also, this study only included counselors within the United States and may not be generalizable to counselors in other parts of the world. Finally, this study included only licensed counselors, limiting the generalizability of the results to counseling students or other mental health professionals.

Operational Definitions

For the purpose of this study, the following definitions were used for these identified key terms. Definitions for variables in this study, weight-bias, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias, were pulled from the instrument development literature (Bacon et al., 2001; Davis-Coelho et al., 2000; Gamst et al., 2004; Vartanian, 2015). Other definitions were pulled from other relevant literature within the weight-bias field.

- Body Mass Index (BMI): a person's weight in kilograms divided by the square of height in meters (Center for Disease Control [CDC], 2020).
- Fat: a natural descriptor of a body, as part of the body positive movement to reclaim stigmatizing terms (Kinavey & Cool, 2019).
- Overweight: BMI of 25.0 to 29.9 (CDC, 2020).
- Obese: BMI 30.0 or higher (CDC, 2020).
- Weight-bias: an individual's negative attitudes towards and stereotypes about people perceived to have higher levels of body fat (Bacon et al., 2001).
- Weight-bias education: a specialized intervention designed to reduce weight-bias (Davis-Coelho et al., 2000).
- Weight-stigma: a set of societal negative attitudes and beliefs directed toward individuals who are perceived to have higher levels of body fat (Pearl, 2018).
- Multicultural competence: the attitudes and beliefs, knowledge, and skills necessary to conduct counseling with diverse clients across cultures (Arredondo et al., 1996; Gamst et al., 2004).

- Personal experiences with weight-bias: an individuals' personal experiences with stigmatizing situations due to their own weight (Myers & Rosen, 1999; Vartanian, 2015).
- Counselors: individuals who earned a master's degree in counseling and are licensed within the United States to practice counseling, may include licensed professional counselors (LPC), licensed mental health counselors (LMHC), licensed clinical professional counselors (LCPC), licensed professional clinical counselor of mental health (LPCC), licensed clinical mental health counselors (LCMHC), and licensed mental health practitioner (LMHP) and may include those will full licensure and those with associate or provisional licensure who are working towards full licensure, such as Licensed Associate Counselor (LAC), Licensed Professional Counselor Associate (LPCA), and Licensed Graduate Professional Counselor (LGPC) (American Counseling Association, n.d.).
- Weight-status: an individual's position within one of weight level classifications (CDC, 2020).
- Race: an individual's self-identified racial identity selected from Non-Hispanic White, Black/African American, Hispanic/Latina/o, Asian, American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, Multiracial, Other.
- Gender: an individual's self-identified gender identity selected from Female, Male, and non-binary/third gender.

Summary

Weight-bias is prevalent in western society, including in physical health and mental health care. Weight-bias can cause psychological harm (Friedman, & Puhl, 2012; Pearl & Puhl, 2018). Those who turn to counseling as a source of healing, and who have been recipients of discrimination and prejudice due to weight, may also experience weight-bias from their mental

health care provider (Kinavey & Cool, 2019). Counselors may intentionally or unintentionally exhibit weight-bias towards their clients and damage the therapeutic relationship causing additional psychological harm and deter clients from seeking mental health support in the future (Kinavey & Cool, 2019). Weight-bias is a multicultural issue but is rarely presented as such in the field of counseling (Bergen & Mollen, 2019). Race and gender have both been identified as factors related to weight-bias among mental health providers yet have not been studied with counselors. Weight-bias education can help counselors to recognize their own weight-biases and reduce these biases to prevent inflicting harm on to clients (Ciao & Latner, 2011; Davis-Coelho, et al., 2000). Personal experiences of weight-bias from others may impact a counselor's own weight-bias towards others. This study sought to understand the relationship between weight-bias and race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias among licensed counselors who earned a master's degree in counseling. The following chapter further explores and analyzes research related to the variables within this study: weight bias, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias.

CHAPTER II: REVIEW OF THE LITERATURE

The purpose of this study was to investigate the five specific factors related to weight-bias among licensed counselors who earned a master's degree in counseling. This chapter consists of a review of the literature related to the outcome variable, weight-bias, and the five predictor variables, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias, in this study. The theoretical framework for this study will be identified and explained. Literature related to weight-bias, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias will be reviewed. The purpose of this study was to investigate how race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias relate to weight-bias among licensed counselors who earned a master's degree in counseling.

Theoretical Framework

This study used the Multicultural Counseling Competencies (MCCs) as its theoretical framework. The MCCs address the beliefs and attitudes, knowledge, and skills necessary to conduct culturally competent counseling (Sue et al., 1992; Ratts et al., 2015). Framing body weight as a cultural consideration requires the current understanding of culture and identity to extend beyond race, ethnicity, gender, sexuality, religion, ability, age, language, and country-of-origin. The counseling profession currently recognizes the importance of addressing counselor bias related to these cultural identities but does not yet include weight-bias in counselor education, research, and clinical practice. The Multicultural and Social Justice Counseling Competencies (MSJCC) recently expanded the MCCs to "reflect a more inclusive and broader understanding of culture and diversity," (Ratts et al., 2015, p.29) thus, opening the door for more cultural identities to be considered, such as body weight. Additionally, several authors have

advocated for body weight and size to be included as a cultural consideration in mental health fields and included in education and training of new mental health care providers in order to fight the bias and subsequent harm within mental health care (Bergen & Mollen, 2019; Brochu, 2019; Kasardo, 2019; McHugh & Chrisler, 2019; Smith, 2019). The MCCs can provide a foundation for counselors to address and develop culturally competent beliefs and attitudes, knowledge, and skills to provide counseling to individuals with higher levels of body fat who may have experienced bias, stigma, prejudice, discrimination, and oppression similar to those with other cultural identities such as race (Basma et al., 2020), religion (Magaldi-Dopman, 2014), and socioeconomic status (Bray & Schommer-Aikins, 2015).

Weight-Bias

Weight-bias was the outcome variable in this study. Weight-bias is understood to be the negative attitudes and beliefs directed towards individuals who are perceived to have excess body weight (Bacon et al., 2001; Pearl & Puhl, 2018). Weight-bias refers to the attitudes and beliefs about body weight held by an individual (Pearl & Puhl, 2018), stigma refers to negative societal beliefs (Pearl, 2018), and discrimination refers to behaviors and unjust treatment towards those in a marginalized group (Allport, 1954; Andreyeva et al., 2008). Weight-bias and stigma often lead to actions and behaviors that discriminate against those perceived to have higher levels of body fat (Pearl & Puhl, 2018). Weight-bias and discrimination are expressed in a variety of relationships and settings including interpersonal relationships, workplace, school, healthcare, and in the media (Andreyeva et al., 2008; Hague & White, 2005; Hunger & Tomiyama, 2014; Pont et al., 2017; Puhl & Heuer, 2009). Inaccurate beliefs about the causes of higher levels of body fat and obesity place the blame and responsibility solely on the individual rather than the

various contributing factors such as genetics and physiology (Puhl et al., 2020; Schwartz et al., 2017).

Weight-bias is often utilized and approved of in society because of beliefs that stigma and shame will motivate people to lose weight (Pont, et al., 2017). However, research has shown that stigma and shame do not facilitate positive changes but further contribute to unhealthy and maladaptive behaviors and beliefs about oneself such as binge eating, social isolation, avoidance of health care services, decreased physical activity, and increased weight gain, which worsen obesity and create additional barriers to healthy behavior change (Pont et al., 2017). Additionally, hyper focus on solutions aimed at the individual level detract from the attention necessary to combat obesity as an environmental and public health problem (Puhl & Heuer, 2009). Weight-bias has been documented as occurring at steady rates over the past 50 years, even as other forms of bias (e.g., race and sexual orientation) have decreased (Charlesworth & Banaji, 2019; Puhl et al., 2020). More literature detailing the prevalence of weight-bias will be discussed in the personal experiences of weight-bias section of this chapter.

Weight-Bias Terminology

Within the weight-bias literature, various terms are used to describe the phenomenon. Many terms are used interchangeably, though there are distinct differences. Weight-bias refers to an individual's negative attitudes and stereotypes about people perceived to have higher levels of body fat (Bacon et al., 2001). Weight-stigma refers to a set of societal negative attitudes and beliefs directed toward individuals who are perceived to have higher levels of body fat (Pearl, 2018). Weight-based discrimination refers to the unjust treatment of individuals perceived to have higher levels of body fat (Allport, 1954; Andreyeva et al., 2008). Sizeism refers to the discrimination against individuals on the basis of their body size/weight (Chrisler & Barney,

2017). This study explored participants' individual negative attitudes and stereotypes about people perceived to have higher levels of body fat; therefore, the term weight-bias will be prioritized throughout this paper. However, weight-stigma, discrimination, and size-ism will also be used to describe each distinct construct as applicable and to remain consistent with terms used in each study.

The phenomenon of weight-bias has also previously been labeled as "fat oppression" or "anti-fat" and defined in the clinical literature as the "fear and hatred of fat people, particularly women, and the concomitant presence of oppressive and discriminatory practices aimed at fat people," (Brown, 1989, p.19). The use of the word "fat" has been controversial over the past few decades. Some claim the word "fat" to be a shaming and negative word and efforts have been made to replace it with terms such as overweight, obesity, and excess weight (Puhl et al., 2011; Puhl et al., 2013; Volger et al., 2012). However, a recent shift to reclaim this word has claimed that "fat" is a natural descriptor of a body and should be used instead of medical words such as "obese" (Bergen & Mollen, 2019; Kinavey & Cool, 2019). As stated in chapter 1, "fat" and "obese" will be used in this paper to describe both the fatness on a body and the medical condition of obesity. Other terms may also be used to stay consistent with terminology used withing the existing literature. This section will highlight literature regarding the experience of having and expressing weight-bias about and towards others. Literature related to experiencing weight-bias will be discussed later in this chapter.

Sources of Weight-Bias

Weight-bias can be expressed in a variety of settings including education, work, media, and healthcare, and from a variety of people including peers, parents, family members, teachers, healthcare professionals, and dating or romantic partners (Hunger & Tomiyama, 2014; Pont et

al., 2017; Puhl & Heuer, 2009). Burmeister et al., (2013) found that graduate student applicants with higher BMIs had a significant disadvantage in offers of admissions following an in-person interview compared to applicants with lower BMIs. Research has also found that k-12 teachers exhibit weight bias in classrooms (Hague & White, 2005). Individuals with obesity report facing discrimination in the workplace by being denied a promotion or fired due to their weight (Andreyeva et al., 2008; Roehling et al., 2007). Media can also play a role in perpetuating weight-bias and stigma. A meta-analysis of weight-bias in child, adolescent, and adult-focused media showed that television and movie characters with larger body sizes are underrepresented compared to actual rates in society, and when included, characters were most commonly portrayed as unattractive, unhappy, angry, less intelligent, having fewer friends or dating/romantic partners, or being the targets of humor (Ata & Thompson, 2010). Several studies have revealed that weight-bias is prominent amongst health care professionals, including physicians, nurses, dietitians, and medical trainees (Kushner et al., 2014; Puhl & Heuer, 2009; Sabin et al., 2012; Phelan et al., 2015; Gudzune, et al., 2011), even obesity researchers and health professionals (Tomiyama et al., 2014).

Weight-Bias in Mental Health

Research has also documented the prevalence of weight bias in mental health. However, much of this foundational research took place prior to the 2000's and there have been limited studies on this topic in recent years. These studies focused on psychology, social work, and marriage and family therapy (Cravens, et al., 2016; Davis-Coelho, et al., 2000; Pratt, et al., 2015; Young & Powell, 1985), but there have been no published peer-reviewed studies focused specifically on weight-bias in the counseling profession. However, two published dissertations

(Adams, 2008; Feister, 2012) were found that investigated weight-bias within the counseling field and will be discussed in the next section.

A seminal study conducted in 1985 by Young and Powell provided images of the same Caucasian middle-aged woman altered to different weight levels to mental health workers (e.g., counselors, family therapists, psychologists, psychiatrists, psychiatric nurses) who subsequently assigned greater levels of symptomology and pathology to the client depicted as overweight or obese than average weight. A similar study in 1991 by Agell and Rothblum utilized case histories that included written information regarding the clients' height and weight. Results showed that psychologists rated clients depicted as obese as more physically unattractive and more "embarrassed" than those depicted as nonobese (Agell & Rothblum, 1991). Those depicted as obese were also rated "kinder" and "softer" than those depicted as nonobese (Agell & Rothblum, 1991).

Davis-Coelho et al. (2000) replicated aspects of these previous studies by providing a first-person self-description and photograph depicting the same Caucasian woman appearing either fat or non-fat to psychologists and asking them to report recommended treatment modality, provisional diagnoses, prognosis, potential client effort and motivation, and overall functioning. Results indicated that younger psychologists (age 40 or younger) predicted the client appearing as fat would put less effort into treatment and assigned worse prognosis (Davis-Coelho et al., 2000). Female psychologists also were more likely than male psychologists to assign worse prognosis (Davis-Coelho et al., 2000). Participants were more likely to diagnose the client with an eating disorder when the client appeared fat and diagnose the client with adjustment disorder when she appeared non-fat (Davis-Coelho et al., 2000). Participants also identified different treatment goals for the client when she appeared fat versus non-fat (Davis-Coelho et al., 2000).

A more recent study focused specifically on mental health providers (psychologists, therapists, social workers, and dietitians) who treat eating disorders found that participants reported having negative stereotypes towards individuals with obesity, including individuals with obesity have poor self-control, have no willpower, overeat, are self-indulgent, unattractive, inactive, insecure, responsible for their obesity, and will not adhere to weight loss treatment or maintain weight loss once achieved (Puhl et al., 2014). Participants also reported an overall feeling of discomfort in treating individuals with obesity and had witnessed weight-bias from other eating disorder professionals (Puhl et al., 2014). Participants' personal experiences with weight impacted levels of weight-bias: individuals with higher BMI had lower scores of weight-bias, while individuals who reported they were currently trying to lose weight scored significantly higher levels of weight-bias than those who were not (Puhl et al., 2014). These findings align with previous studies that show a presence of weight-bias among mental health professionals, yet this study indicates that those who specifically work with individuals with eating disorders hold harmful biases regarding the individuals they are specialized to treat.

Pratt et al. (2015) found significant levels of explicit weight-bias among marriage and family therapy trainees. Demographic characteristics were found to relate to levels of weight-bias, including non-Caucasian participants were more likely to believe obesity is not within a person's control compared to Caucasian participants, doctoral students were also more likely to believe obesity it not within a persona's control compared to master's students (Pratt et al., 2015). Additionally, individuals who self-identified as being overweight or obese and those with higher BMIs scored higher levels of weight-bias compared to those who self-identified as "healthy" weight and had healthy BMIs (Pratt et al., 2015). This finding contradicted previous research that showed individuals with lower BMIs showing greater weight-bias than those with

higher BMIs (Phelan et al., 2014; Schwartz et al., 2006). These mixed results suggest additional research is needed to determine how body size impacts weight-bias towards others among mental health providers.

The results of these studies described above are concerning and document that since the 1980's mental health providers have routinely shown to exhibit weight-bias by assigning harsher levels pathology, diagnosis, prognosis to clients with perceived fatness (Agell and Rothblum; 1991; Davis-Coelho et al, 2000; Phelan et al., 2015; Puhl et al., 2014; Puhl & Heuer, 2009; Young & Powell, 1985). Davis-Coelho et al. (2000) describes the concern as follows:

> A well-intentioned clinician who attempts to work in an unbiased manner with a fat client, but who is not fully aware of his or her own biases, risks introducing fat bias into his or her practice in many subtle ways. This may include assuming that all fat clients have "disordered" eating patterns or assuming that the client's weight is either the source of his or her problems or an expression of psychological maladjustment. (p. 683)

These concerns by Davis-Coelho et al. (2000) have been found to be true within mental health services according to studies (Akoury et al., 2019; Kinavey & Cool, 2019; Schafer, 2014) conducted with clients who have experienced weight-bias in therapy and will be discussed below.

Client Experiences of Weight-Bias

Clients have reported experiencing weight-bias from their mental health providers, often in the form of microaggressions where therapists attributed the client's weight as the source of the presenting concerns and recommending weight-loss as the appropriate treatment (Schafer, 2014). Clients have reported psychologists sharing their own dieting successes, advising clients to follow unproven fad diets, providing lawn furniture as seating after a previous chair had

broken beneath the client the week prior, shaming clients, inciting fear of developing diabetes or having limbs fall off due to diabetes, and assuming that fatness is always due to trauma and that weight loss will occur once the client heals from trauma (Kinavey & Cool, 2019). Akoury et al. (2019) argue that while overt forms of weight-bias may be less common from therapists, microaggressions can happen and are damaging to the therapeutic alliance. Microaggressions refer to the subtle, and often unintentional, negative expressions (Sue et al., 2007) towards a client, and may include stereotypical assumptions about a client due to their weight, overidentification of weight to presenting problems and weight-loss as the solution to presenting problems, minimizing or avoiding discussions of weight or weight-bias, denying the existence of weight-bias from others and stigma from society, prioritizing thin clients over "heavy" clients in group therapy, or appearing disinterested in session (Akoury et al., 2019). Clients have reported that experiencing or anticipating the experience of weight-bias in therapy has led them to miss sessions or terminate early from treatment (Akoury et al., 2019).

Weight-Bias in Counseling

While no peer-reviewed studies could be found examining weight-bias within the counseling field, one published dissertation by Feister (2012) shows the presence of weight-bias among licensed counselors. Participant scores on weight-bias measures detected significant levels of negative attitudes and beliefs regarding individuals with obesity (Feister, 2012). Despite the presence of weight-bias in the sample and reporting having little to no education or training regarding obesity and mental health, participants reported themselves as having sufficient knowledge about the topic of obesity and mental health (Feister, 2012). The author of this study reported that these rates of explicit weight-bias carried even greater significance due to participants being aware of the intent of the study to measure negative attitudes towards individuals with

obesity. Feister (2012) suggested that these findings indicate that either participants had answered honestly and not changed answers to fit social desirability, or participants had adjusted answers to fit social desirability and these scores indicate a general acceptance for expressing bias towards individuals with obesity. Feister (2012) expressed concern regarding this finding, considering the counseling profession's overall emphasis on decreasing bias and argued that the counseling profession and counselors themselves do not view their attitudes towards individuals with obesity as biased, or unjust.

Another published dissertation reported presence of weight-bias among counseling students who had reviewed a case study accompanied by photographs of the client portrayed as either "overweight" or "normal weight" (Adams, 2008). The bias detected in this study was implicit, as the researchers coded written responses and identified subtle differences in how participants described the "overweight" client compared to the "normal weight" client (Adams, 2008). These two dissertations provide some evidence of the existence of weight-bias among counselors, both explicit bias and implicit bias. However, there remains to be any peer-reviewed studies published in academic journals that examine weight-bias in counseling.

Given the presence of weight-bias in mental health care, it is concerning that clients who seek help regarding their mental health may be subjected to bias and discrimination from the very professionals they turn to for healing. To prevent further damage, it is important that mental health professionals recognize and reduce their own weight-bias. Due to the limited research on weight-bias in mental health and lack of research on weight-bias in counseling, this study aimed to begin this focus by examining factors related to weight-bias among licensed counselors who have earned a master's degree in counseling.

Demographic Variables

Race

Previous research shows that weight-bias may be experienced and expressed differently for individuals of different races. Hebl and Turchin (2005) conducted a study examining weight-bias of Black and White males towards Black and White males and females. Results indicated that White males showed preference only for thin females while Black men showed a preference for both thin and slightly overweight females (Hebl & Turchin, 2005). However, this was only true when evaluating in-group women; Black and White men both failed to stigmatize women with obesity of the opposite race (Hebl & Turchin, 2005). In addition, Black and White men both showed significantly more weight-bias towards White men with obesity than Black men with obesity. The authors suggested this may be explained by the societal view of Black male bodies as being athletic compared to white men, thus assigning less bias towards Black men with obesity (Hebl & Turchin, 2005). Race and weight-bias has also been studied among women. Dorsey et al. (2009) found that Black and Hispanic women were more likely than White women to underestimate BMI and describe higher body weights as normal or healthy. Asian, Hispanic, or White women also tend to experience more body dissatisfaction, share similar beauty ideals, and have more anti-fat attitudes than Black women (Grabe & Hyde, 2006; Pepper & Ruiz, 2007; Hebl et al., 2009). Another study examined Asian women in Singapore and found high levels of implicit anti-fat bias, similar to rates in Western samples, yet low levels of explicit bias, indicating a reluctance to openly endorse anti-fat attitudes (Jiang et al., 2017). Barnes et al. (2014) found that among patients with obesity who were seeking weight-loss treatment, weight-bias was significantly stronger for White individuals compared to Black individuals. Examining weight-bias across four different western countries, Puhl et al. (2015) found that Black

individuals demonstrated much lower levels of weight-bias than White individuals. Another study found that Asian and White individuals may be more likely to internalize weight-bias than Hispanic or Black individuals (Himmelstein et al., 2017). However, the study also showed similar rates of experiencing weight-bias across the different races- suggesting that although race may not strongly align with experiencing weight-bias, individuals with different racial identities may interpret and integrate their experiences with weight-bias differently (Himmelstein et al., 2017). Himmelstein et al. (2017) reports that obesity occurs for over 50% of Black women, 44% of Hispanic women, and 33% of White women yet much of the research about weight-bias includes samples of predominantly White women and rarely examines race as a meaningful variable (Himmelstein et al., 2017). This remains true in studies exploring weight-bias within physical and mental health fields. A study examining obesity bias among advanced medical students reported participants were 75% Caucasian, 9% Asian, and 15% other (Puhl, Luedicke et al., 2014). Another study examining weight-bias among professionals treating eating disorders reported 95% of the sample as Caucasian and 5% as other (Puhl, Latner et al., 2014). While studies often report the demographic characteristics of participants, few include race as a meaningful variable in the analysis. One study examined implicit bias among medical doctors (MDs) and included race as a primary variable (Sabin et al. 2012). The sample was reported as 78% White, 15% Asian, 5% as African American, and 2% as Hispanic (Sabin et al., 2012). Results showed strong levels of implicit anti-fat bias among White and Hispanic participants (Sabin et al., 2012). In a study of medical students (65% White, 24% Asian, 6% Hispanic, and 6% Black), results showed that Black participants showed the lowest levels of explicit weight-bias compared to White, Hispanic, and Asian participants (Phelan et al., 2014). This study aimed

to recruit a diverse sample in order to conduct a meaningful analysis of the relationship between race and weight-bias among counselors.

Gender

Previous studies that have explored the relationship between gender and weight-bias reveal gender differences in expressing and experiencing weight-bias. Hebl and Turchin (2005) conducted a study with only male participants, citing their underrepresentation in previous weight-bias research. Results indicated that males do exhibit weight-bias towards others and tend to show more weight-bias towards women than men. O'Brien et al. (2007) found that male participants reported significantly stronger feelings of dislike towards "fat people" than female participants. In 2015, Flint et al. also found higher levels of anti-fat attitudes among males than females. Puhl et al. (2015) examined weight-bias attitudes across four Western countries and found that while women may be more susceptible to experiencing body weight-related stereotypes and negative stigma, men were more likely to report higher levels of weight-bias than women. A study that explored experiences of weight-based prejudice among adolescents showed significantly higher levels of bias for females than males (Bucchianeri et al., 2016). This finding aligned with the findings from Fikkan & Rothblum (2011) who examined previous literature on weight-bias and found that the experiences of weight-bias are much stronger and cause greater harm for women than men. More recently, Himmelstein et al. (2017) found that women also may be more likely than men to internalize weight-bias. These studies conducted with the public indicate that men may be more likely than women to have weight-biases, yet women may be more likely than men to be the target of weight-bias.

Studies focused specifically on mental health professionals reveal somewhat different results. Young and Powell (1985) discussed the implications of societal standards and

expectations connecting thinness with attractiveness and the subsequent impact this has on female mental health provider's beliefs about clients with higher levels of body fat. Young and Powell (1985) argued that women are more likely to react poorly to clients with higher levels of body fat due to their own fears of being fat. Their study found that female mental health workers did indeed assign more negative psychological symptoms to clients with obesity than male mental health workers (Young & Powell, 1985). Among psychologists Davis-Coelho et al. (2000) found that women were more likely than men to predict significantly worse prognosis for clients with higher levels of body fat than clients with societally acceptable body weights. The relationship between gender and weight-bias in the counseling field is less clear. In a published dissertation, Feister (2012) found no significant relationship between gender and weight-bias. However, this is the only published study exploring gender and weight-bias in counseling. To contribute to filling this gap in the literature, this study investigated the relationship between gender and weight-bias among counselors.

Weight-Bias Education

Given the prevalence and damaging effects of weight-bias in society, many researchers have begun efforts to reduce and prevent weight-bias (Davis-Coelho et al., 2000; Hague & White, 2005; Pratt et al., 2015). Several research studies have been conducted in the fields of education, healthcare, and mental health care to evaluate interventions designed to prevent or reduce weight-bias (i.e., Cravens et al., 2016; Hague & White, 2005; Pratt et al., 2015). Many of these studies have utilized weight-bias education as a method to inform individuals about the condition of fatness and/or obesity, the subsequent effects of fatness and/or obesity, and presence and impact of weight-related bias in society and within the designated profession (Hague & White, 2005; Pratt et al., 2015).

Daníelsdóttir et al. (2010) conducted a meta-analysis of published studies focused on reducing anti-fat prejudice. This review revealed conflicting results regarding the efficacy of interventions designed to reduce anti-fat prejudice. Educational interventions showed to be effective in changing beliefs and knowledge about the causes of obesity, but not consistent in reducing anti-fat prejudices (Daníelsdóttir et al., 2010). Other interventions focusing on adopting social norm- and social consensus were found to be more effective in reducing anti-fat prejudices (Daníelsdóttir et al., 2010). These findings align with a recommendation from Pausé (2019) that interventions combining both education about fatness and obesity and emphasis on developing empathy for people with fatness and obesity may be most successful at reducing weight-bias among mental health providers. A combination of acquiring new knowledge and emotional processing has been shown to be effective at changing negative attitudes towards other topics in counseling such as multiculturalism (Castillo et al., 2007) and death/grief (Harrawood et al., 2011).

Delivery Methods

Different disciplines have utilized a variety of formats to deliver weight-bias education including video interventions (Swift et al., 2013; Poustchi et al., 2013), documentaries (Burmeister et al, 2016), internet-based modules (Hague & White, 2005), and in-person workshops, (O'Brien et al., 2010). These formats have all been successful in reducing weight-biases and at least one study found that reduction in negative attitudes towards body weight were sustained at the 6-week follow up (Hague & White, 2005). While weight-bias reducing interventions have been successful with undergraduate students, graduate students, and working professionals, Davis-Coelho et al., (2000) recommend that weight-bias education should take

occur early in one's career to develop awareness and prevent weight-bias prior to entering the profession.

Components of Weight-Bias Education

No evidenced-based-model has yet been developed for weight-bias education. However, many researchers have conducted studies and published recommendations regarding important components found to be successful at reducing weight-bias (Burmeister et al., 2016; Davis-Coelho, 2000; Kahan & Puhl, 2017; Kinavey & Cool, 2019; Pearl & Puhl, 2018). One key aspect of weight-bias education is education regarding the complexity of the medical condition, including the various causes, of higher body fat and obesity. Many people falsely believe that weight is solely controllable by the individual, thus the individual is to blame when they have higher levels of body fat or obesity (Crandall, 1994, Crandall & Martinez, 1996, Hague & White, 2005). When fatness or obesity are identified as complex conditions due to biological, genetic, and environmental contributors rather than solely within an individuals' control, the person is no longer blamed and bias diminishes (Crandall, 1994; DeJong, 1993). Davis-Coelho et al. (2000) support this claim as well, "A critical component of any intervention would involve education that combats the belief that fatness is controllable," (Davis-Coelho et al, 2000, p. 683). In addition to education regarding causes of fatness and/or obesity, attention should be given to developing empathy and combating social beliefs about fatness and obesity (Burmeister et al., 2016; Pausé, 2019). It is also important to include information about the progression from weight-bias to weight-bias internalization and subsequent impact on self-esteem, depression, anxiety, body satisfaction, and suicidality (Kahan & Puhl, 2017; Pearl & Puhl, 2018).

Research also shows the importance of affirming and supportive language in weight-bias education (Bergen & Mollen, 2019; Brochu & Esses, 2011; Kinavey & Cool, 2019; Pont et al.,

2017; Puhl et al., 2011; Puhl et al., 2013; Volger et al., 2012). Individuals can be encouraged to use people-first language, which places the individual first, before the medical condition, and involves using phrases such as “a person with obesity or fatness” vs an “obese or fat person” (Pont et al., 2017). While terms such as “fat”, “obese” and “extremely obese” have been rated as the most undesirable, stigmatizing, blaming, and least motivating, words such as “weight”, “unhealthy weight” or “overweight” have been rated more favorable and motivating for weight loss (Brochu & Esses, 2011; Puhl et al., 2011; Puhl et al., 2013; Volger et al., 2012). More recently, “fat” has been reclaimed as a weight-inclusive term and may now be preferred for some individuals (Bergen & Mollen, 2019; Kinavey & Cool, 2019). Due to the debate on which terms are shaming and which are preferred, it is important to use weight-bias education to teach participants to understand the various terms, learn which terms each client prefers, and use those preferred terms with each client. The importance of non-stigmatizing language is demonstrated in the findings of a study conducted by Puhl et al. (2011) which revealed that 34% of parents would switch doctors if a doctor referred to their child’s weight in a stigmatizing manner, and 24% would avoid future medical appointments with that doctor, showing that shaming terminology from a provider can deter individuals from seeking and receiving health care.

In addition to learning about causes for fatness or obesity and appropriate language and terminology, weight-bias education should include a self-assessment of participants own implicit and explicit bias against fatness and obesity (Daníelsdóttir et al., 2010; Davis-Coelho et al, 2000). Studies have used various tools to measure implicit and explicit weight-bias to help participants gain awareness of their biases, including but not limited to The Implicit Attitudes Test (IAT) (Project Implicit, 2011), Anti-Fat Attitudes (AFA) (Crandall, 1994), Fat Phobia Scale (Bacon et al., 2001), Attitudes towards Obese Persons (ATOP) (Allison et al., 1991), Beliefs

about Obese Persons (BAOP) (Allison et al., 1991), and Universal Measure of Bias-Fat Scale (UMB-FAT) (Latner et al., 2008).

A final component of weight-bias education includes treatment considerations. Treatment considerations include learning that weight loss may not be the only option for course of treatment. Clients seeking medical or mental health care may benefit from treatment that focuses on self-acceptance and self-love rather than solely on weight-loss (Davis-Coelho et al, 2000; Robinson & Bacon, 1996). Clients may or may not seek mental health to focus on weight-loss and professionals need to be prepared to meet the client's expressed wants and needs. Treatment considerations also involve the physical environment where the professional interacts with the client. Davis-Coelho (2000) recommends ensuring that the office has wide doors, large restrooms, few or no stairs, sturdy armless chairs or couches, adequate air conditioning, and publications representing various body sizes in order to help the client feel comfortable in the counseling setting. Pausé (2019) also recommends removing women's health and beauty magazines from waiting rooms due to their emphasis on fat shaming articles, pictures, and advertisements.

These components of weight-bias education described above have all been shown to have varying levels of effectiveness at reducing weight-bias (Burmeister et al, 2016; Daníelsdóttir et al., 2010; Davis-Coelho et al, 2000; Hague & White, 2005; Pausé, 2019). There is not one specific model or component that has shown to be the most effective, therefore more research is required to develop an evidence-based intervention that consistently and effectively reduces weight-bias.

Impact of Weight-Bias Education

Weight-bias education has found some evidence to be effective at reducing weight-bias among a variety of populations including undergraduate students (Burmeister et al., 2016; Ciao & Latner, 2011), teachers (Hague & White, 2005), and medical students (O'Brien et al., 2010; Swift et al., 2013). Hague & White (2005) conducted a study that utilized a web-based intervention designed to change attitudes towards obesity among current and future teachers. The intervention was a self-paced learning module centered on a health-focused approach rather than a weight-focused approach to obesity that took approximately five hours to complete (Hague & White, 2005). Results indicated that negative attitudes towards obesity were reduced following completion of the learning module and remained reduced at a 6-week follow up (Hague & White, 2005).

Ciao and Latner (2011) conducted a study with undergraduate students using written feedback regarding their obesity stigma levels as an intervention after completing a pre-test measuring obesity stigma. Feedback designed to trigger cognitive dissonance highlighted inconsistencies in participants obesity stigma levels and personal values and beliefs of benevolence, universalism, kindness, and equality and was shown to reduce levels of weight stigma at post-test (Ciao & Latner, 2011). Feedback designed to trigger social consensus indicated participants obesity stigma was stronger than their peers and did not reduce weight stigma, nor did feedback that indicated participants obesity stigma aligned with their personal values and their peers (Ciao & Latner, 2011). This study suggests that using cognitive dissonance to challenge specific beliefs about weight that contradict personal values of benevolence and equality can be effective at reducing weight-bias (Ciao & Latner, 2011).

O’Brien et al. 2010 conducted an intervention study aimed at reducing anti-fat prejudice of preservice health students. Participants were assigned to one of three conditions: (1) presented curriculum regarding the controllable reasons for obesity, such as diet and exercise, (2) presented curriculum regarding the uncontrollable reasons for obesity, such as genes and environment, or (3) curriculum unrelated to obesity regarding alcohol use in young people (O’Brien et al., 2010). Explicit and implicit anti-fat prejudice was measured pre- and post- intervention. Those in the second group, who received education about the uncontrollable reasons for obesity, showed a decrease in implicit and explicit anti-fat prejudice at post-test (O’Brien et al., 2010). Those in the first group, who received education about the controllable reasons for obesity, showed an increase in implicit anti-fat prejudice at post-test (O’Brien et al., 2010). No changes in anti-fat prejudice were found at post-test in the third group, who received no education related to obesity (O’Brien et al., 2010). This study demonstrates that education that emphasizes the uncontrollable factors contributing to obesity can reduce weight-bias, while education that confirms the individual’s ability to control weight can increase weight-bias.

Weight-Bias Education in Counseling

No peer-reviewed studies could be found exploring weight-bias education in counseling. However, one published dissertation documented that 54% of licensed counselors had not received any training regarding obesity or weight-bias in their counselor education programs, workshops/trainings, or supervision (Feister, 2012). 76.9% reported seeking out training on weight and obesity no more than “a little” and 50.1% of participants reported seeking out training “none of the time” (Feister, 2012). Those who did report having training regarding obesity or weight-bias reported the most common setting was in workshops/trainings (21.5%), followed by supervision (8.5%), and counselor education programs (8.3%) (Feister, 2012). This finding

suggests that weight-bias education is not prominent in the counseling field, though some counselors have exposure to weight-bias education in various educational settings.

The purpose of this study was to examine how weight-bias education relates to weight-bias in licensed counselors who earned a master's degree in counseling.

Multicultural Competence

According to the American Counseling Association (ACA), counseling is defined as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals," (ACA, 2014, p.20). Counselors encounter and provide services to culturally diverse clients and must be attuned to how culture impacts the counseling process. The ACA code of ethics require counselors to have awareness of -and avoid imposing- their own values, attitudes, beliefs, and behaviors within the counseling relationship (ACA, 2014, p.5). Counselors hold values, attitudes, beliefs, and behaviors regarding various cultural elements including gender, race, sexual orientation, religion, able-bodiedness, socio-economic status (SES), and immigration status which can interfere with the counseling relationship (Abreu, 1999; Arredondo et al., 1996; Boysen & Vogel, 2008). These values, attitudes, and beliefs may present as cultural bias, or negative attitudes and beliefs, regarding individuals and groups with various cultural identities, which can damage the therapeutic alliance and harm clients (Abreu, 1999; Arredondo et al., 1996; Boysen & Vogel, 2008). Because counselors interact with diverse individuals in counseling, it is important that counselors develop multicultural competence to prevent harming clients (Abreu, 1999; Arredondo et al., 1996; Boysen & Vogel, 2008; Fietzer et al., 2018). A set of Multicultural Counseling Competencies (MCCs) were developed (Sue et al., 1992) and continue to evolve (Arredondo et

al., 1996; Ratts et al., 2015) to guide counselors on what multicultural counseling competence is and how to work towards achieving multicultural counseling competence.

Multicultural Counseling Competencies

Since the 1990's when the initial MCCs were introduced and adopted by ACA, the counseling profession has come to understand and believe that recognizing one's own attitudes and beliefs, acquiring knowledge, and developing skills are essential to working with culturally diverse clients as outlined in the MCCs by Sue et al. (1992), Arredondo et al. (1996), and Ratts et al. (2015). "The purpose of the MCCs was to improve the practice of counselors by reducing the perpetration of oppressive counseling practices and increasing the use of inclusive and validating counseling situations for clients," (Fietzer et al., 2018). The initial MCCs focused primarily on racial and ethnic cultural identities (Sue et al., 1992), but interpretation and application of the MCCs has since expanded to include gender, sexuality, socioeconomic status, religion/spirituality, age, and ability (Arredondo & Perez, 2006; Mollen et al., 2003). While the MCCs have been applied to various cultural identities, they have not yet been applied to body weight and size.

In the 30-plus years since the MCCs were introduced, much effort has been made to facilitate the development of multicultural competence of all counselors by emphasizing multicultural education in graduate programs. The Council for Accreditation of Counseling & Related Educational Programs (CACREP) and the American Counseling Association (ACA) have both developed standards and ethical codes that require counselor education programs to infuse multicultural education throughout their curriculum (ACA, 2014; CACREP, 2015). The 2016 CACREP standards identify social and cultural diversity as one of the eight core areas of counseling curriculum required of all accredited programs. Specific standards for social and

cultural diversity are outlined in section 2.F.2.a-h. (CACREP, 2015). In addition to its own set of standards, social and cultural diversity is included in the standards for the other seven core areas (CACREP, 2015). Similarly, the 2014 ACA Code of Ethics includes an entire section titled Multicultural/Diversity Competence in Counselor Education and Training Programs that addresses faculty diversity, student diversity, and multicultural/diversity competence (ACA, 2014). "Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice," (ACA, 2014, p. 15).

Despite the emphasis on multicultural competence and understanding how cultural elements impact the counseling process, a recent study showed that psychologists continue to hold biases about body weight despite inclusion of multicultural education in psychology graduate programs and continuing education (Bergen & Mollen, 2019). No such study has been found exploring the relationship between multicultural competence and weight-bias within the counseling field. However, there are studies in the counseling field that explore multicultural competence and biases regarding other cultural identities, which will be discussed below.

Cultural Bias in Counseling

A vital component of multicultural counseling competence requires self-reflection and self-analysis to recognize biases held regarding cultural groups or identities, understand the impact biases can have on the counselor's work, and work to reduce these biases (Arredondo et al., 1996). Research has shown that counselors are not immune from having biases, including race, religion/spirituality, and socioeconomic status (Abreu, 1999; Basma et al., 2020; Boysen & Vogel, 2008; Bray & Schommer-Aikins, 2015; Castillo et al., 2007; Magaldi-Dopman, 2014).

Basma et al. (2020) examined the relationship between counselor's general multicultural competence and negative attitudes about Arab Americans, a population which is also understudied and unrepresented in counseling research and literature. Results of this study indicated that counselors reported relatively high levels of general multicultural competence (multicultural knowledge and awareness) but showed "very low" levels of cultural competence with counseling "Arabs and Muslims" (Basma et al., 2020, p.48). Participants reported receiving little or no training about Arab Americans in their CACREP training programs (Basma et al., 2020). This study aligns with the idea that general multicultural counseling competence does not necessarily translate to competence with specifics of defined cultural groups and that lack of specialized education regarding diverse cultures may play a role in counselors' negative beliefs or biases. Another study found that students who completed a multicultural counseling course in their graduate program had significantly lower level of bias towards African Americans after completing the course (Castillo et al., 2007). In this study, participants completed instruments to measure multicultural competency and implicit racial prejudice at the start and end of a 15-week multicultural counseling course. Overall, the results indicated that the course significantly increased cultural self-awareness and reduced implicit racial prejudice (Castillo et al., 2007), thus increasing participants multicultural competence.

The counseling profession has also included religion and spirituality under the multiculturalism umbrella. The ACA has adopted 10 spirituality competencies (Young et al., 2002) to guide counselors on this cultural element. Magaldi-Dopman (2014) conducted a study to explore spiritual and religious competency among counseling students and found that despite multiculturalism being a part of their curriculum, spiritual/religious training was treated as an "afterthought" and not sufficiently included in their coursework. Participants reported various

concerns including not having the opportunity to develop personal awareness around spiritual/religious identity issues and conflicts or develop skills to include or respond to spiritual/religious themes in counseling (Magaldi-Dopman, 2014). Results also indicated a concern that their own personal spiritual/religious beliefs could be triggered in session and interfere with their ability to provide competent counseling to clients (Magaldi-Dopman, 2014). All participants in this study attributed their lower levels of competence to their lack of "meaningful training" in their graduate programs, despite all being in CACREP programs that included multicultural education. The findings from this study lend support to the concern that general multicultural education/competence may not lead to counselors having competence regarding body weight and size due to lack of specific focus and emphasis on body weight and size in counselor education curriculum.

Social economic status (SES) is often discussed in counseling as a multicultural consideration. Counselors' attitudes towards poverty have been researched to better understand what their beliefs are regarding the causes of poverty (external vs internal forces) and how this impacts counseling. Bray and Schommer-Aikins (2015) studied school counselors and found a negative relationship between attitudes about causes for poverty and years of experience: school counselors with fewer years of experience were more likely to recognize poverty as a product of external forces rather than individual failings. The authors proposed that this relationship may be due to the multicultural education now common in graduate programs. Results also indicted that those with more multicultural education were more likely to believe that poverty is caused by external forces (Bray & Schommer-Aikins, 2015). Toporek and Pope-Davis (2005) also studied counselors' beliefs about causes for poverty and found that counselors with more sensitive racial attitudes and more multicultural training credited poverty to systemic causes, whereas counselors

with less sensitive racial attitudes and less multicultural training endorsed the belief that poverty is caused by the individual characteristics of the person. Conflicting beliefs about the external vs. internal forces that lead to poverty are similar to the beliefs of the external vs. internal forces that lead to higher levels of body fat and obesity. The results from these studies about counselors and poverty suggest that multicultural education helped to shift counselors' beliefs, which could be effective in shifting attitudes regarding obesity as well.

Weight as a Cultural Consideration

While race, religion/spirituality, and SES are common cultural considerations in counseling, and discussed in counseling research and education, body weight and size are rarely positioned as cultural considerations in counseling. However, several authors have advocated for body weight and size to be included as a cultural consideration in mental health fields and included in education and training of new mental health care providers in order to fight the bias and subsequent harm within mental health care. (Bergen & Mollen, 2019; Brochu, 2019; Kasardo, 2019; McHugh & Chrisler, 2019; Smith, 2019). Bergen & Mollen (2019) compared the medicalization/pathology of fatness to the medicalization/pathology once applied to LGBTQ+ populations. Pathologizing LGBTQ+ individuals and using treatments to convert them to the "correct" sexual/gender identity was once deemed appropriate and helpful, when in fact it was harmful to clients. These practices are no longer tolerated and are actively discouraged/banned due to the resulting harm to clients.

Bergen and Mollen (2019) suggest fatness is also currently treated with conversion therapy; whereby medical and mental health care providers demand and help those with higher levels of fat to change their body size and shape to fit with a societal/medical idea of thin or "healthy". Rather than using weight-inclusive treatments and attending to body weight as a

cultural consideration, mental health care providers are using ineffective weight-loss treatments that do not work and inflict additional harm on the physical and mental health of clients (Bergen & Mollen, 2019). Research has shown that dieting is related to depression, low self-esteem, eating disorders, negative body image, self-blame, confusion, and weight-retention or weight-gain (Bergan & Mollen, 2019; Clifford et al., 2015; Geraci et al., 2015). Bergan and Mollen (2019) suggest mental health care providers address size alongside other diversity variables, explore biases about size within supervision, provide accurate information regarding health and size, consider size in case conceptualization, avoid pathologizing size or overestimating the importance of size in case conceptualization, and reflect on the ethics of size-related beliefs and weight loss counseling in clinical work.

Kasardo (2019) conducted a study exploring the coverage of body size in 29 graduate level multicultural psychology textbooks. Results indicated that 11 textbooks did not mention body size, weight, obesity, body image, eating disorder, dieting, or other related terms (Kasardo, 2019). Of the remaining 18 textbooks, Kasardo (2019) conducted further analysis to reveal whether body size was portrayed through a medical lens or diversity/cultural lens and found that four textbooks included body size as a diversity concern. Three of these four included brief sentences and only one (Cornish et al., 2010) featured a deeper discussion (a 35-page chapter) about size as a diversity concern (Kasardo, 2019).

The assumption seems to be that the higher one's multicultural counseling competence, the more attuned and skilled the counselor will be to recognize and attend to cultural elements within counseling. Additionally, there seems to be faith that the training provided in counseling programs will help students address and correct their cultural biases (Castillo et al., 2007; Toporek & Pope-Davis, 2005). However, the studies included above indicate that current

multicultural education may be helpful in counselors' development of multicultural competence while lacking competence regarding specific cultural identities, including body weight and size (Bergen & Mollen, 2019). Including other cultural identities under the multicultural umbrella has led to the inclusion of these populations in counselor education, research, and supervision, leading to higher levels of multicultural competence. Recognizing body weight and size as a cultural consideration could lead to its inclusion in education, research, and supervision, and thus contribute to higher levels of multicultural competence for counselors.

Personal Experiences with Weight-Bias

Individuals perceived to have excess body fat or obesity experience direct, indirect, and environmental expressions of weight-bias, stigma, and discrimination (Pudney et al., 2020). Direct expression may include being called a derogatory name, indirect expression may include being stared at while eating in public, and environmental expression may include not being able to fit into seats on public transportation (Pudney et al., 2020). Experiences with weight-bias have been reported as occurring most frequently in employment settings, followed by service providers and interpersonal relationships (Puhl et al., 2008). Individuals who experience weight-bias are at higher risk for serious physical and mental health conditions (Friedman & Puhl, 2012), which can begin in childhood and persist into adulthood. Stereotypes related to excess weight begin as young as three years old and children as young as seven years old have dieted to avoid being stigmatized as lazy, dirty, stupid, or mean (Hague & White, 2005). Weight-bias severely impacts quality of life, especially for children. A study by Schwimmer et al. (2003) revealed that quality of life was worse for children and adolescents with severe obesity than for children with cancer. Puhl et al. (2017) found that adolescents who experience weight-based teasing are more likely to experience higher BMI, use eating to cope with stress, and experience

body dissatisfaction 15 years later. Pudney et al. (2020) found that most participants (adults) who had experienced weight-bias reported first experiencing weight-stigma during childhood or adolescence, many of whom could describe specific examples of bias they had encountered as youth. These studies briefly illustrate that experiencing weight-bias contributes to poorer quality of life and other physical and psychological consequences beginning in childhood and continuing into adulthood. Literature related to the impact of weight-based discrimination will be explored below.

Weight-Based Discrimination

Weight-based discrimination has been documented as one of the most common forms of discrimination among American adults, coming in fourth after behind gender, age, and race (Puhl et al., 2008). Andreyeva at el. (2008) conducted a longitudinal study that showed an overall prevalence of experiencing discrimination due to perceived body weight increased significantly from 7% in 1995 to 12% in 2006, and the frequency of experiencing weight-based discrimination across a lifetime also increased from an average of 4.6 to 4.9 times. Another study found 10% of all women and 5% of all men reported experiences with weight-based discrimination (Puhl et al., 2008). Women with moderate obesity (BMI of 30-35) were three times more likely to report experiencing weight-based discrimination than men with similar weights (Puhl et al., 2008). The same study also found that 40% of individuals with BMI of 35 and above have reported experiencing weight-based discrimination (Puhl et al., 2008). A more recent meta-analysis in 2016 reported that prevalence rates have not changed, with 19.2% of individuals with moderate obesity (BMI of 30-35) and 41.8% of individuals with more severe obesity (BMI of 35+) experiencing weight-based discrimination (Spahlholz et al., 2016).

Unlike other sources of discrimination such as race, gender, and religion, there are limited laws that specifically protect people who encounter weight-based discrimination despite data showing that public support exists for such legal protections (Pomeranz & Puhl, 2013; Suh, et al., 2014). Brownell (2005) suggests that negative views of individuals with higher body fat and weight affect public and organizational policy by influencing rules for the allocation of research funds, health insurance coverage, and discrimination in employment and housing. Further exploration of the impact of weight-bias will be presented next.

Impact of Weight-Bias

Research has shown the impact of weight-bias on the physical and psychological wellbeing of individuals with higher levels of body fat or body weight (Friedman & Puhl, 2012; Himmelstein et al., 2017; Puhl et al., 2017). Those who experience weight-bias are also at risk for developing weight-bias internalization (WBI), which can negatively contribute to further physical and psychological functioning. Research related to the physical and psychological impact of weight-bias, including weight-bias internalization, will be presented below.

Physical

An individual who experiences weight-bias is likely to experience decreased physiological health and functioning (Dickerson et al., 2004; Himmelstein et al., 2017). Children who experience weight-bias and then use chronic dieting to lose weight are at risk for physical consequences including delayed puberty, “short stature” syndrome, impaired concentration, social withdrawal, low self-confidence, preoccupation with food, and increased risk of eating disorders (Hague & White 2005). Research has shown that experiencing weight-bias can increase cortisol (stress hormone) levels (Himmelstein et al., 2015; Schvey et al., 2014), thus

affecting hypertension, cardiovascular disease, and fat storage in the abdomen (Dickerson et al., 2004; Muennig, 2008; Tomiyama, 2014).

In addition to the physical impact of stress, behaviors to cope with stress and negative emotions can further impact physical health. Research indicates that individuals with more frequent experiences of weight-bias are less likely to feel motivated to diet and will engage in more unhealthy eating habits, such as overeating to cope with high cortisol levels and negative emotions (Levitan & Davis, 2010; Tomiyama, 2014; Vartanian & Porter, 2016). Unhealthy eating behaviors can develop into patterns consistent with binge eating disorder or food addiction. One study found that 25% of individuals with overweight or obesity met criteria for food addiction which has shown to be a contributing factor to obesity (Davis et al., 2011; Jin, 2012). Sutin and Terracciano (2013) found that individuals who had not yet developed obesity and who had experienced weight discrimination were approximately 2.5 times more likely to develop obesity by follow-up four years later, and those who had already developed obesity at baseline were three times more likely to still be experiencing obesity at follow-up, even when controlling for demographic factors such as age, sex, ethnicity, and education. Weight-based teasing in adolescence can also predict higher BMI and obesity for both women and men 15 years later (Puhl et al., 2017).

Experiencing weight-bias has also been shown to decrease physical activity competence, thus decreasing willingness to engage in physical activity (Schmalz, 2010). Greenleaf et al. (2014) found that children who experience weight-based teasing and bullying also experience less motivation to exercise and feel less confident in being physically active than peers who are not teased. Lewis et al. (2011) found that adults will avoid physical activity and exercise due to fear of being laughed at, stared at, or ridiculed by others. While higher body fat and obesity have

many causes, food intake and physical activity are components that contribute to development of higher body fat and obesity (Wang et al., 2012). The studies presented above indicate that weight-bias impacts food intake and physical activity, which in turn contribute to higher body fat and obesity.

The long-term effects of experiencing weight-bias include the increased risk of developing and continuing to have obesity, and all the physical health risks associated with obesity, such as lower quality of life, higher risk of type 2 diabetes, heart disease, stroke, cancer, and other diseases which are leading causes of preventable, premature death (CDC, 2020; Hales et al., 2020; Puhl, Himmelstein, et al., 2020). The relationship between experiencing weight-bias and developing obesity persists even after controlling for baseline BMI, sex, race, and socioeconomic factors (Jackson et al., 2014; Sutin & Terracciano, 2013), indicating that it is the stigma, not the baseline BMI or other demographics, that is more predictive in developing or perpetuating higher body fat and obesity.

Weight-bias also serves as a barrier to accessing health care. A meta-analysis of the connection between weight-bias and health care utilization found that individuals with higher body fat or obesity were likely to delay or avoid health care due to experiencing weight-bias from health care providers (Alberga et al., 2019). Delaying and avoiding health care can further contribute to poor physical health (Alberga et al., 2019). The findings from these studies counter societal beliefs that weight-bias and stigma will help individuals to lose weight and instead negatively influence one's physical health in a variety of ways including continued or worsening levels of overweight and obesity. Thus, weight-bias has severe physical health consequences for those who experience it.

Psychological

In addition to physical consequences, weight-bias impacts psychological functioning. Research has found that those who experience weight-based bias, discrimination, bullying, or teasing are more vulnerable to a variety of mental health conditions including, depression, anxiety, substance use, low self-esteem, poor body image, and overall lower psychological wellbeing (Friedman et al., 2005; Himmelstein et al., 2018; Pont et al., 2017). Youth who experience weight-based bullying or teasing are more likely to exhibit self-harm behaviors and are twice more likely to think about or attempt suicide than same-weight peers who did not experience such harassment (Eaton et al., 2005; Eisenberg et al., 2003). Individuals who experienced weight-stigma from their parents as children continue to report emotional consequences well into adulthood (Puhl, Moss-Racusin et al., 2008). Experiencing weight-bias also contributes to intense feelings of loneliness, as individuals will retreat from and avoid social relationships and social situations due to direct expression of weight-bias and discrimination by family members and friends (Lewis et al., 2011).

Pudney et al. (2020) conducted a mixed methods study to explore the impact of experiencing weight-bias and found that some individuals remain distressed years after experiencing weight-bias, while others no longer felt distressed. Individuals who were still distressed tended to have lower mental health related quality of life (HRQOL), higher BMIs, more experiences of weight-bias/discrimination, and identified both the body weight and the weight stigma as major contributors to their self-perception (Pudney et al., 2020). Those who were no longer distressed about their past experiences with weight-bias tended to have higher mental HRQOL, no longer care about others' perceptions of them, practice self-love and acceptance, and focus more on their health than their appearance (Pudney et al., 2020). Individuals who experienced weight-bias reported ruminating on memories of times they had

been discriminated against by others, leading to continued negative emotions such as sadness, shame, anger, anxiety, and depression (Pudney et al., 2020). Experiencing weight-bias from others also led to blaming or criticizing oneself for experiencing the stigma rather than recognizing the stigma as unjust discrimination from others (Pudney et al., 2020). Similarly, Lewis et al. (2011) found that individuals who experienced weight-stigma often blamed themselves rather than attributing the stigma to a flaw in the other individual.

Like health care utilization, clients have reported that experiencing or anticipating the experience of weight-bias in therapy has led them to miss sessions or terminate early from treatment (Akoury et al., 2019). Weight-bias itself can impact psychological functioning, which mental health care is designed to treat, but if weight-bias from mental health providers stops clients from utilizing mental health care services, clients are at greater risk for poorer mental health. An even deeper level of psychological impact occurs when an individual internalizes the weight-bias of others.

Weight-Bias Internalization

Weight-bias internalization (WBI) occurs when individuals are aware of the negative weight-based stereotypes of others, believe these stereotypes to be true, use them to belittle or criticize themselves, and devalue themselves due to their body weight (Corrigan et al., 2006; Pearl & Puhl, 2018). Puhl et al. (2018) found that 40% of adults with overweight and obesity have WBI. Given that two-thirds of adults (Flegal et al., 2016) and one-third of youth (Ogden et al., 2016) in the US have overweight or obesity, there are many individuals experiencing weight-bias internalization (Pearl & Puhl, 2018). Hayward et al. (2018) found that (1) WBI can be predicted by the frequency of experiencing weight stigma, (2) WBI predicts more frequent use of maladaptive coping and less frequent use of adaptive coping, and (3) more frequent use of

maladaptive coping predicts more depression, anxiety, and stress symptoms. This cascading effect further impacts the psychological functioning of the individual.

The relationship between weight-bias internalization (WBI) and its impact on health was first studied in 2008 and has since been researched numerous times, with over half of the articles on this relationship published between 2016 and 2017 (Pearl & Puhl, 2018). This analysis reveals a rising trend and interest in understanding this phenomenon. These studies have revealed that the psychological impact of WBI is similar to and perhaps more damaging than weight-bias from others (Pearl & Puhl, 2018). 28 of these studies strongly linked depression to WBI and 11 studies found a significant and positive relationship between anxiety and WBI across varied body sizes, not just individuals with overweight or obesity (Pearl & Puhl, 2018). 11 of these studies indicated that higher WBI was related to lower self-esteem and found that WBI was a better predictor of self-esteem than BMI alone (Pearl & Puhl, 2018). 27 studies between 2008 and 2017 explored WBI and body dissatisfaction and body image (Pearl & Puhl, 2018). Results indicated that higher levels of WBI were consistently and significantly correlated with worse body image and increased body dissatisfaction (Pearl & Puhl, 2018). These results were constant across all body sizes, not just overweight and obese. Again, WBI was an independent predictor after controlling for BMI, depression, and other psychological measures (Pearl & Puhl, 2018). WBI has also been linked to disordered eating (binge eating, food addiction, and other eating pathology) in 31 studies (Pearl & Puhl, 2018).

Additionally, WBI has been linked to general psychological distress including brooding rumination, emotional dysregulation, perceived stress, dissociative experiences, somatic symptoms, and poorer quality of life (Pearl & Puhl, 2018). 42 studies have examined the relationship between WBI and body mass index (BMI) or categorical weight status (normal,

overweight, obesity). These studies show that WBI exists among diverse body sizes, but do not show a consistent, linear relationship between BMI and WBI (Pearl & Puhl, 2018). However, WBI tends to be higher among persons who have higher body weight (Pearl & Puhl, 2018), perhaps due to the higher frequency of weight-bias experienced by those with higher BMIs. Altogether, these findings suggest that WBI may be a stronger predictor of psychological distress than experiences of weight stigma alone (Pearl & Puhl, 2018).

Personal Experiences of Weight-Bias and Weight-Bias Towards Others

It remains unclear how personal experiences with weight-bias impact attitudes and beliefs regarding fatness and obesity about others. The previous section detailed how experiencing weight-bias can lead to weight-bias internalization. While WBI refers to the expression of weight-bias towards oneself, it is not yet clear how experiencing weight-bias impacts expression of weight-bias towards others. Some research exists regarding weight-status and weight-bias with mixed results. Some studies (Phelan et al., 2014; Schwartz et al., 2006) have found that individuals with lower BMIs showed higher levels of weight-bias than individuals with higher BMIs. Other studies have shown the opposite. One study (discussed earlier in this chapter) (Pratt et al., 2015) showed that individuals with higher BMIs showed higher levels of weight-bias than those with lower BMIs. Allison et al. (1991) showed that participants with obesity who were seeking weight-loss treatment showed stronger negative attitudes towards “overweight individuals” compared to participants not experiencing obesity. Friedman et al. (2005) cite additional research (Crandall, 1994; Crandall & Biernat, 1990; Quinn & Crocker, 1999; Crocker & Major, 1989) that shows “overweight individuals do not display positive in-group bias,” (p. 913). Friedman et al. (2005) also explain that this finding is “in contrast with the literature suggesting that other stigmatized groups (e.g., African Americans) develop a positive and

collective identity," (p. 913). However, the recent weight-inclusive movement, including Health at Every Size, is actively working to decrease stigma, which may contribute to a more positive in-group identity for individuals experiencing fatness and obesity. While it has been shown that individuals with higher BMIs are more likely to have experienced weight-bias (Andreyeva et al., 2008; Puhl et al., 2020), individuals of all weight-statuses can and do experience weight-bias (Puhl et al., 2020). Research in this area is lacking, thus the introduction of this variable into this study. Limited research and mixed results from the few published studies suggest additional research is needed to determine how body size and personal experiences with weight-bias impacts weight-bias towards others among mental health providers.

Summary

Research highlighted above indicates that weight-bias is expressed from many sources, including mental health providers (Cravens, et al., 2016; Davis-Coelho, et al., 2000; Pratt, et al., 2015; Young & Powell, 1985), though research within the counseling field is sparce (Adams, 2008; Feister, 2012). Past research has shown that race and gender can influence weight-bias among mental health providers, yet these factors had yet to be studied among counselors. Research has also shown that weight-bias education can be helpful in reducing weight-bias (Cravens, et al., 2016; Daníelsdóttir et al., 2010; Hague & White, 2005; Pratt, et al., 2015). Multicultural counseling is a key aspect of the counseling profession (Arredondo et al., 1996; Fietzer et al., 2018; Sue et al., 1992) yet does not currently address or include body weight and size as a cultural consideration (Bergen & Mollen, 2019; Brochu, 2019; Kasardo, 2019; McHugh & Chrisler, 2019; Smith, 2019). Current research does not yet show an understanding of the relationship between experiencing weight-bias from others and experiencing weight-bias towards others (Phelan et al., 2014; Schwartz et al., 2006). This study aimed to better understand the

relationship between these six variables. This study explored how race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias impact weight-bias among licensed counselors who earned a master's degree in counseling. The methodology of this study is described in the following chapter.

CHAPTER III: METHODOLOGY

Introduction

As described in the previous chapters, weight-bias can have damaging effects on clients and is present in many disciplines within mental healthcare (e.g., Agell & Rothblum, 1991; Davis-Coelho, et al. 2000; Kinavey & Cool, 2019; Young & Powell, 1985). However, few to no studies have explored factors related to weight-bias among counselors. Therefore, the purpose of this study was to investigate how race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias relate to weight-bias among counselors. The following chapter describes the methods used for recruiting participants, procedures, instrumentation, research question, research design, and data analysis in this study.

Participants

Participants in this study included a convenience sample of licensed counselors recruited via multiple methods described in the following section. Inclusion criteria included individuals who had earned a master's degree in counseling and were licensed to practice counseling within the United States, which according to the American Counseling Association (ACA) may include Licensed Professional Counselors (LPC), Licensed Mental Health Counselors (LMHC), Licensed Clinical Professional Counselors (LCPC), Licensed Professional Clinical Counselor of Mental Health (LPCC), Licensed Clinical Mental Health counselors (LCMHC), and Licensed Mental Health Practitioner (LMHP) (ACA, n.d.). Eligible participants included individuals with full licensure and those with associate or provisional licensure who are working towards full licensure, such as Licensed Associate Counselor (LAC), Licensed Professional Counselor Associate (LPCA), and Licensed Graduate Professional Counselor (LGPC) (ACA, n.d). Exclusion criteria eliminated counselors who earned master's in non-counseling fields such as

psychology and social work and those not licensed within the United States to practice counseling, which may refer to licensed social workers, licensed psychologists, licensed marriage and family therapists, licensed school counselors, licensed substance abuse counselors, and other licensed mental health professionals who are not also licensed counselors. Inclusion criteria were stated at the beginning of the recruitment letter and in the informed consent document and participants verified they were eligible to participate in this study. Participants were recruited through state licensing board email lists and professional counseling organizations email lists. Additionally, snowball sampling was used by asking participants to share the survey with other licensed counselors. No incentive was offered for participation in this study.

Conducting an analysis using G*power predicted that 204 participants were needed (f2=0.10, alpha=0.05, power=0.95, number of predictors=5). A total of N=587 participants were included in this study. Participant demographic information was obtained at the end of the online survey. Description of participant demographics are shared in chapter four of this paper.

Procedures

This researcher obtained Institutional Review Board (IRB) approval at the University of North Carolina at Charlotte to conduct survey research with human subjects prior to recruiting participants or collecting data. The researcher provided resources for participants who may have felt discomfort or distress due to the sensitive nature of the instrument assessing personal experiences with weight-bias which asks questions about stigmatizing situations such as “not being hired because of weight, shape, or size”, “having a romantic partner exploit you, because she or he assumed you were ‘desperate’ and would put up with it”, and “overhearing other people making rude remarks about you in public” (Vartarian, 2015). After IRB approval, this researcher recruited participants through direct emails to counselors from professional

counseling organizations email lists. Request for participation was sent to each recruitment source no more than three times. Recruitment material asked individuals who had been invited and/or participated in the study to share the survey with others who may qualify for and be willing to participate in the study in a method known as snowball sampling (Mertens, 2015) which is an appropriate sampling method for this study. After three rounds of emails had been sent to this recruitment source, IRB approval was acquired to recruit participants through state licensing boards email lists. In total, the researcher directly emailed 9,712 potential participants. Informed consent was provided by 805 participants, resulting in a response rate of 8.3%.

This study utilized a web-based survey research method to collect data. Web-based surveys are useful due to their ability to quickly reach many people across a large geographic area at a low cost, which can lead to larger sample sizes when compared to other research designs such as experimental and quasi-experimental (Couper, 2005; Dillman et al., 2014; Mertens, 2015). Web-based surveys have also shown to be an effective way to study special populations and sensitive topics due to the individual being able to respond privately while maintaining their own confidentiality (Dillman et al., 2014; Mertens, 2015). While survey research can be subject to low response rates, this study attempted to increase response rates by sending recruitment letters email addresses provided by counselors to professional counseling associations and state licensing boards. Additionally, this survey incorporated design features recommended by Dillman et al. (2014) to increase appeal to participants, including, (a) showing a limited number of questions per page, (b) allowing participants to skip and/or return to questions later in the survey, (c) and providing simple, clear, written instructions throughout the survey to help the participant know what and how to respond to each question.

Participants were invited to participate in the study via email. Participants were asked to click a link to a web-based survey where they self-identified as a counselor who earned a master's degree in counseling and licensed to practice counseling in the United States before continuing with the survey. Participants viewed an introductory letter explaining the purpose of the study and requesting their participation. Following the introductory letter, participants viewed the informed consent which explained the purpose of the research, risks and benefits of participating, participation as voluntary, anonymous, and confidential and that participants may opt out of the study at any point without penalty. At the bottom of the informed consent page, participants were asked to click "Yes, I have reviewed the document above and provide consent to participate in this study." Participants clicked yes if they provide consent or left the page if they did not wish to continue. Once they clicked yes, they were taken to a new page to complete the instruments and demographics questionnaire. All instruments were completed within Qualtrics across multiple pages. The estimated time to complete the survey was 15 minutes. The average time of completion was 26 minutes. However, participants had the option to return to a partially completed survey at a later date or time, which may have contributed to a higher average time of completion, as 85% of participants completed the survey in less than 15 minutes and 92% of participants completed the survey in less than 20 minutes. No personally identifying information was collected. Data was downloaded from Qualtrics before being uploaded into Statistical Package for Social Sciences (SPSS) software. Data was also stored in the Dropbox drive of the primary researcher, in compliance with university Level 2 data storage guidelines.

Instrumentation

To measure the outcome variable in this study, weight-bias, participants completed one instrument measuring fat phobia. To measure the predictor variables, race, gender, weight-bias

education, multicultural competence, and personal experiences with weight-bias, participants completed a demographic questionnaire and two additional instruments. Participants completed a demographic questionnaire that included questions about their race, gender, and experiences with receiving weight-bias education, one instrument to measure their multicultural competence, and one instrument to measure personal experiences with weight-bias. Written permission was requested and granted by the developers of the Fat Phobia Scale-Short Form (B. Robinson, personal communication, November 12, 2020) and the California Brief Multicultural Competence Scale (G. Gamst, personal communication, November 11, 2020) to use these instruments in this study. The Stigmatizing Situations Inventory-Brief (SSI-B) published by Vartarian (2015) included permission to use the scale and scoring guide in its original form without modifications or adaptations, for non-commercial purposes, and with proper citation. Additional permission from the developer was requested by this author via email to use the SSI-B in this study, which was granted (L. Vartanian, personal communication, November 17, 2020). permission.

Weight-Bias

Fat Phobia Scale- Short Form

The Fat Phobia Scale-Short Form is a self-report scale designed to measure fat phobia, defined by the developers as a pathological fear of fatness, which includes negative attitudes towards and stereotypes about individuals with perceived fatness (Bacon et al., 2001; Robinson et al., 1993). The Fat Phobia Scale- Short Form was developed from the original 50-question Fat Phobia Scale and was designed to be more easily be used in research aimed at measuring and decreasing anti-fat attitudes (Bacon et al., 2001; Robinson et al., 1993). The Fat Phobia Scale-Short Form has a Cronbach alpha reliability score range of .87 to .91, which is an excellent score

within the counseling research field. The Fat Phobia Scale-Short Form consists of 14 items, each consisting of two adjectives "sometimes used to describe obese or fat people" and asks the participant to use a 5-point scale to report which adjective best describes their feelings and beliefs (Bacon et al., 2001). Scores are calculated to produce a final fat phobia score with a range of 1-5, with higher scores indicating more "fat phobia" and lower scores indicating less "fat phobia".

Demographic Variables

Race

To measure race, participants were asked to self-identify their race on the demographic questionnaire. The question asked participants to "How do you identify your race/ethnicity?" Response choices were as follows: Non-Hispanic White, Black/African American, Hispanic/Latina/o, Asian, American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, Multiracial, Other.

Gender

To measure gender, participants were asked to self-identify their gender on the demographic questionnaire. The question will ask participants to "How do you identify your gender?" Response choices were as follows: Female, Male, Non-binary/third gender.

Weight-Bias Education

This researcher was unable to identify or locate an instrument to measure weight-bias education. To assess weight-bias education, the researcher included a multiple-choice question at the beginning of the demographic questionnaire. This question was adapted from Parikh Foxx et al. (2020), which measured extent of career and college readiness training and defined levels of training based on criteria from a survey by Thompson Dorsey (2013). Written instructions asked

participants to choose the response that most accurately describes the extent of weight-bias education they have received. The question was as follows: Based on the benchmarks below, indicate the extent of your education of weight-bias, weight stigma, and/or size-ism. No education will be defined as: have not received any education in weight-bias, weight stigma, and/or size-ism. Low education will be defined as: initial education, introductory content knowledge, single training or presentation, have heard or know about weight-bias, weight stigma, and/or size-ism. Medium education will be defined as: in-depth education, applied content knowledge, multiple trainings or presentations, have been trained and have started implementing or been implementing less than six months. High education will be defined as: comprehensive education, mastery content knowledge, training or presentation provider, have been fully trained and coached and have been implementing for six months or longer and/or coaching and training others. Participants selected either no education, low education, medium education, or high education.

Multicultural Competence

California Brief Multicultural Competence Scale

To determine the level of multicultural competence participants completed a modified version of the California Brief Multicultural Competence Scale (CBMCS) (Gamst et al., 2004). Permission was received by the instrument developer to update some of the multicultural terminology used in the items, such as changing the word “minority” to “marginalized” (G. Gamst, personal communication, February 3, 2021). To verify the reliability of the instrument with these modifications, the Cronbach alpha was measured and had good reliability with a score of .875. The CBMCS was developed to assess and improve the education of counselors regarding multicultural competence, which developers defined as involving three broad areas

including attitudes/beliefs, knowledge, and skills as outlined in the Cross-Cultural Counseling Model (Sue et al., 1982) and the operationalization of these competences by Arredondo et al. (1996) and Sue et al. (1998) The CBMCS consists of 21 questions derived from four major multicultural competence scales: Cross-Cultural Counseling Inventory-Revised (CCCI-R), the Multicultural Awareness, Knowledge, Skills Survey (MAKSS), the Multicultural Counseling Awareness Scale-Form B (MCAS-B), and the Multicultural Competency and Training Survey (MCCTS). The developers of the CBMCS claim this instrument carries advantages over the CCCI-R, MAKSS, MCAS-B, MCCTS due to its "shorter length, development from a strong theoretical foundation, and utilization of a large number of practitioners from various ethnic backgrounds, educational levels, ages, and experiences," (Gamst et al., 2004, p.178). Because social desirability can often confound self-report measures, the developers assessed social desirability throughout the construction and validation of this instrument and found it to be minimal (Gamst et al., 2004).

The CBMCS has a Cronbach's reliability alpha coefficient of .89, which is within the good range for research in the counseling field. The modified version used in this study had a Cronbach's alpha coefficient of .875, also within the good range for research. According to Gamst et al. (2004) and the CBMCS scoring guide, the CBMCS consists of 21 questions and asks the participant to rate their agreement with the statement using a 4-point Likert scale: 1 = strongly disagree, 2= disagree, 3= agree, 4= strongly agree. Responses to each question are summed to generate one total score, with higher numbers indicating higher competence. Additionally, the scores can then be analyzed for each subscale (multicultural knowledge, awareness of cultural barriers, sensitivity and responsiveness to consumers, and non-ethnic ability) to identify more focused levels of proficiency and areas in need of training and

education. Again, higher scores on the subscales indicate higher levels of proficiency while lower scores indicate areas in need of training. This study utilized the total score in its analysis.

Personal Experiences with Weight-Bias

Stigmatizing Situations Inventory-Brief (SSI-B)

Stigmatizing Situations Inventory-Brief (SSI-B) is a self-report scale designed to assess people's experiences with weight stigma by evaluating the frequency they have experienced weight-based stigma in a variety of domains (Vartanian, 2015). SSI-B was developed from the original 50-question Stigmatizing Situations Inventory (SSI) developed by Myers and Rosen (1999) to provide a more efficient version to be used in research when time will not allow for the full version. The SSI-B is not considered a subscale of the full SSI, as the developers claim this brief version provides maximum coverage of the domains represented in the full SSI (Vartanian, 2015). The SSI-B has a Cronbach alpha reliability score range of .84-.85, which is a good score in the counseling research field. The SSI-B consists of 10-items describing situations people encounter because of their weight and asks participants to indicate whether, and how often, each of these situations happens to them (Vartanian, 2015). Using a scale of 0-9, response choices include: "0-never, 1-once in your life, 2-several times in your life, 3-about once a year, 4-several times per year, 5-about once a month, 6-several times per month, 7-about once a week, 8-several times per week, and 9-daily" (Vartanian, 2015, p.125). An overall mean score is computed, ranging from 0-9 to describe stigma frequency. Higher scores indicate increased frequency of experiencing weight-based stigma and lower scores indicate decreased frequency of experiencing weight-based stigma. This study used the overall mean score (0-9) as the data point for the variable of personal experiences with weight-bias.

Demographics

Participants were asked to complete a self-report demographic questionnaire that asked for gender (female, male, transgender male, transgender female, or other), race/ethnicity (Caucasian/White, African American/Black, Latino/a, Asian/Pacific Islander, Native American/Indigenous, multiracial/multiethnic, other), age, counseling specialization (addictions counseling, career counseling, clinical mental health counseling, college and student affairs counseling, K-12 school counseling, marriage, couple, and family counseling, or rehabilitation counseling), status as a counselor educator (yes or no), years of counseling experience, region of the US they practice counseling (West, Central, Southeast, or Northeast), weight status of the participant (underweight, average, overweight, or obese), and whether they have focused on client issues regarding weight-bias in clinical practice (yes or no). These are demographic variables that past research has shown may be related to levels of weight-bias and may help to describe the participants in the study.

Research Question

The research question was: To what extent, if any, does race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias relate to weight-bias among counselors who earned a master's degree in counseling and are licensed to practice counseling in the United States?

Research Design

To answer the research question stated above, a correlational, non-experimental research design was used to investigate the relationship between the variables (Balkin & Kleist, 2017). A standard multiple regression was used to determine how the predictor variables of race, gender,

weight-bias education, multicultural competence, and personal experiences with weight-bias relate to the outcome variable of weight-bias among counselors.

Data Analysis

SPSS was used to perform the data analysis. Initial data screening and checking of assumptions was completed, including incomplete entries, outliers, accuracy, normality, homoscedasticity, and collinearity. A standard multiple regression was used to analyze the data. A standard multiple regression is used to analyze the relationship between a single outcome variable and multiple predictor variables (Mertens, 2015). In this study, there was one outcome variable and five predictor variables, indicating standard multiple regression to be an appropriate method of analysis. Descriptive statistics were used to report differences in scores across demographics (age, gender, race/ethnicity, counseling specialization, counselor educator status, years of counseling experience, region of the US, focus on weight-bias in clinical work, and weight status). The means, standard deviations, and central tendency measures of these descriptive statistics are reported and discussed in the results.

Summary

This chapter described the methodology, including participants, data collection procedures, instrumentation, research question and design, and data analysis. This correlational, non-experimental study measured the relationship of weight-bias and race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias among counselors who earned a master's degree in counseling and are licensed to practice counseling in the US. The data and results were expected to indicate factors that may impact weight-bias among this population of counselors. Given the presence and impact of weight-bias in mental health care but lack of research on this area within the field of counseling, this study may be

considered a pilot study to begin understanding the phenomenon of weight-bias in counseling (Agell & Rothblum, 1991; Davis-Coelho, et al. 2000; Kinavey & Cool, 2019; Young & Powell, 1985). This study aimed to begin the conversation of addressing weight-bias in counseling, counselor education, and counseling research.

CHAPTER IV: RESULTS

The purpose of this study was to investigate factors related to weight-bias among counselors who earned a master's degree in counseling. This study aimed to answer the following research question: To what extent, if any, does race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias impact weight-bias among licensed counselors who earned a master's degree in counseling? The results of this research study are presented in this chapter. This chapter will describe the process for screening data, share descriptive statistics, and report the results from the data analysis.

Data Screening

Prior to data analysis, data was screened using the Statistical Package for Social Sciences (SPSS) software. Data was screened for missing values, outliers, and normality. Additionally, assumptions of linearity and homoscedasticity necessary for multiple regression were examined using a scatterplot.

Missing Values

The survey in this study was completed online using Qualtrics. Qualtrics recorded informed consent from 805 participants. Two hundred and fifteen participants completed 67% or less of the survey and were excluded from data analysis. Qualtrics recorded the remaining 590 as having completed 100% of the survey. Upon closer examination, two remaining participants did not report any demographic information. As two of the predictor variables were race and gender, this missing data was deemed as problematic, and these participants were not included in data analysis. An additional participant did not complete any items on the Fat Phobia Scale. This participant was also excluded from the analysis. Data analysis included all remaining participants (N=587). To detect additional missing values, Little's Missing Completely at Random (MCAR)

test was conducted and determined that the remaining missing data was not statistically significant ($\chi 2 = 1.981$, $df=3$, $p=.576$).

Outliers, Normality, and Multicollinearity

Univariate outliers were detected by generating Z-scores and boxplots for the scores on the Fat Phobia Scale-Short Form (FBS), California Brief Multicultural Competence Scale (CBMCS), and Stigmatizing Situations Inventory-Brief (SSI-B). Outliers were z-scores with an absolute value greater than 2.68 and were detected on all three measures. Analysis was run twice, once with the outliers remaining in the data set and once with the outliers removed from the data set. The outliers remining in the data set did not significantly change the outcome of the analysis, therefore they were included in the final analysis. Normality was screened using the Shapiro-Wilk normality test and detected issues regarding normality on the FBS ($p < .001$), CBMCS ($p < .001$), and SSI ($p < .001$). Upon visual examination, data for the FBS and CBMCS appeared to have a normal distribution. The assumption of noncollinearity was met by examining the variance influence factor (VIF) for each predictor variable, none of which were above 3.

Descriptive Statistics

Participant Demographics

Table 1 shows the frequencies and percentages of demographics reported by participants. Participants were asked to complete a 9-item demographic questionnaire that asked about their race, gender, age, counseling specialization, status as a counselor educator, years of counseling experiences, region, weight-status, and clinical experience regarding weight-bias. All participants reported being counselors licensed in the United States and had earned a master's degree in Counseling ($N=587$). The population sample was collected from licensed professional counselors in the United States. Participants were asked to report their gender identity from three

options: female, male, and third gender/non-binary. A total of *n*=493 (84%) identified as female, *n*=88 (15%) identified as male, and *n*=6 (1%) identified as non-binary/third gender. Participants identified their race/ethnicity by selecting from eight racial/ethnic identity groups. A total of *n*=466 (79.4%) identified as non-Hispanic White; *n*=66 (11.6%) identified as Black/African American; *n*=17 (2.9%) identified as multiracial; *n*=15 (2.6%) identified as Hispanic/Latinx; *n*=9 (1.5%) identified as other; *n*=6 (1.0%) identified as Asian; *n*=4 (0.7%) identified as Native American/Alaska Native; *n*=1 (0.2%) identified as Native Hawaiian/other Pacific Islander; and *n*=1 (0.2%) did not report race. Participants reported age by selecting from five age ranges. A total of *n*=47 (8.0%) reported as 18-29 years of age; *n*=171 (29.1%) reported as 30-39 years of age; *n*=144 (24.5%) reported as 40-49 years of age; *n*=120 (20.4%) reported as 50-59 years of age; *n*=104 (17.7%) reported as 60+ years of age; and *n*=1 (0.2%) did not report age.

Participants reported counseling specialization from seven options. A total of *n*=481 (81.9%) reported Clinical Mental Health Counseling; *n*=34 (5.8%) reported Addictions Counseling; *n*=25 (4.3%) reported Marriage, Couple, and Family Counseling; *n*=19 (4.3%) reported K-12 School Counseling; *n*=13 (2.2%) reported College and Student Affairs Counseling; *n*=10 (1.7%) reported Rehabilitation Counseling; and *n*=5 (0.9%) reported Career Counseling. Participants were asked whether they were a counselor educator from choices of yes or no. A total of *n*=484 (82.5%) reported not being a counselor educator; *n*=100 (17.0%) reported being a counselor educator; and *n*=3 (1.7%) did not report whether or not they were a counselor educator. Participants were asked to report years of counseling experience using five different ranges. A total of *n*=74 (12.6%) reported 0-3 years; *n*=116 (19.8%) reported 4-6 years; *n*=116 (19.8%) reported 7-10 years; *n*=115 (19.6%) reported 11-15 years, and *n*=166 (28.3%) reported 16+ years. Participants were asked to report which region of the United States in which

they work using four options. A total of *n*=450 (76.7%) reported the Southeast; *n*=95 (16.2%) reported the West; *n*=19 (3.2%) reported Central; *n*=22 (3.7%) reported the Northeast; and *n*=1 (0.2%) did not report region.

Participants were asked to select their weight-status from four options. A total of *n*=10 (1.7%) reported as underweight; *n*=266 (45.3%) reported as average; *n*=231 (39.4%) reported as overweight; *n*=78 (13.3%) reported as obese; and *n*=2 (0.3%) did not report weight. Finally, participants were asked whether they had focused on client issues regarding weight-bias in their clinical practice. A total of *n*=264 (45.0%) reported yes and *n*=323 (55.0%) reported no.

Table 1

Demographics of Participants

Variable	Number of Responses (*N=587)*	Percentage
Gender		
Male	88	15.0%
Female	493	84.0%
Non-binary/third gender	6	1.0%
Race		
Non-Hispanic White	466	79.4%
Black/African American	68	11.6%
Hispanic/Latinx	15	2.6%
Asian	6	1.0%
Native American/Alaska Native	4	0.7%
Native Hawaiian/other Pacific Islander	1	0.2%
Multiracial	17	2.9%
Other	9	1.5%
Age (in years)		
18-29	47	8.0%
30-39	171	29.1%
40-49	144	24.5%
50-59	120	20.4%
60+	104	17.7%

Variable	Number of Responses (*N=587)*	Percentage
Counseling Specialization		
Addictions Counseling	34	5.8%
Career Counseling	5	0.9%
Clinical Mental Health Counseling	481	81.9%
College and Student Affairs Counseling	13	2.2%
K-12 School Counseling	19	3.2%
Marriage, Couple, and Family Counseling	25	4.3%
Rehabilitation Counseling	10	1.7%
Counselor Educator		
Yes	100	17.0%
No	484	82.5%
Counseling Experience (in years)		
0-3	74	12.6%
4-6	116	19.8%
7-10	116	19.8%
11-15	115	19.6%
16+	166	28.3%
Region (of United States)		
West	95	16.2%
Central	19	3.2%
Southeast	450	76.7%
Northeast	22	3.7%
Weight Status		
Underweight	10	1.7%
Average	266	45.3%
Overweight	231	39.4%
Obese	78	13.3%
Issues of weight-bias in clinical practice		
Yes	264	45.0%
No	323	55.0%

Instrument Reliability

Reliability for the three instruments used in this study is provided below. A Cronbach's alpha of internal consistency was determined for each instrument: Fat Phobia Scale-Short Form (FBS), California Brief Multicultural Competence Scale (CBMCS), and Stigmatizing Situations Inventory Brief (SSI-B). The Cronbach's alpha of the Fat Phobia Scale-Short Form (FBS) had a reliability of .865. The Cronbach's alpha of the California Brief Multicultural Competence Scale (CBMCS) had a reliability of .875. The Cronbach's alpha of the Stigmatizing Situations Inventory Brief (SSI-B) had a reliability of .873. All reliability coefficients are within the good range for demonstrating evidence of measurement internal consistency.

Bivariate Correlations

To determine whether correlations existed between the predictor variables (race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias) and the outcome variable (weight-bias), Pearson product coefficients were conducted. Dummy coding was used to analyze categorical variables. Participants who reported their race/ethnicity as non-Hispanic White in the survey were coded as White (0). Participants who reported their race/ethnicity as Black/African American, Hispanic/Latinx, Asian, Native American/Alaska Native, Native, Hawaiian/other Pacific Islander, Multiracial, or Other were coded as non-white (1). Participants who reported their gender as Female were coded as Female (0), participants who reported their ender as male were coded as Male (1), and participants who reported their gender as third gender/non-binary were excluded from the analysis due to too few in this group (n=6). Table 2 shows the correlations between the predictor and outcome variables. Results showed statistically significant relationships between variables. There was a statistically significant positive relationship between male and weight-bias (r= .159, p<.001), indicating that males

showed more weight-bias than females. There was a statistically significant negative correlation between weight-bias education and weight-bias (r= -.210, p<.001), indicating that as weight-bias education increased, weight-bias decreased. There was also a statistically significant negative correlation between multicultural competence and weight-bias (r=-.215, p<.001), suggesting that as multicultural competence increased, weight-bias decreased. The relationship between non-white and weight-bias was not statistically significant (r=-.059, p=.153). There was also not a statistically significant relationship between personal experiences with weight-bias and weight-bias (r= -.080, p=.051). Pearson product correlations were also conducted between each predictor variable. There was a statistically significant relationship between non-white and multicultural competence (r= .165, p<.001), indicating non-white individuals showed higher levels of multicultural competence. There was a statistically significant negative correlation between gender-male and multicultural competence (r= -.084, p=.044), indicating males showed lower levels of multicultural competence. A positive correlation also existed between weight-bias education and multicultural competence (r= .302, p<.001), indicating that as levels of weight-bias education increased, multicultural competence also increased. Weight-bias education and personal experiences with weight-bias were also positively correlated (r= .161, p<.001), indicating as rates of weight-bias education increased, reports of personal experiences with weight-bias also increased. Finally, a positive correlation existed between multicultural competence and personal experiences with weight-bias (r= .195, p<.001), indicating as multicultural competence increased, reports of personal experiences with weight-bias also increased.

Table 2

Pearson Correlation between Predictor and Outcome Variables

Variable	Weight-Bias	Non-white	Male	Weight-Bias Education	Multicultural Competence	Personal Experiences with Weight-Bias
Weight-Bias	1	-.075	.154*	-.255*	-.201*	-.121
Non-White		1	-.120	.039	.187*	-.010
Male			1	-.103	-.092	-.005
Weight-Bias Education				1	.294*	.161*
Multicultural Competence					1	.195*
Personal Experiences with Weight-Bias						1

Note. *p<.001 (2-tailed)

Multiple Regression

A standard multiple regression was used to analyze the relationships between the predictor variables and the outcome variable to answer the research question: To what extent, if any, does race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias impact weight-bias among licensed counselors who earned a master's degree in counseling? Table 3 displays the means and standard deviations of variables and were as follows: Weight-bias (N= 587, M=3.22, SD= .51). The weight-bias mean of 3.22 and standard deviation of .51 aligned with the psychometrics from the validation of the instrument by the developers (M= 3.6, SD= 0.64) (Bacon et al., 2001). Weight-bias education was scored as a total score on a scale of 0-3 (N=587, M=1.46, SD=.873). The weight-bias education measure was developed for this study therefore no other studies were available to compare the psychometrics. Multicultural competence was scored as a total score on a scale of 21-84 (N= 587, M= 65.391,

SD= 7.36). The multicultural competence scores were compared to the instrument validation psychometrics reported by Gamst et al., 2004). However, these authors reported only subscale means and did not report full scale means. Averages of the subscales revealed an overall mean of 2.88 on a scale of 1-4. This study used total score, but when the average of 65.39 was averaged from the 21 questions, an overall mean score of 3.11 aligned with, though higher, the 2.88 reported by the developers in 2004. It is possible that overall levels of multicultural competence have increased since this instrument was developed. Personal experiences with weight-bias were scored as a mean score on a scale of 0-9 (*N*= 587, *M*= 1.01, *SD*= 1.09). Personal experiences with weight-bias scores were compared with psychometrics from the development of the original, full-length instrument, Stigmatizing Situations Inventory, (Myers & Rosen, 1999), as the brief version (Vartanian, 2015) did not report overall mean scores. This study found lower mean scores and standard deviations (*M*= 1.01, *SD*= 1.09) than reported by the original instrument developers (*M*= 1.90, *SD*= 2.0) (Myers & Rosen, 1999). This difference may be due to the instrument being validated on a clinical weight-loss seeking sample, while this study used a non-clinical sample.

Table 3

Means, Standard Deviations of Variables

Variable	*N*	*M*	*SD*
Weight-Bias	587	3.22	.51
Weight-Bias Education	587	1.46	.873
Multicultural Competence	587	65.39	7.36
Personal Experiences with Weight-Bias	587	1.01	1.09

Results of the multiple regression are reported in Table 4. Results indicate that the predictor variables explained a statistically significant portion of the variance in weight-bias scores ($F(5,572)=10.101$, $p<.001$, $R^2=.081$, *adjusted* $R^2=.073$). Based on the R^2, approximately 8.1% of the variance in weight-bias was explained by the predictor variables as a group. Three predictor variables contributed significantly to the prediction of weight-bias: male ($B=.186$, $p=.001$), weight-bias education ($B= -.087$ $p=.001$), and multicultural competence ($B= -.010$, $p= .001$), The largest beta coefficient was for male ($B=.186$), meaning males showed higher weight-bias, followed by weight-bias education ($B= -.087$), meaning as weight-bias education increased, weight-bias also decreased, and finally multicultural competence ($B= -.010$), meaning as multicultural competence increased, weight-bias also decreased.

Table 4

Multiple Regression Evaluating Predictors of Weight-Bias

Variable	*B*	Std. Error	β	*t*-value	*p*-value
Non-White	-.013	.052	-.010	-.242	.809
Male	.186	.058	.130	3.206	.001
Weight-Bias Education	-.087	.025	-.149	-3.483	.001
Multicultural Competence	-.010	.003	-.144	-3.350	.0017
Personal Experiences with Weight-Bias	2.10	.020	.036	-.852	.394

Summary

The purpose of this study was to examine factors that may contribute to weight-bias among licensed counselors who earned a master's degree in counseling. This study intended to show whether and to what extent a relationship existed between weight-bias and race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias. This chapter presented the results from this research study by presenting processes and results for data screening, descriptive statistics, bivariate correlations, and multiple regression analysis.

Results indicated there was a statistically significant relationship between the group of predictor variables (race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias) and the outcome variable (weight-bias), with gender, weight-bias education, and multicultural competence contributing significantly to the model. Results indicated that males showed higher levels of weight-bias, higher levels of weight-bias education correlated with lower levels of weight-bias, and higher levels of multicultural competence correlated with lower levels of weight-bias.

CHAPTER V: DISCUSSION

This research study examined the relationships between one outcome variable, weight-bias, and five predictor variables, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias. The results of the data analyses were reported in the previous chapter. This chapter will discuss the results, describe limitations of this study, explore implications of the findings, and recommendations for future research. This chapter and paper will conclude with a final summary.

Discussion of Results

Demographic Data

The demographics of participants in this study aligned somewhat with demographics of the population of counselors across the United States. DataUSA (2017) reports counselors as predominantly White, non-Hispanic (61.9%) and Black, non-Hispanic as the second most common race/ethnicity (19.4%). The sample in this study was primarily White, non-Hispanic (79.4%), and secondly Black/African American (11.6%), which aligns with the national data. DataUSA (2017) also reports counselors as predominantly female (73.3%) and secondly male (27%) In this study, females represented 84% of the sample and males represented 15% of the sample. While this sample aligned with the pattern of racial and gender majority and secondary groups, the percentages of each group were exaggerated beyond the national data. Data USA (2017) also reports an average age of 41.7 among counselors. This sample asked for age using ranges, so comparison of averages was not possible. However, 53.6% of counselors were between the ages of 30-49, which does align with an average age of 41.7 years.

Regarding counseling specialization, the large majority were clinical mental health counselors (81.9%), with addictions counselors coming in second (5.8%) and career counselors

coming in last (0.9%). These specialization categories were derived from CACREP program specializations (CACREP, 2015). The sample in this study consisted mostly of clinical mental health counselors, which aligned with the inclusion criteria of being a licensed counselor and with the large number of clinical mental health counseling master's programs across the country (*n=352)*. The vast majority of participants were not counselor educators (*n*=484, 82.5%). Statistics regarding the rate of licensed counselors who are also counselor educators was not available to compare to the sample in this study. However, it is not surprising that less than 20% were counselor educators. This sample represented counselors with a wide variety of years of counseling experience. The largest range reported was 16+ years (28.3%), followed by an even distribution of 11-15 years (19.6%), 7-10 years (19.8%), and 4-6 years (19.8%). The smallest group was counselors with 0-3 years (12.6%). Overall, this sample was quite experienced, with two-thirds (67.7%) having 7 or more years of experience, and almost half (47.9%) having 11+ years of experience.

This study included a nationwide (US) sample, though approximately three-quarters (76.7%) reported working in the Southeast region, followed by 16.2% in the West. This distribution across regions was likely due to recruitment methods. Few state-level counseling associations published the member directories online, and of those who did, many were in the West. Additionally, the state counseling board membership directory that was used during recruitment was in the Southeast and consisted of a much larger membership directory, which contributed a great number of participants. Participants were asked to report their weight-status using four categories, and the majority (52.7%) of participants reported their weight-status as either overweight (39.4%) or obese (13.3%). The Center for Disease Control (CDC) reported over two-thirds of US adults as overweight or having obesity, with an obesity prevalence rate of

42.4% among adults in 2017-2018 (CDC, 2020). The prevalence of overweight and obesity in this sample were lower than the national averages. This may be a true reflection of the sample or may be due to the design of the question in asking participants to choose their weight-status from categories, rather than asking for height and weight which could have been used to calculate a BMI, which the CDC uses to define overweight and obesity. Finally, slightly less than half of participants indicated they have focused on client issues of weight-bias in clinical practice. This suggests that the majority counselors have not addressed weight-bias with clients despite the high prevalence of overweight and obesity in the US, over two-thirds of adults (CDC, 2020), and a prevalence rate of 19-42% of individuals with obesity experiencing weight-based discrimination (Spahlholz et al., 2016).

Multiple Regression Analysis

The group of five predictor variables, race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias were analyzed in relation to weight-bias among licensed counselors within the United States who earned a master's degree in counseling. Results indicated this group of predictor variables explained a statistically significant portion of the variance in weight-bias scores ($F(5,553)=9.459$, $p<.001$, $R^2=.079$, *adjusted* $R^2=.070$). The model shows this group of predictor variables account for approximately 8.1% of the variance in weight-bias scores. Within this model, three variables contributed significantly to the model: gender, weight-bias education, and multicultural competence. Results regarding each of the predictor variables will be discussed in the following section of this chapter. While this 8.1% is statistically significant, it leaves 91.9% of the variance unaccounted for. As this study was one of the first to explore factors related to weight-bias in counseling, it is not surprising that this single study did not fully capture a thorough explanation of weight-bias among counselors. Future

research could seek to identify additional factors related to weight-bias and will be explored in a later section in this chapter.

Weight-Bias

In this sample, the average level of weight-bias was 3.22 on a scale of 1-5, with 1 indicating low levels of weight-bias, and 5 indicating high levels of weight-bias. The minimum score was 1.50 and the maximum score was 5.00. An average of 3.22 (*SD*= .51) shows this sample of counselors holds a moderate level of weight-bias. No peer-reviewed published studies have shown rates of weight-bias among counselors. However, one published dissertation reported moderate levels of weight-bias among counselors (Feister, 2012). This study used different instruments to measure weight-bias, but the instruments used have strong psychometric properties and are often used in weight-bias research in other fields. The levels of weight-bias found in this sample aligns with the levels found by Feister (2012). This study took place nearly decade ago, which suggests that weight-bias among counselors has remained stable over the past decade.

Race

Bivariate correlations between race and weight-bias revealed no statistically significant relationship (r=-.059, p=.153). Previous research on the relationship between race and weight-bias had produced mixed results. Some studies found differences between racial groups regarding anti-fat attitudes (Jiang et al., 2017) and weight-bias (Barnes et al., 2014; Puhl et al., 2015) among the general population. Within health fields, race has rarely been included as a meaningful variable related to weight-bias. When race was included, Sabin et al. (2012) found stronger levels of anti-fat bias among White and Hispanic medical doctors compared to Asian

and African American medical doctors. Pratt et al. (2015) found higher levels of weight-bias among Caucasian marriage and family therapy trainees compared to non-Caucasian trainees.

The current study sought to include race as a meaningful variable to expand the understanding of how race and weight-bias may be related. Due to low representation in several of the racial groups of participants, analysis was conducted between white and non-white groups. While the findings in this study do not suggest a significant relationship between race and weight-bias, prevalence of weight-bias among the racial groups somewhat aligns with previous research. White participants showed higher levels of weight-bias (n= 464, M=3.23) than non-white participants (n= 117, M= 3.13). When means were compared between all racial groups, White participants still showed more weight-bias than Black/African American participants (n= 67, M= 3.16), Hispanic/Latinx participants (n= 15, M= 3.09), and multiracial participants (n= 16, M= 3.19). Other racial groups had low representation but indicate baselines for documenting weight-bias among counselors. Asian participants (n=6) scored an average of 3.23, which matched the score of White participants. Native Americans/Alaska Natives (n= 4) showed the highest level of weight-bias of any racial group with an average of 3.36. Native Hawaiian/other Pacific Islander racial group (n= 1), scored 2.14, which was the lowest of all racial groups but only included one participant. Finally, the racial group Other (n= 8) scored 3.01.

One consideration in interpreting the findings of this study is the intersectionality between race, gender, and weight for different racial groups. Ogden et al. (2014) reported obesity prevalence rates of over 50% in Black women, 44% in Hispanic women, and 33% in White women. However, Black and Hispanic women have been found more likely to describe overweight or obesity as healthy or normal compared to White women (Dorsey et al., 2009). Body dissatisfaction has also been found to be lower in Black women than Asian, Hispanic, and

White women, with Black women showing less idealization of thinness than Asian and White women (Grabe & Hyde, 2006; Evans & McConnell, 2003).

Studies have also shown lower levels of anti-fat attitudes among Black women compared to White and Hispanic women (Pepper & Ruiz, 2007; Hebl et al., 2009). One study reported the layering of racial bias and weight-bias for Black and Hispanic individuals to be concerning due to similar inaccurate stereotypes of these racial groups and individuals with higher body weights being lazy and unintelligent (Himmelstein, 2017). The same study explored experiences of weight-bias and internalization of weight-bias and found no racial differences in who experienced weight-stigma but found Black and Hispanic participants less likely to internalize weight-bias compared to White and Asian participants (Himmelstein, 2017). The authors of that study suggested the tendency of Black women to experience lower levels of body dissatisfaction, lower levels of anti-fat attitudes, and less idealization of thin bodies protected against internalizing weight-bias for Black women despite having a higher prevalence of obesity (Himmelstein, 2017). The relationship between weight-bias internalization and expression of weight-bias towards others is not well documented in previous research, so it remains an area to further explore regarding the relationship between race and weight-bias among counselors.

The findings of the present study aligned with these previous findings. All racial groups indicated moderate levels of weight-bias, with highest rates of weight-bias among Native American/Alaska Natives, White, and Asian participants, and lower rates among Black/African American, Hispanic/Latinx, multiracial, Native Hawaiian/other Pacific Islander, and other participants. However, due to the small number of participants in each non-white racial group, these findings may not be generalizable and could benefit from being explored in future studies.

Gender

A statistically significant relationship was found between male and weight-bias (r= .159, p<.001), which suggested that males showed higher levels of weight-bias than females. A non-binary/third gender option was included in the survey, but due to the low number (n= 6), analysis included only males and females. However, the average level of weight-bias for the non-binary/third gender (M= 2.56) was lower than the average for males (M=3.41) and females (M= 3.18). The findings in this study align with previous studies that also showed males having higher levels of weight-bias than females (O'Brien et al., 2007; Flint et al., 2015; Puhl et al., 2015). However, these results differ from previous studies on mental health professionals. Young and Powell (1985) found that female mental health workers assigned more negative psychological symptoms towards individuals with overweight or obesity than male mental health workers. Davis-Coelho et al. (2000) also found female psychologists to be more likely than male psychologists to assign worse prognosis for individuals with higher levels of body fat. The only published study in counseling was a dissertation (Feister, 2012), which showed no significant relationship between gender and weight-bias. The findings in the present study align with weight-bias research within the general population, but not with previous research on weight-bias within the mental health fields.

One consideration for this finding is the imbalance between males (n=88, 15.0%) and females (n= 493, 84.0%). It is possible that with a larger sample size of males, rates of weight-bias have been different. Another consideration is the difference in societal weight norms and expectations between males and females. Weight-bias is perpetuated in the media by idealization of smaller bodies and under-representation and misrepresentation of larger bodies, especially between males (muscular) and females (thin) (Ata & Thompson, 2010). A study found that over one-third of females on television were underweight despite only 5% of the general female

population being underweight (Greenberg et al., 2003). Greenberg et al (2003) also found that overweight and obese individuals make up 13% of females and 24% of males on television, compared with 51% of females and 59% of males in the general US population. When bigger bodies are included, they are often targets of stigmatization and humor (Ata & Thompson, 2010). A relationship between higher consumption of television and higher levels of weight-bias has been found in males as young as third grade (Harrison, 2000). Another study with children found a positive relationship between amount of time spent watching television and playing video games with weight-stigmatizing attitudes among males and a negative relationship between liking figures portrayed as overweight and magazine use among females (Latner et al., 2007). A study exploring the expression of fat-related humor in television shows and movies showed that adult males perpetuated fat commentary more frequently than adult females or children of either gender (Himes & Thompson, 2007), indicating media support for males to express weight-bias towards others. Another study found that weight-loss infomercials and advertisements overwhelmingly portray men as the scientific expert regarding the weight-loss product or service and portray women as the target of the weight-loss product or service (Blaine & McElroy, 2002). This portrayal reinforces the idea that men are allowed to directly perpetuate weight-bias and instruct others (especially women) to lose weight.

A final consideration in interpreting the results from this study is the 21- and 36-year gap since the studies that documented higher levels of weight-bias among female mental health providers were conducted (Davis-Coelho et al., 2000; Young & Powell, 1985). Women have historically been held to high beauty and weight standards, which contributed to weight-discrimination against women. One study showed the prevalence experiencing weight-based discrimination for women was 10% and only 5% for men (Puhl et al. 2008). Women with

moderate obesity were also three times more likely to report experiencing weight-based discrimination than men with similar weights (Puhl et al., 2008). Studies have also shown the link between experiencing weight-bias and developing weight-bias internalization (Hayward et al., 2018; Pearl & Puhl, 2018), so it is possible female counselors in the 1980s and early 2000s were more likely than male counselors to internalize weight-bias and endorse weight-biased attitudes and beliefs. However, in recent years there has been increasing awareness in society to challenge these ideas. With changes in media due to increasing availability of internet and social media, several campaigns have promoted weight-positivity among women. Female counselors in 2021 may have shifted further away from holding weight-biases and/or may be less willing than male counselors to express weight-biased attitudes and beliefs. Future research would be beneficial to further explore the relationship between gender and weight-bias among counselors.

Weight-bias Education

The relationship between weight-bias education and weight-bias was found to be statistically significant (r= -.210, p<.001), and indicated that as weight-bias education increased, weight-bias decreased. This finding aligns with previous research that has shown weight-bias education to be an effective at reducing weight-bias among various populations, including undergraduate students (Burmeister et al., 2016; Ciao & Latner, 2011), teachers (Hague & White, 2005), and medical students (O'Brien et al., 2010; Swift et al., 2013). No peer-reviewed studies could be found exploring weight-bias education in counseling. Thus, this is the first study to explore the relationship between these two variables.

In this study, weight-bias education was defined using four levels: no education, low education, medium education, and high education. Over half of all participants (n= 344, 58.7%) reported no (n= 59, 10.1%) or low (n=285, 48.6%) levels of education. These findings reveal that

10% of the sample had not received any education in weight-bias, weight stigma, and/or size-ism and less than half of the sample had low education, which was defined as: initial education, introductory content knowledge, single training or presentation, have heard or know about weight-bias, weight stigma, and/or size-ism. These findings also show that approximately one-quarter (*n*=152, 25.9%) of counselors had medium education, which had been defined as: in-depth education, applied content knowledge, multiple trainings or presentations, have been trained and have started implementing or been implementing less than six months. Encouraging results showed 15.2% counselors with high education, which had been defined as: comprehensive education, mastery content knowledge, training or presentation provider, have been fully trained and coached and have been implementing for six months or longer and/or coaching and training others. The breakdown of weight-bias education among counselors reveals the counseling profession still has work to do in educating counselors and counseling students about issues related to body weight and size. It also shows that there are counselors (15.2%) who have high education on this topic and could be supported in providing this education to other counselors.

Multicultural Competence

Multicultural competence and weight-bias were found to have a statistically significant relationship (r=-.215, p<.001), suggesting that as multicultural competence increased, weight-bias decreased. This finding is exciting, because it indicates that counselors with higher levels of multicultural awareness, knowledge, skills, and advocacy may be less likely to impart weight-biased attitudes, beliefs, and behaviors towards clients of larger body weights. Since the 1990s, the counseling profession has been utilizing the Multicultural Counseling Competencies (Sue et al., 1992, Arredondo et al., 1996, Ratts et al., 2015) to guide counselors on multicultural

counseling competence, reduce oppressive practices, and increase the use of inclusive and validating experiences for clients (Fietzer et al., 2018). While multicultural competence has been found to be helpful in reducing some cultural biases, studies have shown low levels of cultural competence with specific cultural elements such as race (Basma et al., 2020; Castillo et al., 2007) and religion/spirituality ((Magaldi-Dopman, 2014). However, higher multicultural competence was found to decrease counselor bias regarding SES (Bray & Schommer-Aikins, 2015; Toporek and Pope-Davis, 2005). The findings of the present study align more with the findings of the studies regarding SES (Bray & Schommer-Aikins, 2015; Toporek and Pope-Davis, 2005). However, while the relationship is significant, this sample of counselors still indicated moderate levels of weight-bias, suggesting that multicultural competence alone is not sufficient to reduce weight-bias among counselors.

Personal Experiences with Weight-bias

Personal experiences with weight-bias and weight-bias were not found to have a statistically significant relationship in this study (r= -.0801, p=.051). Overall, reports of personal experiences with weight-bias were quite low in this study. Out of a possible score of 0-9, the sample scored an average of 1.01. The most common score was 0 and was reported by 14.3% (n= 84) of participants, indicating they had never personally experienced weight-bias. Less than 7% of participants scored higher than 3, with the highest score being a 7.90, which indicated a moderate amount of weight-bias over the lifetime. One consideration in this finding is recognition of weight-bias. Over half of the participants in this study reported having no or little education about weight-bias. It is possible that this lack of education interfered with recognition of weight-bias in their own lives. General population rates of weight-based discrimination range between 5% and 10% (Puhl et al., 2008), and occurred on average 4.9 times per lifetime

(Andreyeva at el., 2008). The results from this sample indicate a much lower prevalence rate than found in those studies. The relationship between experiencing weight-bias from others and having weight-bias towards others has not been documented in the literature. Some research exists regarding weight-status and weight-bias and shows mixed results regarding relationship between BMI and levels of weight-bias (Allison et al., 1991; Phelan et al., 2014; Pratt et al., 2015; Schwartz et al., 2006). However, these studies did not directly link experiences of bias, stigma, or discrimination to levels of weight-bias. The present study explored the relationship between personal experiences with weight-bias and found no relationship to levels of weight-bias among counselors.

Contributions of the Study

This study contributed to the field of counseling as one of only three studies addressing weight-bias in counseling. Two dissertations about weight-bias in counseling have been published in the past 13 years (Adams, 2008; Feister, 2012). This author could find no articles or studies regarding weight-bias published in counseling journals. This significant gap in the literature posed concern, given the presence of weight-bias among clinicians in other mental health fields, and the harmful impact of weight-bias on individuals. The lack in literature suggested lack of awareness, knowledge, skill, and advocacy regarding the power, privilege, oppression, stigma, and bias related to body weight among counselors. Deficits in these areas could imply counselors may not be conducting culturally competent counseling with clients of larger body weight and size, and thus harming clients. This study aimed to address this gap in the literature by exploring the factors related to weight-bias among counselors and found three meaningful factors: gender, weight-bias education, and multicultural competence. Further, this study provides insight to the level of weight-bias among counselors, which was found to be

moderate. This study provided a starting place for future research to build upon. Ideas for future research will be discussed in a later section of this chapter.

Limitations

As with all research, this study had limitations regarding its design, implementation, and results. First, this study invited counselors who were either members of a state level counseling association or had registered an email address with a state level licensing board. The researcher could not control how well these counselors represent the general population of counselors across the United States or who opened the email and decided to participate. Further, the research design used instruments and questions where participants self-reported, thus data may not accurately represent true thoughts, feelings, and beliefs of participants. Social desirability may have influenced participants responses to the items in the survey. However, these limitations were addressed by not collecting any personally identifiable information and allowing participants to take the survey anonymously, within a location and time of their choosing. Additionally, this study asked counselors about their own attitudes, beliefs, and feelings, but did not ask about behaviors. Nor did the study investigate client's experiences of counselor weight-bias. Further research about weight-bias in counseling is needed to better understand this phenomenon from various angles and perspectives.

This study was conducted during a worldwide pandemic and a period of political and social unrest in the United States. It is possible these factors contributed to participants willingness to participate or influenced their responses in ways the researcher could not account for or control. This study included licensed counselors within the United States who earned a master's degree in counseling. Therefore, these results may not be generalizable to licensed counselors with master's degrees in other fields or other mental health providers outside of the

counseling field. Additionally, these results may not be generalizable to counselors in other countries. Finally, this study utilized a correlational non-experimental design. Therefore, no causal relationship could be found or implied. This study found a significant relationship between the group of predictor variables and the outcome variable, but it cannot be stated that male, weight-bias education, or multicultural competence cause weight-bias among counselors.

Implications

The literature discussed previously in this paper documented the negative impact weight-bias can have on individuals. This study found counselors to have moderate levels of weight-bias. This implies counselors may be unknowingly causing harm to clients, which violates ethical codes set forth by the ACA to protect client welfare (ACA, 2014). Counselors have an ethical duty to develop awareness of cultural biases, acquire knowledge regarding various cultural identities and experiences, develop culturally reflective counseling skills to address these concerns in counseling, and use advocacy to improve well-being for clients and society (Arredondo et al., 1996; Ratts et al., 2015; Sue et al., 1992). This study found three significant factors related to weight-bias among counselors: male, weight-bias education, and multicultural competence. Implications from these results include educating counselors and counseling students about issues related to body weight and weight-bias, inclusion of body weight and size as a cultural consideration in counseling, and continuing efforts to develop culturally competent counselors. While this study included only licensed counselors, implications for counselor education and supervision can be also made. CACREP accredited counselor education programs are required to "reflect current knowledge and projected needs concerning counseling in a multicultural and pluralistic society," (CACREP, 2016, 2.A). CACREP recognizes social and cultural diversity as one of the eight core areas of counseling curriculum. Given the findings of

this study, moderate levels of weight-bias among counselors, it is imperative to work to reduce weight-bias before counselors enter the workforce. The following discussion of implications can be applied to all levels of counselors including practicing counselors, counselor educators and supervisors, and counseling students and supervisees.

As weight-bias education was found to have significant contribution to lower levels of weight-bias, utilizing weight-bias education is an important implication from this study for the counseling profession. Weight-bias education should be included in graduate counseling program curriculum, continuing education, workshops, trainings, and conference presentations to help counselors recognize the importance of this topic, access assessment tools to measure personal levels of weight-bias, and learn strategies to reduce its impact in clinical work. Weight-bias education interventions can inform counselors and counseling students of the factors related to developing and expressing weight-bias found in this study (being male, lack of weight-bias education, and low levels of multicultural competence) and other factors as they are revealed through future research. To help counselors recognize the harm that can be caused by expressing weight-bias to clients, weight-bias education interventions could also include examples and stories from clients on how weight-bias impacted their experiences in counseling. Providing personal accounts from clients can help illustrate common micro-and macro-aggressions that can occur in counseling relationships to help counselors avoid perpetuating weight-bias towards clients.

Education should also include information and discussion regarding the controllability factor of body weight and size to help counselors understand the complexity of factors that contribute to higher body weights. Interventions focused on explaining and exploring factors that contribute to higher body weights can be helpful in reducing weight-bias, but this should not be

the sole focus of education. This message perpetuates the untrue belief that higher weights are bad and are justified only when we understand WHY this might happen to someone. Instead, an emphasis on the fundamental right to be fat is necessary to help counselors deconstruct their own biases about the importance of body weight and existing meaning-making associated with body weight. This deconstruction will help counselors shift towards attitudes, beliefs, and behaviors rooted in size-inclusivity and size-affirmation. Additionally, education must include strategies for clinicians to ensure their physical spaces are inclusive and affirming for all sizes (i.e., comfortable seating, adequate air conditioning, publications or artwork representing various body sizes, and removing women's health and beauty magazines that perpetuate unhealthy body ideals from waiting rooms).

In addition to utilizing weight-bias education, the counseling profession must include body weight and size as a multicultural consideration, along with other cultural considerations such as race, ethnicity, gender, sexual orientation, age, religion, able-bodiedness, language, and country-of-origin. Body weight and weight-bias could be included in multicultural counseling course curriculum and infused into other courses as a cultural consideration in counseling. Counselor educators could provide information regarding the presence and impact of weight-bias in society and in mental healthcare and facilitate discussion about personal attitudes and beliefs to help students recognize how these may or may not align with societal expectations and the values of the counseling field. Counselor educators could include individuals with higher body weights in case studies and role plays to help students conceptualize and practice integrating awareness, knowledge, and skills in attending to themes of weight stigma and bias. Providing opportunities for students to practice talking about body weight in a size-affirming manner will help prepare them to address issues related to body weight with clients. Body weight and size

must also be included in discussions of power, privilege, and oppression from the individual, family, community, and systemic levels in the same ways race, gender, sexuality, etc. are included. Body weight and size also needs to be included in conversations regarding intersectionality to help counselors and counseling students better understand power dynamics and layering effects of carrying multiple stigmatized identities or combinations of stigmatized and privileged identities. Previous research has explored various cultural identities in relation to weight-bias and found mixed results, suggesting that further research and education is needed for counselors to integrate weight-bias into multicultural competent counseling. Finally, this study showed that higher levels of multicultural competence contributed to lower levels of weight-bias. Therefore, continued attention to the development of multicultural competence will help protect counselors and counseling students from developing and/or perpetuating weight-bias. Failure to address body weight as a cultural consideration in counselor education programs produces new counselors who are unprepared to provide size-affirming counseling services to individuals of all body weights and sizes and will cause harm to clients who seek counseling to heal.

Future Research

This study is one of three published dissertations addressing weight-bias in counseling. With no peer-reviewed published studies in counseling journals, there are many avenues and directions for future research to take place. First, research could continue to focus on understanding the prevalence of weight-bias in counseling and identifying factors that contribute to weight-bias among counselors. Factors from this study (race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias) could be re-examined and grouped with new variables until a good understanding of how/why weight-bias exists in counselors is reached. Future studies could focus on increasing participant sample diversity or

studying specific gender, racial, or other cultural groups to better understand how demographic variables influence weight-bias among counselors. Second, future studies could begin to explore the presence and impact of weight-bias in counseling. These areas have been minimally explored in related mental health fields, but not within counseling. Studies could explore client experiences of weight-bias in counseling, assessment of weight-related concerns in counseling, and counselor weight-status matching/not matching client weight-status and impact on counseling relationship. Further, weight-bias education interventions in counselor education or workshops/trainings/presentations could be explored to better understand best practices for counselors to learn about and reduce weight-bias.

Conclusion

In conclusion, past literature has documented the prevalence of weight-bias in society and among mental health providers. However, limited research has focused on issues of weight-bias in counseling (Adams, 2008; Feister, 2012), with only one focused on factors related to attitudes towards obese persons (Feister, 2012). The present study explored the relationship between five predictor variables (race, gender, weight-bias education, multicultural competence, and personal experiences with weight-bias) and one outcome variable (weight-bias). Results showed a moderate level of weight-bias among counselors and identified three significant factors (male, having lower levels of weight-bias education, and having lower levels of multicultural competence) contributed to higher levels of weight-bias. These results provide a starting point for addressing and reducing weight-bias among counselors. Counselors, counseling students, and ultimately clients, could benefit from the inclusion of body weight and size as a cultural consideration in counseling and counselor education. This study builds on the findings of the two published studies on weight-bias in counseling (Adams, 2008; Feister, 2012) and contributes

additional knowledge about factors related to weight-bias among counselors. Future studies can build from the findings of this study, until a clear understanding of weight-bias in counseling is achieved. This paper explored an introduction to the topic of weight-bias in counseling, explored literature related to all variables, explained the methodology of the study, reported results from data analysis, and discussed the findings, limitations, and implications of this study. Counselors have an ethical responsibility to do no harm to clients. Addressing body weight and size as a cultural consideration in counseling will help counselors protect clients and engage in relationships with clients where healing and wellness can flourish.

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APPENDIX A: Recruitment for Research Study

Dear Counselor,

My name is Katie Christensen and I am doctoral student in the Counselor Education and Supervision program at the University of North Carolina at Charlotte. The purpose of this study is to investigate weight-related issues in counseling.

You are invited to participate in a self-report online survey if you a) *are a counselor licensed in the United States* **and** b) *earned a master's degree in counseling*. Your participation in this study will contribute to a better understanding of weight-related issues in the counseling field. Participation is completely voluntary. Your answers are strictly confidential and your identity will not be shared with anyone. To participate, please complete the following online survey via the link in this email. This survey should take approximately 10-15 minutes of your time. There is no compensation for your participation in this study.

You are invited to participate in this study if you meet the following criteria:

1) Provisionally or fully licensed as a counselor in the United States of America

   and

2) Earned a master's degree in counseling

This study is approved by the UNC Charlotte IRB, study #21-0297 and is under the direction of my Advisor Dr. Sejal Parikh Foxx. For any questions or concerns related to this study, please contact Katie Christensen at kchris23@uncc.edu. UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office via email at uncc-irb@uncc.edu if you have questions about how you are treated as a study participant.

To expand the reach for participants, please feel free to forward this call for participation to anyone that you think meets the inclusion criteria.

Follow this link (or copy and paste into browser) to review the informed consent and begin the survey:

http://uncc.qualtrics.com/jfe/form/SV_aV7vt93rcNIsgHs

Thank you,

Katie Christensen, MA, LPCA, NCC
Doctoral Candidate, University of North Carolina at Charlotte
Primary Investigator
Email: kchris23@uncc.edu

Dissertation Chair:

Sejal Parikh Foxx, Ph.D.
Department Chair, Professor, University of North Carolina at Charlotte
Faculty Advisor
E-mail: sbparikh@uncc.edu

APPENDIX B: Follow-up Recruitment for Research Study

Dear Counselor,

You were recently sent an email inviting you to participate in a short online survey. **This is a follow-up email requesting your participation**. The purpose of this study is to investigate weight-related issues in counseling.

You are invited to participate in a self-report online survey if you a) *are a counselor licensed in the United States* **and** b) *earned a master's degree in counseling*. Your participation in this study will contribute to a better understanding of weight-related issues in the counseling field. Participation is completely voluntary. Your answers are strictly confidential and your identity will not be shared with anyone. To participate, please complete the following online survey via the link in this email. This survey should take approximately 10-15 minutes of your time. There is no compensation for your participation in this study.

You are invited to participate in this study if you meet the following criteria:

1) Provisionally or fully licensed as a counselor in the United States of America

   and

2) Earned a master's degree in counseling

This study is approved by the UNC Charlotte IRB, study #21-0297 and is under the direction of my Advisor Dr. Sejal Parikh Foxx. For any questions or concerns related to this study, please contact Katie Christensen at kchris23@uncc.edu. UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office via email at uncc-irb@uncc.edu if you have questions about how you are treated as a study participant.

To expand the reach for participants, please feel free to forward this call for participation to anyone that you think meets the inclusion criteria.

Follow this link (or copy and paste into browser) to review the informed consent and begin the survey:

http://uncc.qualtrics.com/jfe/form/SV_aV7vt93rcNIsgHs

Thank you,

Katie Christensen, MA, LPCA, NCC
Doctoral Candidate, University of North Carolina at Charlotte
Primary Investigator
Email: kchris23@uncc.edu

Dissertation Chair:

Sejal Parikh Foxx, Ph.D.
Department Chair, Professor, University of North Carolina at Charlotte
Faculty Advisor
E-mail: sbparikh@uncc.edu

APPENDIX C: Social Media Recruitment for Research Study

Dear Counselor,

My name is Katie Christensen and I am doctoral student in the Counselor Education and Supervision program at the University of North Carolina at Charlotte. The purpose of this study is to investigate weight-related issues in counseling.

You are invited to participate in a self-report online survey if you a) *are a counselor licensed in the United States* **and** b) *earned a master's degree in counseling*. Your participation in this study will contribute to a better understanding of weight-related issues in the counseling field. Participation is completely voluntary. Your answers are strictly confidential and your identity will not be shared with anyone. To participate, please complete the following online survey via the link in this email. This survey should take approximately 10-15 minutes of your time. There is no compensation for your participation in this study.

You are invited to participate in this study if you meet the following criteria:

1) Provisionally or fully licensed as a counselor in the United States of America

   and

2) Earned a master's degree in counseling

Follow this link (or copy and paste into browser) to review the informed consent and begin the survey:

http://uncc.qualtrics.com/jfe/form/SV_aV7vt93rcNIsgHs

To expand the reach for participants, please feel free to forward this call for participation to anyone that you think meets the inclusion criteria.

This study is approved by the UNC Charlotte IRB, study #21-0297 and is under the direction of my Advisor Dr. Sejal Parikh Foxx. For any questions or concerns related to this study, please contact Katie Christensen at kchris23@uncc.edu. UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office via email at uncc-irb@uncc.edu if you have questions about how you are treated as a study participant.

Thank you,

Katie Christensen, MA, LPCA, NCC
Doctoral Candidate, University of North Carolina at Charlotte
Primary Investigator
Email: kchris23@uncc.edu

Dissertation Chair:

Sejal Parikh Foxx, Ph.D.
Department Chair, Professor, University of North Carolina at Charlotte
Faculty Advisor
E-mail: sbparikh@uncc.edu

APPENDIX D: Online Informed Consent Form

Dear Participant,

As a counselor licensed to practice in the United States, you are being invited to participate in a quantitative research study that will examine weight-related issues in counseling. You are eligible to participate if you a) are a counselor licensed in the United States of America and b) earned a master's degree in counseling. Your participation will involve completing a survey that will take approximately 10-15 minutes. This survey will ask questions about your personal experiences, feelings, and beliefs regarding weight-related issues, counselor education, and multiculturalism.

The benefits of your participation in this study include contributing to the current knowledge, characteristics, and views regarding weight-related issues in the counseling profession as well as implications for counselor educators and trainees. There are limited known risks in participating in this study such as feeling discomfort or distress due to the sensitive nature of some questions regarding your own experiences with weight-related issues. Should you experience discomfort or distress, you are encouraged to seek counseling with a provider of your choice. As with any online related activity the risk of a breach of confidentiality is always possible. To the best of our ability your answers in this study will remain confidential. We will minimize any risk by collecting data completed anonymously. The primary investigator and faculty adviser will be the only persons who will have access to the responses provided participants. You may withdraw or decline without penalty at any time. After this study is complete, identifiers will be removed from the data and the data could be used for future research studies or distributed to another investigator for future research studies without additional informed consent.

You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may change your mind and stop at any time.

This study is approved by the UNC Charlotte IRB, study #21-0297 and is under the direction of my Advisor Dr. Sejal Parikh Foxx. For any questions or concerns related to this study, please contact Katie Christensen at kchris23@uncc.edu. UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's 130 Research Compliance Office via email at uncc-irb@uncc.edu if you have questions about how you are treated as a study participant.

By clicking "I agree" you are (1) confirming you have read the information above, (2) confirming you are a ***counselor licensed to practice in the United States***, (3) confirming you earned a ***master's degree in counseling***, and (4) providing informed consent to participate in this study. Print this page for your records.

Thank you for taking the time to participate.

I Agree

APPENDIX E: Demographics Questionnaire

Instructions: Please indicate your answer for the following demographic questions.

1. Based on the benchmarks below, indicate the extent of your education of weight-bias, weight stigma, and/or size-ism.

No Education	Have not received any education in weight-bias, weight stigma, or sizeism
Low	Initial education, introductory content knowledge, single training or presentation, have heard or know about weight-bias, weight stigma, or sizeism
Medium	In-depth education, applied content knowledge, multiple trainings or presentations, have been trained and have started implementing or been implementing less than six months
High	Comprehensive education, mastery content knowledge, training or presentation provider, have been fully trained and coached and have been implementing for six months or longer and/or coaching and training others

1) No Education
2) Low Education
3) Medium Education
4) High Education

2. How do you identify your gender?
    1) Male
    2) Female
    3) Non-binary/third gender

3. How do you identify your race/ethnicity?
    1) Non-Hispanic White
    2) Black/African American
    3) Hispanic/Latino/a
    4) Asian
    5) Native Hawaiian/other Pacific Islander
    6) American Indian/Alaska Native
    7) Multiracial
    8) Other

4. What is your age (in years)?
    1) 18-29
    2) 30-39
    3) 40-49
    4) 50-59
    5) 60 or older

5. Which option best describes your counseling specialization?
    1) Addictions counseling
    2) Career counseling
    3) Clinical Mental Health counseling
    4) College and Student Affairs counseling
    5) K-12 School counseling
    6) Marriage, Couple, and Family counseling
    7) Rehabilitation counseling

6. Are you a counselor educator?
    1) Yes
    2) No

7. How many years of counseling experience do you have?
    1) 0-3
    2) 4-6
    3) 7-10
    4) 11-15
    5) 16+

8. In which region of the United States best describes where you work?
    1) West
    2) Central
    3) Southeast
    4) Northeast

9. Which option best describes your own weight-status?
    1) Underweight
    2) Average weight
    3) Overweight
    4) Obese

10. In your clinical practice, have you focused on client issues regarding weight-bias?
    1) No
    2) Yes

APPENDIX F: Fat Phobia Scale- Short Form

Directions: Listed below are 14 pairs of adjectives sometimes used to describe **obese** or **fat** people. For each adjective pair, please place an **X** on the line *closest to the adjective* that you feel best describes your feelings and beliefs.

1.	lazy	___5___	___4___	___3___	___2___	___1___	industrious
2.	no will power	___5___	___4___	___3___	___2___	___1___	has will power
3.	attractive	___1___	___2___	___3___	___4___	___5___	unattractive
4.	good self-control	___1___	___2___	___3___	___4___	___5___	poor self-control
5.	fast	___1___	___2___	___3___	___4___	___5___	slow
6.	having endurance	___1___	___2___	___3___	___4___	___5___	having no endurance
7.	active	___1___	___2___	___3___	___4___	___5___	inactive
8.	weak	___5___	___4___	___3___	___2___	___1___	strong
9.	self-indulgent	___5___	___4___	___3___	___2___	___1___	self-sacrificing
10.	dislikes food	___1___	___2___	___3___	___4___	___5___	likes food
11.	shapeless	___5___	___4___	___3___	___2___	___1___	shapely
12.	undereats	___1___	___2___	___3___	___4___	___5___	overeats
13.	insecure	___5___	___4___	___3___	___2___	___1___	secure
14.	low self-esteem	___5___	___4___	___3___	___2___	___1___	high self-esteem

Scoring Instructions:
Step 1: For items 3, 4, 5, 6, 7, 10, and 12, score as follows:
1 2 3 4 5
Step 2: For items 1, 2, 8, 9, 11, 13, and 14, score as follows:
5 4 3 2 1
Step 3: Add up the score for each item to get the total score. Then divide by 14 (or the number of items answered, whichever is less). The range of scores is 1 – 5. High scores = more 'fat phobia'. Low scores = less 'fat phobia'.

Please contact BE Robinson for permission to use the scale.

APPENDIX G: Stigmatizing Situations Inventory- Brief (SSI-B)

Below is a list of situations that people encounter because of their weight. Please indicate whether, and how often, each of these situations happens to you.

0 Never	1 Once in your life	2 Several times in your life	3 About once a year	4 Several times per year	5 About once a month	6 Several times per month	7 About once a week	8 Several times per week	9 Daily

Being singled out as a child by a teacher, school nurse, etc., because of your weight.	0 1 2 3 4 5 6 7 8 9
Being stared at in public.	0 1 2 3 4 5 6 7 8 9
Children loudly making comments about your weight to others.	0 1 2 3 4 5 6 7 8 9
Having a doctor recommend a diet, even if you did not come in to discuss weight loss.	0 1 2 3 4 5 6 7 8 9
Having a romantic partner exploit you, because she or he assumed you were 'desperate' and would put up with it.	0 1 2 3 4 5 6 7 8 9
Overhearing other people making rude remarks about you in public.	0 1 2 3 4 5 6 7 8 9
Not being hired because of your weight, shape or size.	0 1 2 3 4 5 6 7 8 9
Having family members feel embarrassed by you or ashamed of you.	0 1 2 3 4 5 6 7 8 9
Having people assume you overeat or binge eat because you are overweight.	0 1 2 3 4 5 6 7 8 9
Being glared at or harassed by bus passengers for taking up 'too much' room.	0 1 2 3 4 5 6 7 8 9

APPENDIX H: California Brief Multicultural Competence Scale (CBMCS) and Modified Version

California Brief Multicultural Competence Scale (CBMCS)

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

		Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*
1.	I am aware that being born a minority in this society brings with it certain challenges that the leading majority does not have to face.	1	2	3	4
2.	I am aware of how my own values might affect my client.	1	2	3	4
3.	I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	1	2	3	4
4.	I am aware of institutional barriers that affect the client.	1	2	3	4
5.	I have an excellent ability to assess, accurately, the mental health needs of lesbians.	1	2	3	4
6.	I have an excellent ability to assess, accurately, the mental health needs of older adults.	1	2	3	4
7.	I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	1	2	3	4
8.	I am aware that counselors frequently impose their own cultural values upon minority clients.	1	2	3	4
9.	My communication skills are appropriate for my clients.	1	2	3	4
10.	I am aware that being born in the leading majoirty in this society carries with it certain advantages.	1	2	3	4
11.	I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	1	2	3	4
12.	I have an excellent ability to critique multicultural research.	1	2	3	4
13.	I have an excellent ability to assess, accurately, the mental health needs of men.	1	2	3	4
14.	I am aware of institutional barriers that may inhibit minorities from using mental health services.	1	2	3	4
15.	I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	1	2	3	4
16.	I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	1	2	3	4
17.	I can discuss research regarding mental health issues and culturally different populations.	1	2	3	4
18.	I have an excellent ability to assess, accurately, the mental health needs of gay men.	1	2	3	4
19.	I am knowledgeable of acculturation models for various ethnic minority groups.	1	2	3	4
20.	I have an excellent ability to assess, accurately, the mental health needs of women.	1	2	3	4
21.	I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds.	1	2	3	4

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (In Press, 2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development, 37*

CBMCS Modified Version

1. I have an excellent ability to assess accurately the mental health needs of gay men.
2. I have an excellent ability to assess accurately the mental health needs of lesbians.
3. I have an excellent ability to assess accurately the mental health needs of persons with disabilities.
4. I have an excellent ability to assess accurately the mental health needs of older adults.
5. I have an excellent ability to assess accurately the mental health needs of men.
6. I have an excellent ability to assess accurately the mental health needs of persons who come from low socioeconomic backgrounds.
7. I have an excellent ability to assess accurately the mental health needs of women.
8. I am aware that counselors frequently impose their own cultural values on clients from marginalized groups.
9. I am aware that being born a White person in this society carries with it certain advantages.
10. I am aware of institutional barriers which may inhibit individuals from marginalized groups from using mental health services.
11. I am aware that being born into a marginalized group in this society brings with it certain challenges that White people do not have to face.
12. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.
13. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.
14. I have an excellent ability to critique multicultural research.
15. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons with different cultural/ racial/ethnic backgrounds.
16. I can discuss within group differences among ethnic groups (e.g., low socioeconomic status [SES] Puerto Rican client vs. high SES Puerto Rican client).
17. I can discuss research regarding mental health issues and culturally different populations.
18. I am knowledgeable of acculturation models for various marginalized groups.
19. My communication is appropriate for my clients.
20. I am aware of institutional barriers that affect the client.
21. I am aware of how my own values might affect my client.

APPENDIX I: Instruments Request and Confirmation

Permission request Fat Phobia Scale-short form Dissertation ×

Katie Christensen <kchris23@uncc.edu> Wed, Nov 11, 2020, 4:38 PM
to robin009

Hello Dr. Robinson,

My name is Katie Christensen and I am completing my PhD in Counselor Education and Supervision at the University of North Carolina at Charlotte. I am interested in using the Fat Phobia Scale-Short Form in my dissertation study, and am seeking your permission. I have accessed the questions and scoring guide through the Rudd Center at Yale University. My study will explore factors related to weight-bias among mental health counselors. While weight-bias research is growing in the mental health field, research is still scarce within the counseling field. I believe the use of the Fat Phobia Scale-Short Form in my study will be a valuable contribution to this emerging area of research in counseling.

Thank you for your consideration,
Katie Christensen

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Katie Christensen, M.A., LPCA, NCC
Doctoral Candidate, Counselor Education and Supervision
Department of Counseling
University of North Carolina at Charlotte
kchris23@uncc.edu
(425) 879-4376

Beatrice (Bean) Robinson PhD, LP <robin009@umn.edu> Nov 12, 2020, 7:29 PM
to Jane, Heidi, me

[Caution: Email from External Sender. Do not click or open links or attachments unless you know this sender.]

Hi Katie,
Thank you so much for your interest in our work. It is very gratifying that so many researchers and students around the world continue to use our Fat Phobia Scale to investigate international attitudes toward and stigma around fat people.

I am happy to give you "official" permission to use our Fat Phobia Scale in your PhD dissertation in Counselor Education and Supervision at the University of North Carolina, Charlotte investigating factors related to weight-bias among mental health counselors. It would be helpful if you could tell me a little more about your research, who is sponsoring your research, where is the research taking place, what the aims are, methods, sample, etc. etc.

If you do use our instrument, we would appreciate you giving us copies of any revisions or modifications of the instrument, including a copy of any translations or modifications (and a description of the method you used to translate/modify it), letting us know the sample you used it with, reliability or validity results you get while using the scale on your particular sample, method and results/findings from your work (including any articles, reports, or theses you write using our instruments or materials), and any other information you feel would be of use and interest to us.

I have enclosed a list of the following items that may be of interest to you.
I would be happy to send you copies of # 5, the original 50-item scale; # 1, the short 14-item version of the Fat Phobia Scale; and #6, Restricted Activities Scale (as well as any other items you request).

Please contact Heidi Fall (fallx004@umn.edu) and let her know what materials you would like. She can email them to you. Be sure to copy both of us on all your correspondence and requests so we both know what is going on.

1. _____ Fat Phobia Scale Revisited: The Short Form. This includes the 14-item short form of the F-Scale and scoring instructions. (Bacon, J. G., Scheltema, K. E., & Robinson, B. E. (2001). Fat Phobia Scale revisited. The short form. *International Journal of Obesity & Related Metabolic Disorders, 25*(2), 252-257.)

2. _____ Fat Phobia: Measuring, Understanding and Changing Anti-Fat Attitudes (Robinson, B. E., Bacon, J. G., & O Reilly, J. (1993) Fat phobia: Measuring, understanding, and changing anti-fat attitudes. *The International Journal of Eating Disorders, 14*(4), 467-480.)

3. _____ Obesity: A Move from Traditional to More Patient-Oriented Management. (Robinson, B. E., Gjerdingen, D. K., & Houge, D. (1995). Obesity: A move from traditional to more patient-oriented management. *The Journal of the American Board of Family Practice, 8*(2), 99-108.)

4. _____ The "If Only I Were Thin…" Treatment Program: Decreasing the Stigmatizing Effects of Fatness. (Robinson, B. E., & Bacon, J. G. (1996). The "If only I were thin…" treatment program: Decreasing the stigmatizing effects of fatness. *Professional Psychology: Research and Practice, 27*(2), 175-183.)

5. _____ 50 item fat phobia (F-Scale) and scoring instructions. (Robinson, B. E., & Bacon, J. G. Self-Esteem/Body Image Program, 1993.)

6. _____ REACT (Restricted Activity Scale) and scoring instructions. (Robinson, B. E., & Bacon, J. G. Self-Esteem/Body Image Program, 1990.)

7. _____ Methods for Measuring Attitudes and Beliefs about Obese People: A Review of the Fat Phobia Scale. (Yuker, H., Allison, D. B., & Faith, M. (1995). Methods for measuring attitudes and beliefs about obese people. In D. B. Allison (Ed.), *Handbook of assessment methods for eating behaviors and weight-related problems: Measures, theory, and research* (pp. 81-118). Thousand Oaks, CA: SAGE Publications.)

8. _____ Fat Phobia and the F-Scale: Measuring, Understanding and Changing Anti-Fat Attitudes. (Robinson, B. E., & Bacon, J. G. (1997). Fat phobia and the F-scale: Measuring, understanding, and changing anti-fat attitudes *Melpomene Journal, 16*(1), 24-29.)

Good luck in your work and keep us posted.

Sincerely,

Beatrice "Bean" E. Robinson, PhD, Professor
Minnesota Licensed Psychologist
Minnesota Licensed Marriage & Family Therapist & State Approved MFT Supervisor
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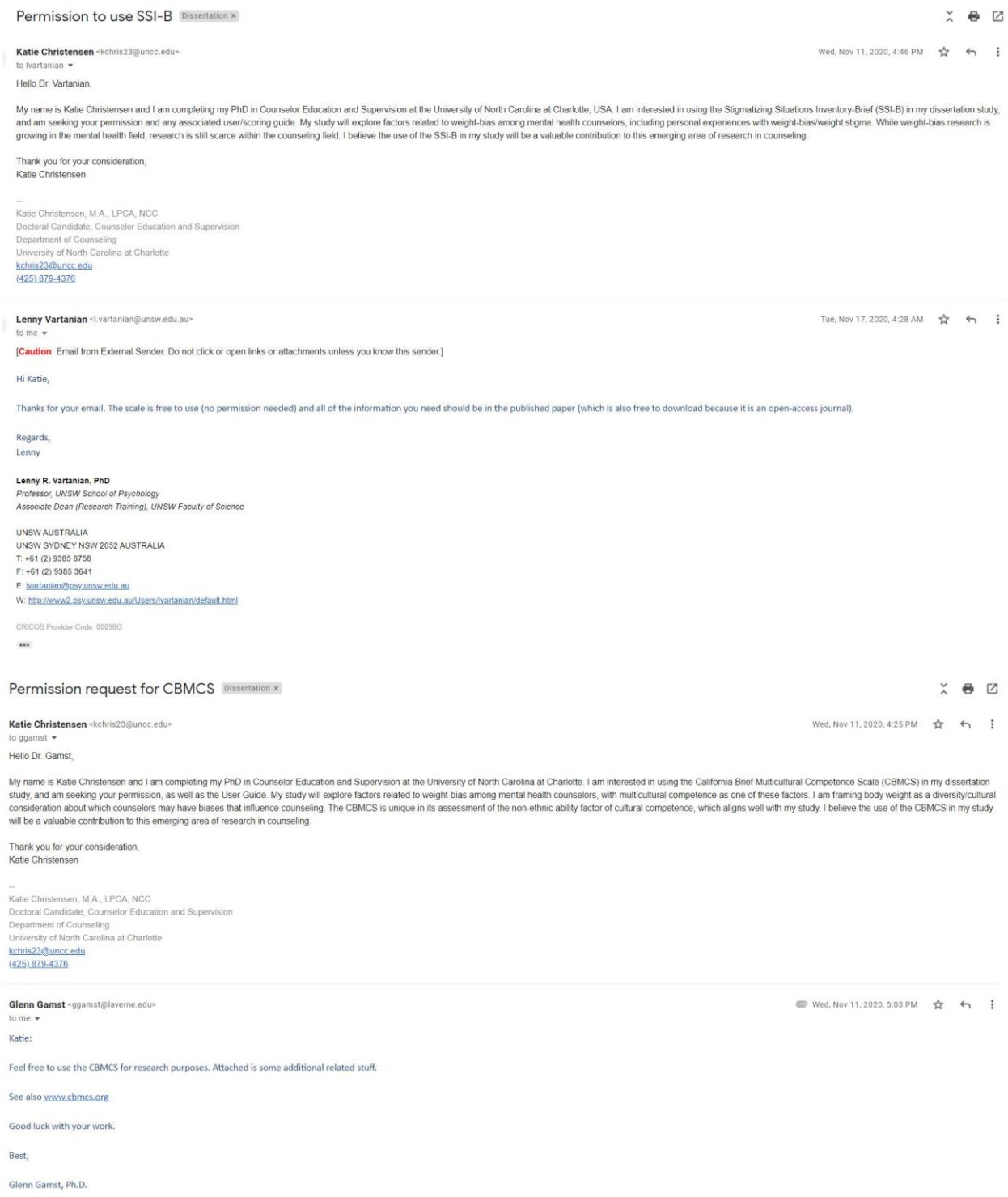
Beatrice "Bean" Ellen Robinson, PhD, Professor
MN Licensed Psychologist, MN Licensed Marriage & Family Therapist, MN State-Approved Supervisor

Program in Human Sexuality/Center for Sexual Health



Permission to use SSI-B Dissertation ×

Katie Christensen <kchris23@uncc.edu> Wed, Nov 11, 2020, 4:46 PM
to lvartanian

Hello Dr. Vartanian,

My name is Katie Christensen and I am completing my PhD in Counselor Education and Supervision at the University of North Carolina at Charlotte, USA. I am interested in using the Stigmatizing Situations Inventory-Brief (SSI-B) in my dissertation study, and am seeking your permission and any associated user/scoring guide. My study will explore factors related to weight-bias among mental health counselors, including personal experiences with weight-bias/weight stigma. While weight-bias research is growing in the mental health field, research is still scarce within the counseling field. I believe the use of the SSI-B in my study will be a valuable contribution to this emerging area of research in counseling.

Thank you for your consideration,
Katie Christensen

--
Katie Christensen, M.A., LPCA, NCC
Doctoral Candidate, Counselor Education and Supervision
Department of Counseling
University of North Carolina at Charlotte
kchris23@uncc.edu
(425) 879-4376

Lenny Vartanian <l.vartanian@unsw.edu.au> Tue, Nov 17, 2020, 4:28 AM
to me

[**Caution**: Email from External Sender. Do not click or open links or attachments unless you know this sender.]

Hi Katie,

Thanks for your email. The scale is free to use (no permission needed) and all of the information you need should be in the published paper (which is also free to download because it is an open-access journal).

Regards,
Lenny

Lenny R. Vartanian, PhD
Professor, UNSW School of Psychology
Associate Dean (Research Training), UNSW Faculty of Science

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W: http://www2.psy.unsw.edu.au/Users/lvartanian/default.html

CRICOS Provider Code: 00098G

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Permission request for CBMCS Dissertation ×

Katie Christensen <kchris23@uncc.edu> Wed, Nov 11, 2020, 4:25 PM
to ggamst

Hello Dr. Gamst,

My name is Katie Christensen and I am completing my PhD in Counselor Education and Supervision at the University of North Carolina at Charlotte. I am interested in using the California Brief Multicultural Competence Scale (CBMCS) in my dissertation study, and am seeking your permission, as well as the User Guide. My study will explore factors related to weight-bias among mental health counselors, with multicultural competence as one of these factors. I am framing body weight as a diversity/cultural consideration about which counselors may have biases that influence counseling. The CBMCS is unique in its assessment of the non-ethnic ability factor of cultural competence, which aligns well with my study. I believe the use of the CBMCS in my study will be a valuable contribution to this emerging area of research in counseling.

Thank you for your consideration,
Katie Christensen

--
Katie Christensen, M.A., LPCA, NCC
Doctoral Candidate, Counselor Education and Supervision
Department of Counseling
University of North Carolina at Charlotte
kchris23@uncc.edu
(425) 879-4376

Glenn Gamst <ggamst@laverne.edu> Wed, Nov 11, 2020, 5:03 PM
to me

Katie:

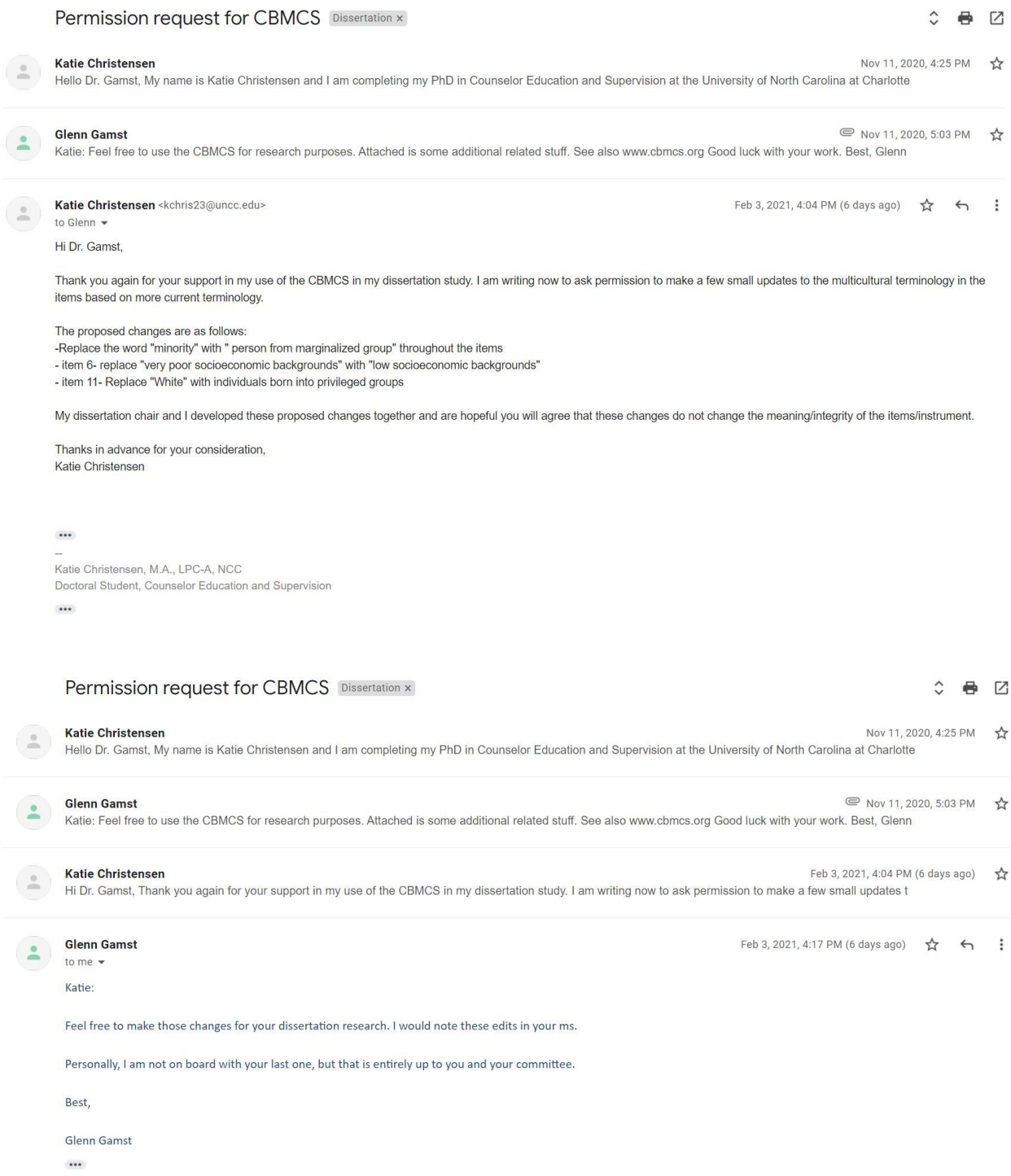
Feel free to use the CBMCS for research purposes. Attached is some additional related stuff.

See also www.cbmcs.org

Good luck with your work.

Best,

Glenn Gamst, Ph.D.



Permission request for CBMCS Dissertation ×

Katie Christensen Nov 11, 2020, 4:25 PM
Hello Dr. Gamst, My name is Katie Christensen and I am completing my PhD in Counselor Education and Supervision at the University of North Carolina at Charlotte

Glenn Gamst Nov 11, 2020, 5:03 PM
Katie: Feel free to use the CBMCS for research purposes. Attached is some additional related stuff. See also www.cbmcs.org Good luck with your work. Best, Glenn

Katie Christensen <kchris23@uncc.edu> Feb 3, 2021, 4:04 PM (6 days ago)
to Glenn

Hi Dr. Gamst,

Thank you again for your support in my use of the CBMCS in my dissertation study. I am writing now to ask permission to make a few small updates to the multicultural terminology in the items based on more current terminology.

The proposed changes are as follows:
-Replace the word "minority" with " person from marginalized group" throughout the items
- item 6- replace "very poor socioeconomic backgrounds" with "low socioeconomic backgrounds"
- item 11- Replace "White" with individuals born into privileged groups

My dissertation chair and I developed these proposed changes together and are hopeful you will agree that these changes do not change the meaning/integrity of the items/instrument.

Thanks in advance for your consideration,
Katie Christensen

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Katie Christensen, M.A., LPC-A, NCC
Doctoral Student, Counselor Education and Supervision

Permission request for CBMCS Dissertation ×

Katie Christensen Nov 11, 2020, 4:25 PM
Hello Dr. Gamst, My name is Katie Christensen and I am completing my PhD in Counselor Education and Supervision at the University of North Carolina at Charlotte

Glenn Gamst Nov 11, 2020, 5:03 PM
Katie: Feel free to use the CBMCS for research purposes. Attached is some additional related stuff. See also www.cbmcs.org Good luck with your work. Best, Glenn

Katie Christensen Feb 3, 2021, 4:04 PM (6 days ago)
Hi Dr. Gamst, Thank you again for your support in my use of the CBMCS in my dissertation study. I am writing now to ask permission to make a few small updates t

Glenn Gamst Feb 3, 2021, 4:17 PM (6 days ago)
to me

Katie:

Feel free to make those changes for your dissertation research. I would note these edits in your ms.

Personally, I am not on board with your last one, but that is entirely up to you and your committee.

Best,

Glenn Gamst