GRADUATE TRAINING IN BODY IMAGE COMPLEXITY: EVOLVING COMPETENCE TO MEET EMERGING RESEARCH

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DEDICATION

It is in moments like this one, reflecting on the journey that has brought me to the close of one adventure and the beginning of another, that I find myself filled with gratitude for those who have accompanied me along this path. This project is dedicated to my loved ones who have served as my guides, companions, mentors, and friends. Sharing this life with you has been my greatest joy.

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themselves. Your presence in my life has been a divine gift; in the love we share, I have always had a home. Thank you for believing in me and reminding me of who I am and where I come from.

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ABSTRACT

SAMANTHA R. LEE

GRADUATE TRAINING IN BODY IMAGE COMPLEXITY: EVOLVING COMPETENCE TO MEET EMERGING RESEARCH

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Positive psychologists and feminist theorists have advocated for a paradigm shift from pathologizing conceptualizations of body image to growth-fostering and celebratory approaches. The researcher conducted an exploratory examination of graduate training in body image topics by soliciting training directors and current students from the 339 counseling and clinical psychology programs accredited by the American Psychological Association (APA) and the Canadian Psychological Association (CPA). Participants completed the Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS; Brown, Cash, & Mikulka, 1990), the Attitudes About Treating Larger-Bodied Clients/Patients Scale (Puhl, Latner, King, & Leudicke, 2014), and a training and education survey designed for this online study to assess perspectives toward integration of body image considerations in practice and exposure to pathologizing and affirming training. The researcher hypothesized that (1) training in body positivity and celebration of body diversity would be rare with a focus on pathological concerns more prevalent; (2) perception accuracy would be covered more frequently than the relationship between body image and mental/physical health considerations; (3) counseling psychology programs would cover size as a cultural variable more frequently than clinical

psychology programs; (4) programs with a focus in social justice and/or multiculturalism would cover body image and size topics more frequently than programs without a social justice/multicultural focus; (5) trainees who received more training in body image topics would endorse less weight bias in practice; and (6) trainees with higher body esteem would endorse less weight bias in practice. The researcher utilized correlated groups t-tests, independent sample t-tests, and Pearson correlations to test her hypotheses. Descriptive and exploratory analyses were also conducted. Results provided mixed support for the researcher's hypotheses and indicated that students were exposed to pathological more than positive topics and mental and physical health was emphasized more than size perception accuracy. No significant differences were evident between counseling and clinical programs and no relationship was evident between exposure/body esteem and endorsement of bias. Qualitative analyses revealed notable trends in trainee self-perceived incompetence in practice and limited encouragement of self-reflection in training pertaining to topics of body image. Limitations, implications for practice, and areas for future research are discussed.

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CHAPTER I

INTRODUCTION

> A morally desirable standard of beauty would be multifold and achievable, consistent with different colors, sizes, and ages; it would not be at odds with movement, strong feeling, important work. It would be a source of joy for its impulse would be to celebrate and decorate something that is seen as intrinsically attractive: the ordinary, individual human body. That we find such a thought strange, even counterintuitive, indicates how far we are from knowing that the body is good (Andre, 1994, pp. 21-22).

Overview

Research examining the construct of body image has evolved notably in the past century. Although pathologizing of the body remains dominant, evidenced through recommendations of dieting and exercise for larger-bodied individuals, a minority of researchers advocate for a paradigm shift from a pathological focus on body dissatisfaction and distortion to an empowering focus on positive body image with an appreciation and celebration of body diversity (Abakoui & Simmons, 2010; Bergen & Mollen, in press; Touster, 2000). With a foundation in tenets of positive psychology, researchers have suggested that addressing pathological components of individuals' relationships with their bodies while failing to encourage the development of positive relationships can result in an absence of pathology and vitality (Cash & Pruzinsky, 2002). Proponents of a shift toward positive perspectives of the body have noted that failing to

encourage vitality in clients is unethical practice that may be indicative of incompetence in an area integral to the human experience—individuals' relationships with their bodies (Cash & Pruzinsky, 2002).

Robust findings support the relevance of training in body affirmative practice with an increasing statistical majority of individuals in the U.S. belonging to a marginalized group as larger-bodied individuals (Fryar, Carroll, & Ogen, 2014) and regardless of weight, the vast majority of Americans are discontent with their bodies (Bedford & Johnson, 2006; Fiske, Fallon, Blissmer, & Redding, 2014; Hurd, 2000). There are many deleterious effects of negative body image, including insecure attachment (Cash, Thériault, & Annis, 2004); decreased psychological well-being during pregnancy, increased risk for depression (Fuller-Tyszkiewicz, Skouteris, Watson, & Hill, 2013); decreased self-esteem and increased anxiety, life dissatisfaction, and depression in adolescence (Kostanski & Gullone, 1998; Sujoldžić & De Lucia, 2007); and impairments in sexual functioning (Woertman & Van Den Brink, 2012).

Mental health practitioners have consistently endorsed explicit and implicit anti-fat bias, posited harmful myths regarding size, and reported discomfort working with clients who have body image concerns in therapy (Puhl, Luedicke, & Grilo, 2014; Tomiyama et al., 2015; Turner, Tatham, Lant, Mountford, & Waller, 2014). While leading researchers in the field of body image have addressed limitations in theory, research, and practice (e.g., Cash & Pruzinsky, 2002; Cash & Smolak, 2011), research examining graduate psychology training and education in body image topics remains scarce.

Limitations in the Research

Of the limited research examining training and education in body image topics, the majority has focused on medical students, illuminating prevalent anti-fat bias in case conceptualization, treatment planning, and practice. Limited research has critically examined graduate education in psychology (e.g., McHugh & Kasardo, 2012; Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009) with most scholarship instead confined predominantly to undergraduate training as explored through textbook and syllabi content (e.g., Goodwin, McHugh, & Touster, 2003; Touster, 2000). However, no known research has explored graduate training and education within the field of psychology across curriculum and external training (e.g., practicum, workshops, and conferences). Additionally, no known research has examined the perspectives of students and training directors regarding the perceived importance of body image topics in training and education, size as a multicultural consideration, and perceived competence in working with clients regarding body image and size in practice.

Research Questions

Through the current study, the researcher sought to address the existing gaps in the literature and develop a foundational understanding of current graduate training in clinical and counseling psychology. Specifically, the researcher sought to provide an overview of the curriculum of APA-accredited programs in Canada and the U.S. as it relates to body image topics, the perceived importance of body image topics among training directors, and students' potential biases and confidence in addressing body image in practice. The following research questions undergirded the present investigation:

1. To what extent does graduate training and education in clinical and counseling psychology include pathology of the body (e.g., eating disorders, dissatisfaction, and distortion) and body celebration (e.g., body positivity, appreciation, and acceptance)?
2. How do clinical and counseling psychology training and education differ, if at all, in inclusion of and approach toward body image topics (i.e., pathologizing and medicalizing, as a cultural variable, or positively)?
3. How does exposure to education and training in topics of body image impact trainee bias, perceived competence, and willingness to work with larger-bodied individuals?
4. How does trainee body esteem relate to trainee endorsement of weight bias in work with larger-bodied individuals?

Definition of Terms

Cash and Pruzinsky (2002) identified terminology and interchangeable use of incongruent definitions as among the primary sources of difficulty in examining body image within the field resulting in division by impeding the development of a more holistic, comprehensive, and multifaceted operationalization of body image. Cash and Pruzinsky (2002) noted that researchers frequently and incorrectly use different facets of body image as interchangeable, comprehensive definitions of the construct. Thompson, Heinberg, Altabe, and Tantleff-Dunn (1999) highlighted the complexity of the construct of body image, outlining 16 operationalizations commonly misinterpreted and incorrectly utilized as synonyms including weight satisfaction, body image, body image disturbance,

body distortion, body percept, body image disorder, body schema, body dysphoria, size perception accuracy, appearance evaluation, appearance orientation, appearance satisfaction, body satisfaction, body esteem, and body concern.

While many of the terms Thompson and colleagues (1999) identified remain prevalent in the literature, researchers have expanded the list to include body image avoidance, body acceptance, body appreciation, positive body image, body empowerment, and body image investment, among others (Cash, 2012). Accordingly, for the purposes of the current study, definitions of the terminology referring to positive body image are outlined below. Additional definitions of key terms are provided in the ensuing chapter. For the purposes of the current exploration, *body positivity* and *body celebration* were used to encompass moving from a pathologizing of the body through an emphasis on body dissatisfaction and treatment approaches geared toward modifying the body (primarily in the form of weight loss) toward vitality-fostering education, practice, and training that emphasizes body acceptance and appreciation.

- *Appearance Esteem*: Mendelson, Mendelson, and White (2001) defined body esteem as an individual's evaluation of their body and appearance. Body esteem is often used interchangeably with appearance esteem and is commonly measured in terms of an individual's satisfaction with their body and weight (Cash & Pruzinsky, 2002).
- *Body Acceptance and Love*: Identified as a feature within the overall framework of body positivity, Tylka and Wood-Barcalow (2015) described body acceptance and love as distinct from body satisfaction and marked by an affection for and

comfort with the body's capabilities, its unique characteristics, and its connection with others (e.g., ethnic heritage).

- *Body Appreciation*: Corresponding with body acceptance, body appreciation is a feature of body positivity that refers to a respect and honoring of one's body as evident in positive self-talk and filtering of restricting portrayals of beauty, such as the thin ideal (Avalos, Tylka, & Wood-Barcalow, 2005). Subsequent definitions have equated body appreciation with gratitude for one's body (Frisén & Holmqvist, 2010; Wood-Barcalow, Tylka, & Augustus-Horvath, 2010).
- *Body Satisfaction*: Body satisfaction is generally understood as the absence of discrepancy between an individual's perceived and ideal self and consists of an individual's contentment with their weight, shape, and features (Cash & Pruzinsky, 2002).
- *Body Pride*: Castonguay and colleagues described body pride as a prevailing, positive emotion an individual experiences toward their body dependent on their behavior and physical characteristics (Castonguay, Gilchrist, Mack, & Sabiston, 2013). Webb, Wood-Barcalow, and Tylka (2015) noted that while body pride may coincide with body positivity, if the source of pride is successful adherence to sociocultural ideals, body pride may be marked by a preoccupation with maintaining adherence incongruent with body positivity. However, if the source of an individual's pride is the body's ability or representation of relationship with others, then it can be conceptualized as corresponding with current understandings of body positivity (Tylka & Wood-Barcalow, 2015).

- *Positive Body Image*: Tiggemann (2015) offered a broad definition of positive body image as "love and acceptance of one's body…and appreciation of its uniqueness and the functions it performs" while emphasizing the important caveat that positive body image is self-defined and varies in conceptualization and expression in accordance with an individual's experience (p. 168). In a more detailed operationalization, Wood-Barcalow and colleagues (2010) described positive body image as:

  An overarching love and respect for the body that allows individuals to (a) appreciate the unique beauty of their body and the functions that it performs for them; (b) accept and even admire their body, including those aspects that are inconsistent with idealized images; (c) feel beautiful, comfortable, confident, and happy with their body, which is often reflected as an outer radiance, or a "glow;" (d) emphasize their body's assets rather than dwell on their imperfections; and (f) interpret incoming information in a body-protective manner whereby most positive information is internalized and most negative information is rejected or reframed. (p. 112)

Psychologists have incorporated, and as a result, maintained, pathologizing medical model conceptualizations of the body, specifically of size, that have resulted in prejudicial beliefs and discriminatory practice (Abakoui & Simmons, 2010; McHugh & Kasardo, 2012). Through the persistent use of words such as *overweight* and *obese*, researchers and practitioners have reinforced an association that large bodies are inherently negative, excessive, and pathological (Abakoui & Simmons, 2010). For the

purposes of the current study, *larger-bodied individuals* was used to acknowledge size as a component of multicultural diversity marked by a unique, shared experience except when referencing particular works in which authors have used the terms *fat*, *overweight*, and *obese*, in which cases the author has retained the original works' words.

CHAPTER II

LITERATURE REVIEW

Within the past three decades, body image research has flourished with psychologists leading the effort. Expanding beyond the original focus on pathology, the body image discourse is slowly beginning to shift from a pathology-driven medical model to a multicultural social justice initiative founded in positive psychology and feminist theory (Murnen & Seabrook, 2012; Tylka, 2011; Tylka & Wood-Barcalow, 2015; Worrell, 2001). While this shift is evident in recent proposals and practice recommendations, research exploring the implementation of body positivity in practice and training is scarcer. Given the robust literature supporting the significance of body image topics to a variety of clinical and lay populations as well as the implications of negative body image on overall well-being (Cash et al., 2004; Fuller-Tyszkiewicz et al., 2013; Kostanski & Gullone, 1998; Sujoldžić & De Lucia, 2007; Woertman & Van Den Brink, 2012), the importance of training applied psychologists about body image is clear. The current study represents the first known examination of body image, size, and body positivity in graduate training in clinical and counseling psychology.

Given the correspondence between the nascent movement toward body celebration and the foundational tenets of the field of psychology, specifically counseling psychology, the researcher joins with the pioneering efforts in size and body positivity literature calling for inclusion of size as a cultural variable integral to the human experience requiring intentional consideration in theory, research, training, and practice

(Abakoui & Simmons, 2010; Bergen & Mollen, in press; Touster, 2000). An examination of the rich history of body image literature, the complex and evolving nature of the construct of body image, and the vital need for inclusion of considerations of the body reveals the importance of attending to these issues in the training of clinical and counseling psychologists.

Body Image: An Evolving Construct

Throughout the development of body image research and theory, arriving at a comprehensive, consistent definition of body image has been elusive. Cash and Pruzinsky (2002) identified terminology and incongruent definitions among the primary sources of difficulty in meaningfully examining body image, resulting in division within the field and impeding the development of a more holistic, comprehensive, and multifaceted operationalization of body image. In its broadest sense, the term *body image* refers to the "mental representation of how one views self" (Walters-Brown & Hall, 2012, p. 553). Body image is multifaceted, individualized, and inextricably linked to perceptions of self, identity, and one's experience in the world (Chrisler & Ghiz, 1993; Hurd, 2000).

In a commentary on the multifaceted nature of body image, Hutchinson (1985) wrote:

> Your body image has been formed out of every experience you have ever had: the way your parents related to and touched your body as a baby and a growing child; what you have learned from your role models about what it is like to live in and value a body; the acceptance and rejection you have felt from your peers; every

> negative and positive piece of feedback you and your body have ever received from people whose opinions count to you; and the ways you have perceived your body to fit or not fit the cultural image. (p. 63)

Hutchinson's (1985) conceptualization remains pertinent in outlining the inherently individualized and complex nature of the development and manifestation of body image. To capture this complexity, Cash and Pruzinsky (2002) adopted the term *body images* to communicate the multidimensionality of a historically oversimplified construct. Explorations of body image have primarily been confined to size, weight, accuracy of perception, and dissatisfaction. Researchers have explored body image as a form of pathology that afflicts an individual rather than a relationship between an individual and their body inherent to the human experience.

Scientific understanding of the development of body image, and specifically positive body image, is slowly evolving. In their groundbreaking work, Cash and Pruzinsky (1990) expanded the field's understanding of body image beyond its traditional singular emphasis on weight to include consideration of disability and rehabilitation, disfigurement, and appearance-related surgeries, areas previously unexplored. These areas, particularly the relationship between body image and physical disability, continue to be overlooked in the literature (Halliwell, 2015). Despite advances in research and theory, discourse surrounding the topic of body image continues to be reduced to its foundational role in psychology as pathology in the form of body dissatisfaction.

History of Scientific Inquiry

The origins of empirical investigations surrounding the topic of body image first emerged in the field of neurology (e.g., in relation to phantom limb syndrome) with body image subsequently explored in the field of clinical psychology as a component of disordered eating (Thompson, 1990). From the inception of the concept of body image through an applied psychology lens, researchers have historically confined body image to its role in the promulgation of eating disorders. Initially, researchers predominantly focused research on body image to those impacted by eating disorders and gradually expanded to athletes and larger-bodied individuals (Thompson, 1990). Historically, the construct, paralleling its exploration, has been limited in definition and understanding to an individual's accuracy of body perception (i.e., accuracy of size estimation) and level of dissatisfaction (see Thompson, 1990, for a review). The limited scope of initial research exploring treatment approaches to body image concerns is evident through early applied researchers' emphasis on addressing body dissatisfaction through video and mirror confrontation procedures specifically geared toward increasing size accuracy (Goldsmith & Thompson, 1989; Gottheil, Backup, & Cornelison, 1969; Pierloot & Houben, 1978; Norris, 1984). Generally, researchers focused on topics of disordered eating and, in what was then considered a relatively rare clinically significant form, Body Dysmorphic Disorder (BDD) (Thompson, 1990).

In 1985, Rodin, Silberstein, and Striegel-Moore shifted the discourse around body image from an infrequent clinical concern inextricably linked to disordered eating to a widespread phenomenon affecting individuals across a variety of identities. In their

pivotal work, Rodin and colleagues (1985) coined the term "normative discontent," referencing a prevalent experience of body dissatisfaction across clinical and nonclinical samples (p. 267). Early scholars exploring body dissatisfaction supported Rodin and colleagues' (1985) phenomenon of normative discontent discovering that most individuals, particularly women, experienced a degree of body dissatisfaction (Cash, Winstead, & Janda, 1986; Nielson, 1979; Silberstein, Striegel-Moore, & Rodin, 1987; Wooley & Wooley, 1984), a finding that has remained constant in the literature for more than three decades (Bedford & Johnson, 2006; Fiske et al., 2014; Garner, 1997; Hurd, 2000).

Given the robust literature supporting normative discontent, Silberstein and colleagues (1987) proposed that this phenomenon was not only normal, but inherent to the female experience based on a review of literature predominantly conducted with young (adolescence through early adulthood), White girls and women in the U.S. While research examining body image in men and boys gained momentum in the following decades, girls and women continue to endorse increased levels of body dissatisfaction and dysmorphia beyond those found in men and boys (Dye, 2015; Fallon & Rozin, 1985; Lokken, Ferraro, Kirchner, & Bowling, 2003; Pingitore, Spring, & Garfield, 1997). Researchers have proposed that the intersection between size and gender is particularly significant due to the rigid expectations for women's adherence to societal appearance ideals and the increased severity of consequences for women's deviation from the ideal body size in every sphere from education and employment to psychological and physical well-being (see Fikkan & Rothblum, 2012 for a review).

These landmark studies in early body image literature largely equated body image with body dissatisfaction, which was subsequently further constrained to explorations of the desire to lose weight and accuracy of size perception. Throughout the 1990s, the body image literature experienced an unprecedented expansion in areas of theory, research, and practice (Cash & Smolak, 2011), which resulted in researchers' concomitant understanding of the applicability and nature of body image. The 1990s were characterized by a shift from predominantly psychodynamic perspectives of body image to cognitive-behavioral and feminist theoretical conceptualizations (Cash & Pruzinsky, 2002). Including considerations of body image when conceptualizing and treating mental well-being is imperative and its incorporation in training and education is considered long overdue by many researchers. Fisher (1990) captured this point, stating, "Human identity cannot be separated from its somatic headquarters in the world" (p. 18). Subsequent researchers provided a growing framework for this perspective that has historically been referred to as embodiment.

Embodiment

Cash (2008) described body image as one's experience of their own embodiment. Embodiment, captured by Andre (1994), is an individual's experience of their body as their "way of being in the world: of being some-particular-where; of taking in the place by seeing it, hearing it, touching it…aware of [their] bodies or aware of the world through them, we *are* our bodies" (p. 10-11). This inextricable link between the self and the body, while revolutionary during the early body image literature, has largely been supported and reinforced through feminist theory and research uncovering the connection

between an individual's identity and one's experience of their body. This relationship—complex, multifaceted, and inherent—appears to be bidirectional in nature with embodiment influencing sense of self and one's identity influencing the experience of being in relationship with one's body. From a sociocultural perspective, appearance esteem and body satisfaction have been identified as two of the most influential determinants of global self-esteem, one's overall sense of their holistic selves (Cash & Pruzinsky, 2002).

Self-Objectification

In their groundbreaking work, Fredrickson and Roberts (1997) postulated objectification theory, describing sexual objectification as a form of oppression saturating Western culture in which women are "treated *as a body* (or collection of body parts) valued predominantly for its use to (or consumption by) others" (p. 174, italics in original). Fredrickson and Roberts (1997) noted that although objectification is a shared experience among women, it is filtered through intersecting identities to impact women in unique ways. Beyond being disembodied by others, objectification theorists posit that, through the experience of objectification, girls and women are socialized to engage in self-objectification (Fredrickson & Roberts, 1997). Objectification has been linked to negative mental health consequences including diminished motivation, self-efficacy, and cognitive functioning (Gapinski, Brownell, & LaFrance, 2003). Researchers have identified objectification theory as integral to the understanding of body image development throughout the lifespan (e.g., as a mediator between disordered eating and

age; Tiggemann, Lynch, & Dannemiller, 2001; and as a risk factor for psychological distress during menopause; Bergen & Mollen, 2012).

Feminist scholars were among the first to posit an intersectional perspective, examining the influence of multiple components of the self or social identities on body image. In her overview of a relational approach to developing a positive body image, Hutchinson (1985) outlined the intricately connected nature of women's bodies and identities, noting that objectification maintains women's disconnection with their bodies (disembodiment) and disempowerment. Andre (1994) later described this process as women's alienation from themselves and the world resulting from internalization of objectification. In particular, being female has often been inextricably interwoven with the thin-ideal, with women who meet the societal expectations of what is beautiful also being perceived as more feminine (Cash, Gillen, & Burns, 1977; Gillen, 1981; Heilman & Saruwatari, 1979; Mazur, 1986; Unger, 1985). Beauty has long been acknowledged as a foundational component of the female identity with girls and women who adhere to cultural expectations of beauty not only affirming their female identity for themselves, but also for garnering others' approval (Striegel-Moore, 1993).

Beyond female identity, early researchers found a relationship between feelings pertaining to self-appraisal and body-appraisal, supporting a link between self-concept and body image with distress or dissatisfaction in one area accompanying commensurate distress or dissatisfaction in the other (Secord & Jourard, 1953). Hesse-Biber and colleagues found that individuals', specifically women's, body image impacted their subsequent sense of academic, social, and psychological ability and impairment (Hesse-

Biber, Clayton-Matthews, & Downey, 1988). Cash and Pruzinsky (2002) noted that body image could serve as a filter through which individuals perceive themselves and their social self-efficacy. Consistent with their findings, Farrar, Stopa, and Turner (2015) found that interventions increasing positive self-image resulted in increased body satisfaction as well.

As Farrar and colleagues' (2015) work evidenced, just as one's experience of being in their body can influence their sense of self, researchers have found that the opposite relationship exists. Researchers have examined cultural identities, including ability (physical and intellectual), family systems, religion/spirituality, race/ethnicity, age, class, and feminist identity, as potential protective factors for the development of positive body image and/or limiting the likelihood of body dissatisfaction or disordered eating (Homan & Boyatzis, 2010; Striegel-Moore & Cachelin, 1999; Swami, Airs, Chouhan, Leon, & Towell, 2009; Tiggemann, 2001; Tiggemann & Stevens, 1999). Regarding some cultural identities (e.g., ability and family system), privilege has been identified as a protective factor with individuals who are able-bodied (and participate in sports; Tiggemann, 2001) and have supportive family systems (Striegel-Moore & Cachelin, 1999) at decreased risk of developing body dissatisfaction and disordered eating behaviors.

Secure attachment to God (Homan & Boyatzis, 2010) and feminist identity (Tiggemann & Stevens, 1999) have also been associated with decreased risk for disordered eating behaviors. While there is promising literature exploring the role of cultural identities in embodiment and identifying protective factors in the development of

positive body image, findings related to many identities (e.g., intellectual ability, race, ethnicity, age, and class) have been conflicting. Tiggemann (2015) proposed that inconsistent findings may, in some cases (e.g., age), be the result of co-occurring body acceptance/appreciation and body dissatisfaction, furthering the concept that body positivity and body dissatisfaction are not mutually exclusive. It is also possible that intersecting identities marked by varying degrees of privilege and oppression and differing aesthetic ideals may be explanatory factors resulting in conflicting experiences. An additional limitation is researchers' predominant focus on pathology-related risk and protective factors in contrast to growth-fostering and positivity-enhancing factors, leaving these areas of research largely overlooked and understudied; an omission the current researcher sought to address.

Andre (1994) proposed recognition of embodiment as a core component of morality, noting that ideal morality not only promotes respect and appreciation of unique bodies, but also values "all the ways in which our bodies are ourselves" (p. 17). Cash and Pruzinsky (2002) posited that being in tune with one's body or embodiment is essential to the quality of the human experience. Illustrating the essential nature of embodiment, Andre (1994) deemed the failure to consider the undeniable connection between the body and the self in medical practice to be both a moral and epistemological shortcoming. While researchers have found support for embodiment as an intervention to treat maladaptive self-body perceptions and mental representations (e.g., Muller-Pinget, Carrard, Ybarra, & Golay, 2012), a focus on embodiment in practice is relatively new to psychology.

In Piran's (2015) cutting-edge approach to treatment and prevention of eating disorders, she identified fostering positive ways of inhabiting the body (embodiment) as a primary treatment for body dissatisfaction. Researchers have outlined characteristics of positive embodiment, in contrast to disrupted embodiment, including a positive connection between self and the body marked by positive self-talk, a sense of agency and functionality, awareness of needs and engagement in self-care and expression of body desires, and a subjective inhabitation of the body in contrast to internalized objectification (Piran, 2015). Researchers call for an expansion in the understanding of functionality, as outlined in Piran's conceptualization, beyond physical ability to avoid discriminatory practices of and approaches to body positivity that would depict physical ability as a prerequisite for body positivity (Webb et al., 2015), an ableist perspective. This shift toward focusing on enhancing a positive connection between the self and the body has been widespread throughout recent body image literature with many components of positive embodiment corresponding with the field's nascent but developing understanding of positive body image.

Body Positivity

Following the growth of the body image literature in the 1990s, the 21st century brought unprecedented sustained attention to research in topics of body image. In a review of two well-known research databases, PsycINFO and Medline, Cash and Smolak (2011) found that body image studies published between 1990 and 2000 represented fewer than half the number of body image articles published between 2000 and 2011. This influx in publications was also marked by a groundbreaking paradigm shift away

from perspectives Cash and Pruzinsky (2002) had previously deemed pathology-driven and toward a more inclusive, accepting, and celebratory perspective of body positivity. In their call to researchers and practitioners within the field, Cash and Pruzinsky (2002) highlighted the relevance of positive psychology to current body image discourse, noting that focusing on eliminating pathology (i.e., body dissatisfaction) without encouraging and fostering adaptive body positivity is an insufficient and potentially harmful approach to practice that results in "intermediate mental health characterized by a lack of pathology but the absence of vitality" (p. 57).

Positive body image, originally explored in studies of body dissatisfaction and the prevention of disordered eating and feminist literature, has increasingly been the focus of researchers' attention in the past decade (e.g., Tylka & Wood-Barcalow, 2015). In their development of the Body Image Quality of Life Inventory, Cash and Fleming (2002) found that, contrary to previous assumptions that women's body image was "a ubiquitous experience of normative discontent," 603 racially diverse college women in their study identified more positive than negative influences on their lives across 19 domains ranging from interpersonal dynamics to body-related behaviors (e.g., grooming and weight-management) (p. 459). Researchers have replicated this finding in subsequent studies (e.g., Avalos et al., 2005). In a review of positive body image, Tylka (2011) shed light on how body positivity and body dissatisfaction can co-occur simultaneously.

Tylka (2011) highlighted that positive body image, frequently oversimplified as the mere antithesis of negative body image or the absence of pathology, is not mutually exclusive from negative body image. Although positive body image is marked by unique

characteristics absent in negative body image, positive and negative body image can co-occur (Tylka, 2011). Building upon Wood-Barcalow and colleagues' (2010) definition, Tylka and Wood-Barcalow (2015) identified characteristics of positive body image including being multifaceted (consisting of body appreciation, body acceptance and love, broad conceptualizations of beauty, adaptive investment in appearance, and filtering of information in a body-protective manner), holistic, simultaneously stable and malleable, protective regarding physical and psychological well-being, related to unconditional body acceptance by others, and experienced through the lens of individuals' intersecting cultural identities.

Intersectionality

While researchers have explored the influence of intersectionality in hopes of understanding the development of body image including risk and protective factors (e.g., Striegel-Moore & Cachelin, 1999), findings have been conflicting, representing the complex and individualized nature of the construct of body image. However, findings have consistently demonstrated the significance of social class, race, and ethnicity in shaping body image ideals with recent research identifying social class as the most impactful factor in determining perceived acceptability of size (Swami, 2015). Swami (2015) found that being larger-bodied was perceived as more socially acceptable among people from lower social classes with greater differences existing in body image ideals across class even compared to global cultural factors (e.g., Western versus non-Western).

Initially, when researchers examined the intersection between racial and ethnic identities and body image, they predominantly focused on race as a protective factor

(e.g., non-adherence to the thin-ideal among African American and Black women decreasing the likelihood of disordered eating); however, the literature has been limited by comparisons to White women and girls as the most researched population regarding body image dissatisfaction and its relationship to disordered eating (Capodilupo & Kim, 2014). Researchers have identified appearance variables most salient across racial groups (e.g., skin tone; hair texture; extremes of feeling invisible or receiving unwanted and harmful attention, such as in the form of microaggressions; and exclusion from representation in the media have been identified as particularly influential factors in African American and Black women's body image; Capodilupo & Kim, 2014). Additionally, researchers have posited that decreased endorsement of weight-based discrimination among minority populations may be the result of individuals being more aware of race-based discrimination and/or harmful stereotypes that normalize larger body sizes for women of color (Fikkan & Rothblum, 2012) compared to size-based discrimination.

Men and the Muscular Ideal

In early explorations of body image dissatisfaction, men and boys were largely overlooked or dismissed with researchers positing that men did not experience body dissatisfaction (Mishkind, Rodin, Silberstein, & Striegel-Moore, 1986). A developing body of literature examining the relationship between gender and body image has provided robust support for the experience of body image dissatisfaction among men and boys that, while paralleling women and girls in prevalence, is distinguished by adherence to a muscular ideal (see Parent, 2013 for a review). The muscular ideal refers to the

desire for men and boys to increase in size, and particularly in muscularity, corresponding to media portrayals of men (Parent, 2013). Boys as young as 8 have expressed a desire to meet the functional ideals for men (i.e., physical strength and athletic performance) (Tatangelo, Connaughton, McCabe, & Mellor, 2017).

Adherence to the muscular ideal has been linked to detrimental health outcomes including decreased body esteem, disordered eating behaviors, excessive exercise, depression, body dysmorphia, and steroid use (Parent, 2013). Men engage in anabolic-androgenic steroid (AAS) use more frequently compared to women with the most common reasons for use including appearance-related motivations (i.e., increasing muscularity and general physical appearance) and performance-related motivations (i.e., increasing strength) (Cohen, Collins, Darkes, & Gwartney, 2007; Ip, Barnett, Tenerowicz, & Perry, 2011). Researchers have identified negative body image as one of the leading risk factors for use of AAS with appearance-motivated AAS use being linked to muscle dysmorphia (Murray, Griffiths, Mond, Kean, & Blashill, 2016). While research examining body image in men and boys has increased in the past decade, additional exploration is necessary pertaining to intersectionality and approaches to training and practice in topics of body image with men and boys.

Transgender Populations

Although literature examining body image in transgender adolescent and adult populations represents a growing body of research, it remains relatively scarce. Jones, Haycraft, Murjan, and Arcelus (2016) found 18 articles exploring body image in transgender samples independent of disordered eating. Findings have been inconsistent

pertaining to the prevalence of body image dissatisfaction among transgender samples compared to cisgender samples (Jones et al., 2016). However, researchers have consistently found support for the efficacy of gender confirmation treatment (in the form of hormones and/or gender confirmation surgery) in the reduction of body dissatisfaction (Jones et al., 2016). Congruent with this finding, researchers have found a positive relationship between passing (being perceived as their identified gender) and identity consolidation and body satisfaction (De Vries et al., 2014; De Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; McGuire, Doty, Catalpa, & Ola, 2016; van de Grift et al., 2016b).

In a qualitative exploration of 90 transgender adolescents, McGuire and colleagues identified body satisfaction pertaining to gender identity and gender expression and body dissatisfaction related to the intersection of gender and size to be most salient (McGuire et al., 2016). McGuire and colleagues' (2016) findings replicated previous research demonstrating the significance of body characteristics that impact perception of gender (e.g., figure and voice) in overall appearance satisfaction for transgender adults (van de Grift et al., 2016a). Transgender people have identified body modification (e.g., in the form of exercise, dieting, tattoos, surgery, and hormone therapy) as a means through which they feel more connected to their bodies (McGuire et al., 2016). In addition to considering sex-specific areas of satisfaction or dissatisfaction, researchers have emphasized the importance of a holistic approach to treatment with transgender populations that encompasses societal pressures to adhere to the thin-ideal and the muscular ideal for women and men respectively (Jones et al., 2016).

Size as a Cultural Construct

According to the 2014 National Health and Nutrition Examination Survey (NHANES), the vast majority (78.3%) of individuals in the U.S. meet the current body mass index (BMI) criteria for being "overweight," "obese," or "extremely obese," a population that has been consistently growing since 1960 (Fryar et al., 2014). In 2014 in the U.S., this percentage constituted approximately 249.5 million people whose unique experiences may be being overlooked or pathologized directly and/or tacitly in current graduate psychology training and education. Researchers have consistently demonstrated that larger-bodied individuals, especially women of size, experience size-based oppression in employment, education, romantic relationships, mental and physical health (Fikkan & Rothblum, 2012).

Further, researchers have identified similar processes undergirding the oppression experienced by larger-bodied individuals and racism through which prejudicial values and beliefs are perpetuated (Crandall, 1994) with accompanying detrimental health consequences for marginalized groups (Chrisler & Barney, 2017). Sizeism has been linked to indirect health consequences (e.g., being misdiagnosed and/or excluded from medical services due to weight) and direct health consequences including, but not limited to high cholesterol, Type II diabetes, and cancer (Chrisler & Barney, 2017). A noteworthy distinction, however, when compared to other forms of oppression, is the relative perceived social acceptability of sizeism (Crandall, 1994; Watts & Cranney, 2009) to which psychologists are not immune and which may help explain the lack of size-positive perspectives in training.

There is widespread acknowledgement in psychology and medicine that culture influences the development and experience of body image (Cash & Pruzinsky, 2002), although perspectives regarding the relationship between culture and body image vary. Early researchers proposed that size, a notably influential component within the broader body image and body positivity framework, is a crucial diversity variable influencing an individual's experience of being in the world, marked by privilege, oppression, and intersectionality (Andre, 1994; Aronson, 1997; Renck Jalongo, 1999). In her exploration of the intersecting nature of body and identity, Andre (1994) coined the term *bodily status-characteristics* to refer to components of appearance that communicate power and/or oppression (e.g., size and race/ethnicity, size and gender), invariably influencing self-concept, experiences, and worldview. In the more than 2 decades since Andre's (1994) proposal, researchers continue to advocate for critical consideration and inclusion of size in psychology training and practice; however, size and other considerations of the body (with the exception of infrequent inclusion of ability status) remain predominantly excluded from discourse of cultural variables and multicultural practice (Bergen & Mollen, in press).

In their pioneering work, Sue and colleagues (1982) were the first to propose that working with diverse populations requires a unique set of multicultural competencies. Researchers have conceptualized multicultural competence as consisting of three primary domains: self-awareness of personal biases and limitations of competence, knowledge of multicultural considerations and a willingness to seek additional knowledge when needed, and the ability to implement skills in work with diverse populations (Pederson,

1997; Sue, Arredondo, & McDavis, 1992). Consistent with the APA Standards of Accreditation (2015), the researcher posits that ethical and competent training should include size as a multicultural variable integrated in graduate training so that trainees develop requisite knowledge, attitudes, and skills to practice effectively with larger-bodied individuals.

The guiding principles underlying accreditation eligibility include an expectation that "education and training…should be based on the existing and evolving body of general knowledge and methods in the science and practice of psychology" with consideration of cultural diversity variables (APA, 2015, p. 4). While the broad definition of diversity provided by the Commission on Accreditation (CoA) does not explicitly mention size, the definition is preceded by "includes, but is not limited to," implying that multicultural competence consists of consideration beyond the areas of diversity listed to encompass populations with whom psychologists can anticipate working (p. 3). In addition to body image being widely accepted as central to the understanding and treatment of individuals with eating disorders (American Psychiatric Association, 2013), body image is a relevant and pressing consideration in the presentation of diverse groups of clients including oncology patients (Burg, 2016), and individuals with chronic pain (Senkowski & Heinz, 2016), cystic fibrosis (Tierney, 2012), and spinal cord injuries (van Diemen, van Leeuwen, van Nes, Geertzen, & Post, 2017). Given the robust literature supporting the pervasiveness of body image concerns, one could argue that topics of size, body image, and body celebration would be relevant to the ethical and competent treatment of the vast majority of clients, if not *all* clients.

From a multicultural lens, then, considerations of size, embodiment, and body celebration become increasingly paramount to topics of research, training, and practice.

Clinical and Counseling Psychology Tenets

Early investigations of counseling psychology and clinical psychology led some researchers to propose a merging of the fields on the basis that the fields shared more commonalities than differences (Brems & Johnson, 1996; Watkins, 1990). However, proponents of the fields remaining separate yet interdependent have highlighted notable distinctions including unique areas of specialty (e.g., vocational and multicultural psychology within counseling psychology training and education) and perspectives (e.g., counseling psychology as health-oriented and clinical psychology as dysfunction-oriented) that served to strengthen the discipline of psychology (Schofield, 1966). In a review of APA-accredited counseling psychology and clinical psychology programs, Brems and Johnson (1996) identified curricular differences including increased inclusion of multicultural psychology/therapy courses in counseling psychology programs compared to clinical psychology programs, a trend that has remained evident across diversity topics (White, 2013).

Training and Education

Education is a paramount consideration as it has been identified as one of the primary mediums through which anti-fat bias can be explored and challenged to foster the development of multiculturally competent practitioners (Brownell & Rodin, 1994). Historically, the field of psychology has mirrored societal marginalization and oppression of larger-bodied individuals and pathologizing of the relationship between individuals

and their bodies. Psychologists have largely failed to integrate considerations of size and body image into training, research, theory, and practice with an acknowledgement of the impactful role these factors have in the human experience. Diverse representations of larger-bodied individuals have been excluded from textbooks; researchers, trainers, and educators have predominantly focused on a pathologizing, medical model of the body and size has been omitted from multicultural training curriculum (McHugh & Kasardo, 2012). Beyond omission, psychologists have tended to pathologize weight with recent modifications to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*; APA, 2013) including consideration of adding obesity as a mental illness (Caplan, 2011). While this proposal was not implemented in *DSM-V* (APA, 2013), the inclusion of "overweight or obesity" as a V code and its consideration as a diagnosis are indicative of the field's historical and contemporary pathologizing approach toward size. Although McHugh and Kasardo (2012) inferred there is little to no inclusion of fat oppression and sizeism in graduate curriculum based on APA-accreditation site visits, there is no known research that has systematically reviewed graduate training and education pertaining to body image, size, or body positivity. Instead, psychologists have largely adopted the medical field's approach regarding size (obesity) which has perhaps unsurprisingly resulted in widespread and persistent weight bias.

Weight Bias Among Health Professionals

Anti-fat prejudice has been defined as "a negative attitude toward (dislike of), belief about (stereotype), or behavior against (discrimination) people perceived as being fat" (Daníelsdóttir, O'Brien, & Ciao, 2010, p. 47). In the first decade of the 21st century,

this form of prejudice increased by 66%, comparable to race-based prejudice, which has historically been the focus on multicultural training in psychology (Daníelsdóttir et al., 2010). The endorsement of anti-fat prejudice, also called sizeism, is best captured when delving into the history of body image research, which originated with studies of body dissatisfaction. Initially, researchers deemed the link between body dissatisfaction and obesity to be a "common sense observation" that did not require research as it could be assumed that all larger-bodied individuals were dissatisfied with their bodies (Thompson, 1990, p. 27). The remnants of this assumption and similar harmful sizeist myths endure through theories and curriculum that perpetuate a pathologized focus on the body and individuals' relationships with their bodies.

Researchers have consistently found pervasive weight bias among psychologists that affects client diagnoses and prognosis independent of other factors (Abakoui, 1998; Agell & Rothblum, 1991; Davis, 1998; Davis-Coelho, Waltz, & Davis-Coelho, 2000; Young & Powell, 1985). Additionally, practitioners who work with larger-bodied individuals and clients presenting with weight-related concerns have endorsed pro-thin/anti-fat biases (Puhl, Latner, et al., 2014; Schwartz, O'Neal Chambliss, Brownell, Blair, & Billington, 2003; Teachman & Brownell, 2001). While promising research has suggested that implicit anti-fat bias has decreased in the previous decade, explicit anti-fat bias has increased among health professionals (Tomiyama et al., 2015). Despite research demonstrating that experiences of weight-based oppression are in fact linked to stress (Muennig, 2008), increased functional disability (Schafer & Ferraro, 2011), worse self-rated health (Schafer & Ferraro, 2011), disordered eating (Haines, Neumark-Sztainer,

Eisenberg, & Hannan, 2006), and depression and suicidality (Eisenberg, Neumark-Sztainer, & Story, 2003), mental health practitioners and medical field professionals continue to endorse these biases in diagnosis, prognosis, client evaluation, and treatment.

The scant research that has been conducted in graduate training pertaining to body image and size generally mirrors theoretical approaches to these constructs, primarily focusing on pathology (e.g., eating disorders; Worthington-White, 2001) or trainee biases. Research exploring weight bias among trainees has predominantly focused on medical students. Explorations of medical school student samples have revealed that one-third of students endorse moderate or strong explicit anti-fat bias, over half of students exhibit implicit weight bias (39% anti-fat and 17% anti-thin bias), and most students (67%) are unaware of their biases (Miller et al., 2013). Wear, Aultman, Varley, and Zarconi (2006) found that medical students not only endorsed weight bias (e.g., assuming weight is linked to lack of control), but also identified obese patients as the primary target of derogatory humor by students as well as residents and attending physicians, which was perceived as acceptable in those settings (Wear et al., 2006). Puhl and Brownell (2001, p. 788) previously identified the social condoning of weight-based discrimination, identifying sizeism as the "last acceptable basis of discrimination," a sentiment that medical students reiterated (Wear et al., 2006). Researchers found comparable findings with the majority of students in the helping professions, including clinical psychology student interns, medical residents and psychiatry residents, expressing confidence in their ability to provide quality care to patients of size while one-third of students reported feeling frustrated with larger-bodied patients, believing that

larger-bodied individuals lack motivation and that patients of size present more professional difficulties (Puhl, Luedicke, et al., 2014). Additionally, just one-quarter of students (25%) identified working with patients of size as rewarding while 13% of students expressed an explicit dislike for working with larger-bodied individuals (Puhl, Luedicke, et al., 2014).

Researchers have found similar weight bias among professional counseling graduate students at two southeastern universities (Adams, 2008) and school psychology graduate students (Jackson, 2014). Additionally, Adams (2008) found that professional counseling graduate students similarly endorsed increased perceived difficulty working with larger-bodied individuals and ascription of more pathology to larger-bodied individuals. Adams (2008) found that counseling graduate students perceived interventions to be equally effective regardless of size and expressed equal desire to work with larger-bodied individuals, corresponding with previous findings in samples of mental health practitioners (e.g., Young & Powell, 1985). However, it is important to note that while no difference in desire was reported, students utilized more qualifiers when expressing a willingness to work with larger-bodied individuals (e.g., "I am willing to work with her as long as she is willing"), which may be indicative of implicit biases similar to those seen in medical student samples (e.g., that larger-bodied individuals are more difficult to work with).

Dieting and exercise as the gold standard of treatment. Weight bias is evident in perceptions of clients of size as well as treatment approaches. Despite its well-documented detrimental effects, dieting continues to be the most commonly prescribed

treatment for larger-bodied individuals (Mann et al., 2007). Dieting is generally defined as an alteration in eating behaviors, commonly characterized by a decreased caloric intake with the primary goal of weight reduction (Tomiyama, Ahlstrom, & Mann, 2013). Interestingly, although there is an underlying assumption that weight loss accompanying dieting and exercise will result in increased health benefits, existing dieting research rarely explores the relationship between dieting and health, instead measuring the efficacy of diets defined as short-term weight loss (Tomiyama et al., 2013). Not only are diets generally not effective in leading to long-term weight loss, but researchers have also not found substantial evidence supporting positive health outcomes (Mann et al., 2007).

Researchers have identified detrimental health consequences of dieting including lower self-esteem, negative body image, increased risk for the development of disordered eating, cognitive impairments, and increased depressive and anxious symptomology (McFarlane, Polivy, & McCabe, 1999). Although findings have been inconsistent, researchers also suggest that, contrary to assumptions of a link between weight and detrimental health outcomes, dieting and accompanying weight fluctuations may be linked to serious health concerns including Type II diabetes, hypertension, cardiovascular morbidity, and increased all-cause mortality (see Montani, Schutz, & Dulloo, 2015, for a review). Despite its harmful effects, dieting increased between 1950 and 2008 by 43% for women and 33% for men (Montani et al., 2015). Although promising research has been conducted on nondieting, size-affirmative interventions (e.g., Clifford et al., 2015), recommendations by the World Health Organization (WHO) and National Institutes of Health (NIH) continue to emphasize weight loss as a primary intervention in what has

been deemed the obesity epidemic (Wadden, Webb, Moran, & Bailer, 2012). Beyond the significant potential health consequences of chronic dieting, the recommendation of dieting and exercise is inherently problematic in communicating that a large body size is innately bad. Unsolicited weight loss advice by physicians is among the leading barriers to seeking regular medical care identified by women of size (Amy, Aalborg, Lyons, & Keranen, 2006).

Treatment of children of size. Indicative of the field's continued endorsement of pathologizing medical models, the APA recently released the Clinical Practice Guideline for the Behavioral Treatment of Obesity and Overweight in Children and Adolescents draft that recommends weight management strategies for children who are categorized as overweight or obese based on BMI (APA, 2017a). Publicly-posted comments to the draft from professionals within the fields of psychology and medicine have critiqued the proposal's lack of a clear empirical basis, stigmatization of size, and dismissal of the detrimental effects of weight management strategies (APA, 2017c). The APA has historically identified "childhood obesity and unhealthy weight control behaviors in children and youth" as a "national public health concern"; however, the current proposal is in direct conflict with the APA's previous commitment to evidenced-based approaches founded in cultural considerations (APA, 2009). While calls to medicalize size have traditionally been founded in the literature linking size to detrimental health outcomes, a growing minority of researchers have proposed that minority stress in the form of stigmatization and bullying are the cause of the emotional, social, and physical consequences misattributed to size (Kornilaki, 2011). Additionally,

some researchers have recommended body-affirmative interventions (e.g., Hill et al., 2004), yet these remain largely unacknowledged by researchers, practitioners, and governing organizations, including the APA. APA's influence is unmatched in setting the framework for research, theory, practice, and training for professionals within the field of psychology through accreditation standards and guidelines. Accordingly, failing to acknowledge the evolving literature regarding the detrimental effects of pathologizing size and the ethical need for inclusion of size as a diversity variable may account for similar shortcomings in graduate training programs.

Size and Body Considerations in Curriculum

Recent researchers examining multicultural training in graduate psychology programs (e.g., White, 2013) have failed to incorporate size as a diversity variable worthy of consideration and inclusion in training. In a critical review of the integration of multicultural and social justice tenants in 54 graduate counseling psychology programs, Pieterse and colleagues found that while the majority of the course syllabi reviewed included consideration of racial groups and sexual minorities, other cultural identity variables including age, ability, gender, immigrant status, socioeconomic status, and spirituality were covered by fewer than one-third of programs surveyed (Pieterse et al., 2009). Additionally, size was not included as a diversity variable in the study; only one of programs surveyed included a topic pertaining to size ("sizeism") in multicultural course curriculum (Pieterse et al., 2009).

In a review of undergraduate psychology textbooks, Touster (2000) found not only underrepresentation of diverse bodies, but also harmful endorsement of weight bias

(e.g., that weight is inherently synonymous with being unhealthy and omitting the harmful effects of previous treatment approaches including dieting). From a multicultural framework, Touster (2000) argued that the field of psychology, consistent with its foundational tenets of social justice and celebration of diversity factors, needs to recognize literature dispelling previously endorsed oppressive myths and move toward a more affirmative and accepting stance on the topic of size. Goodwin et al. (2003) further illuminated that women of size are particularly excluded from the most frequently utilized psychology textbooks and topics of anti-fat prejudice and oppression are notably omitted.

In an exploration of factors hindering clinicians' use of evidence-based approaches to the treatment of disordered eating behaviors, Turner et al. (2014) found that body image work was among the primary areas of concern for clinicians in the fields of psychology, social work, nursing, psychiatry, and occupational therapy. Accordingly, while little research has explicitly examined graduate training and education pertaining to topics of size and body image, it is evident that this area serves as a noteworthy and potentially detrimental gap in the training of professionals within the field of psychology. More than three decades after Andre's (1994) call to professionals within the medical profession to include embodiment considerations in practice as a moral imperative, research exploring training and education pertaining to topics of body image, size, and body positivity remains scarce.

Tylka (2011) recommended the following implications for research, practice, and training: psychoeducation on positive body image development and characteristics,

specifically educating therapists and clients on the influential role of protective filtering, self-defining beauty in an inclusive way, connecting with others who are body positive for interpersonal support; incorporation of interventions that emphasize body acceptance, embodiment, and functionality; enhancing media literacy; and reframing healthy behaviors as forms of self-care and expression of body acceptance and respect. Reflecting the shift in societal discourse and the research, Tylka (2011), along with other proponents of positive body image, called for a paradigm shift among practitioners from merely seeking to alleviate symptoms of pathology to helping individuals develop appreciation and celebration of their bodies.

Importance of Current Study

Psychologists are charged with meeting the ever-changing needs of the people they serve. In the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (2017b), the APA directed psychologists to meet the needs of the diverse people they serve with consideration of the advancements in research. Reviewing the conclusions of the 1973 Vail Conference on competence and training within the field of psychology, Korman (1974) commented that training must be "congruent with the needs of a significant range of clients in a community" as practitioners have an obligation to provide "genuinely broad and non-discriminatory" services (p. 445). Korman (1974) commented that insufficient training marks a failure of an ethical obligation to trainees and the community, a trend evident in the relatively limited literature examining health professionals' approaches to topics of body image and size.

Nearly 25 years after Chrisler and Ghiz (1993) argued for an expansion of consideration of body image in conceptualizations beyond its historical intertwining with disordered eating, advances in theory, practice, and training remain unrealized. Recent reviews of psychology's approach to the topic of size (e.g., Bergen & Mollen, in press) illuminate a stance of non-affirmative care, resembling the field's historic pathologizing approach to sexual orientation that called for ill-advised change efforts. Given the indisputably influential role of size in women's experience of the world and its intersection with gender, race/ethnicity, and class, among other cultural variables, the need for inclusion of size considerations in training and practice is undeniable.

While several hallmark texts examine theory, research, and practice components of this significant and often overlooked area of psychology, the current study is the first to systematically examine graduate training and education within the field of psychology pertaining to topics of size, body image, and body positivity. Congruent with the APA Ethical Principles of Psychologists and Code of Conduct (2016a) to maintain competence, pursue training and education in emerging areas within the field, and do no harm, the researcher sought to critically review the implementation of training recommendations previously outlined and develop an understanding of the current training and education standards within clinical and counseling psychology graduate training.

Based on a review of the literature, the current study was founded in the following hypotheses that were tested through quantitative analysis:

(H1) It was hypothesized that graduate curriculum and training opportunities would cover pathological topics more frequently than positive and celebratory topics.

(H2) Of the topics covered, it was hypothesized that, paralleling the focus of body image research, size and perception accuracy would be covered more frequently than body image as it pertained to physical and mental health concerns.

(H3) It was hypothesized that counseling psychology programs would cover topics of size as a cultural variable more frequently compared to clinical psychology programs.

(H4) Programs that had a focus in social justice and/or multiculturalism would cover body image and size topics more frequently than programs that did not have a focus in social justice and/or multiculturalism.

(H5) Trainees with more exposure to education and training in topics of body image would endorse less weight bias and frustrations about working with larger-bodied individuals.

(H6) Trainees with higher body esteem would endorse less weight bias about working with larger-bodied individuals compared to trainees with lower body esteem.

To expand knowledge about sizeism in training, the researcher pursued the answers to the following research questions by employing qualitative methodology:

1. In what ways, if any, do training and education in body image topics and characteristics of a program (e.g., clinical versus counseling psychology or

area of specialty/focus) relate to doctoral students' personal experiences of receiving comments pertaining to their own bodies within their program (e.g., from clients, faculty members and students)?

2. In what ways, if any, do training and education in body image topics and characteristics of a program (e.g., clinical versus counseling psychology, area of specialty/focus) relate to doctoral students' experiences of how bodies (e.g., weight, size, ability status) are discussed within their programs by staff, students, and faculty members?

CHAPTER III

METHOD

Design

The present study represents the first known evaluation of body image topics in graduate clinical and counseling psychology training through the perspectives of doctoral students and training directors. The study was conducted through an online survey; participation was solicited through emails to the training directors for all 339 APA-accredited and CPA-accredited (Canadian Psychological Association, CPA) clinical and counseling psychology programs in the U.S. and Canada. Programs were initially identified for inclusion in the current study through the APA program database (http://www.apa.org/ed/accreditation/programs/index.aspx) and were subsequently confirmed using the CPA website (https://www.cpa.ca/accreditation/cpaaccredited programs/). While Canadian programs were previously eligible for APA-accreditation and included in the APA database, the field has moved toward "mutual accreditation recognition" (APA, 2018) in which programs are no longer concurrently accredited and are instead accredited by the APA or CPA separately based on region. CPA-accredited programs are now solely accessible through the CPA website.

The survey consisted of participants' self-report of basic demographic information (e.g., age, gender, race/ethnicity, sexual orientation, ability status, and region), topics covered through formal curriculum and external training (e.g., practicum, workshops, research, and conferences), perceived competence working with larger-

bodied individuals and body image topics in practice, and completion of the Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS; Brown et al., 1990) and a modified version of the Attitudes about Treating Obese Patients scale (Puhl, Latner, et al., 2014).

Participants

Participants consisted of training directors and doctoral students in APA-and CPA-accredited clinical and counseling psychology programs in the U.S. and Canada. After obtaining Institutional Review Board (IRB) approval, the researcher identified 339 programs meeting the inclusion criteria for the proposed study through the APA's online database of currently accredited programs. Of the APA-accredited programs solicited for the current study, 74 programs identified as counseling psychology programs (23.79%), 235 were clinical psychology programs (75.56%), and 2 programs were combined clinical-counseling psychology (0.64%). Of the CPA-accredited programs, 4 identified as counseling psychology programs (14.29%), 23 were clinical psychology programs (82.14%), and 1 was a combined clinical-counseling program (3.57%). Of the 409 training directors contacted, 21 participated in the current study, resulting in a notably low director response rate (5.13%). Response rates for programs and student participants (n = 114) cannot be calculated due to the researcher's inability to identify the number of students solicited following the initial request to the training directors and the limitations accompanying confidentiality (i.e., limiting identification of specific programs represented). Training directors were notified and solicited through an initial email and two subsequent follow-up emails in 2-week intervals, including a request for current

doctoral student participation (see Appendix A). For programs with more than one training director listed, both training directors were contacted and solicited for participation in the study.

Inclusion and Exclusion Criteria

Prior to participating in the study, participants were presented with an eligibility question. To be included in the proposed study, participants had to endorse being a current training director or doctoral student with a minimum of 1 year in their current program and a minimum of 1 completed semester of clinical experience at the doctoral level in an APA- or CPA-accredited program. These criteria were selected to ensure that student participants were in the program for a sufficient amount of time to reflect on the program's curriculum, external opportunities for training, and the student's own experiences as a practitioner. Due to a failure to meet the criteria of either being a current training director or doctoral student with a minimum of 1 year in their current program and a minimum of 1 completed semester of clinical experience at the doctoral level, 8 of the initial 143 participants were excluded from analyses.

Training Directors

While the training directors included in the current study identified with a wide range of diversity variables, most identified as White (90.48%), heterosexual (80.95%), able-bodied (76.19%) women (66.67%) who, at the time the study was completed, had served in their current position as training director for 2-5 years (57.14%). Participants ranged in age from 35 to 67 years (M = 50.14, SD = 11.09) and noted their in time in their current positions from < 1 year to 17 years (M = 2.38, SD = 3.98). Training

directors endorsed a broad range of theoretical orientations; the most widely endorsed were Cognitive-Behavioral Theory (CBT) (52.38%) and Interpersonal Theory (42.86%). For additional demographic information, see Table 1.

Table 1

Training Director Demographics

Variable	Level	*M* (*SD*)	*n*	%
Age	30 – 39 years	50.14	4	19.05
	40 – 49 years	(11.09)	6	28.57
	50 – 59 years		5	23.81
	60 – 69 years		6	28.57
Gender	Female		14	66.67
	Male		7	33.33
Race/Ethnicity	White		19	90.48
	Latino(a)(x)/Hispanic		1	4.76
	Bi- or Multi-Racial/Multi-Ethnic		1	4.76
Sexual Orientation	Gay		1	4.76
	Lesbian		1	4.76
	Bisexual		2	9.52
	Heterosexual		17	80.95
Ability Status	Able-Bodied		16	76.19
	Disabled		4	19.05
	Unreported		1	4.76

(Table Continued)

Time in Current Position	≤ 1 year	2.38 (3.98)	3	14.29
	2 – 5 years		12	57.14
	6 – 10 years		4	19.05
	> 10 years		2	9.52
Theoretical Orientation[a]	Cognitive-Behavioral		11	52.38
	Interpersonal		9	42.86
	Psychodynamic/ Psychoanalytic		7	33.33
	Multicultural		6	28.57
	Feminist		6	28.57
	Relational-Cultural		3	14.29
	Acceptance and Commitment		3	14.29
	Emotion-Focused		2	9.52
	Positive		2	9.52
	Systemic		2	9.52
	Narrative		1	4.76
	Person-Centered		1	4.76

[a] Totals exceed 100% because participants were able to choose more than one theoretical orientation.

Doctoral Students

Doctoral student participants in the current study represented a diverse range of cultural identities and levels of professional experience. Most doctoral student participants were between 25 and 29 years of age (64.04%) and identified as White (84.21%), heterosexual (75.44%), able-bodied (87.72%) women (85.96%). Participants ranged in age from 22 to 37 years (M = 28.21, SD = 3.16). Participants ranged in time in current program (M = 7.36 semesters, SD = 3.12) and clinical experience (M = 5.94 semesters, SD = 3.09). Most participants (66.15%) reported having a minimum of 5 semesters of clinical experience and identifying with Cognitive-Behavioral Theory (68.42%). Although no known survey has been conducted providing an overview of

graduate student and training director demographics within the field of psychology, the results of the 2017 APA Graduate Study in Psychology Summary Report provide information for graduate student racial and gender demographics. Compared with extant findings, White, female graduate students may be overrepresented in the current study at 84.21% and 85.96% respectively in comparison to 72.40% and 72.10% respectively in the psychology graduate student population (Cope, Michalski, & Fowler, 2016). For additional information regarding the demographic information of doctoral student participants, see Table 2.

Table 2

Student Demographics

Variable	Level	*M* (*SD*)	*n*	%
Age	20 – 24 years	28.21	12	10.53
	25 – 29 years	(3.16)	73	64.04
	30 – 34 years		21	18.42
	35 – 39 years		8	7.02
Gender	Female		98	85.96
	Male		11	9.65
	Non-Binary/Third Gender		5	4.39

(Table Continued)

Variable	Level	*M* (*SD*)	*n*	%
Race/Ethnicity[a]	American Indian or Alaska Native		3	2.63
	White		96	84.21
	Latino(a)(x)/Hispanic		5	4.39
	Middle Eastern/North African		1	0.88
	Black or African American		1	0.88
	Asian or Pacific Islander		13	11.40
	Bi- or Multi-Racial/Multi-Ethnic		2	1.75
	Other (Indian Asian; Jewish)		2	1.75
Sexual Orientation	Gay		1	0.88
	Lesbian		2	1.75
	Bisexual		11	9.65
	Heterosexual		86	75.44
	Queer		8	7.02
	Pansexual		5	4.39
	Asexual		1	0.88
Ability Status	Able-Bodied		100	87.72
	Disabled		7	6.14
	Unreported		7	6.14
Highest Level of Education	Bachelor's Degree in Psychology or Related Field		17	23.61
	Bachelor's Degree in an Unrelated Field		1	1.39
	M.A. or M.S. in Clinical Psychology		26	36.11
	M.A. or M.S. in Counseling Psychology		12	16.67
	Other (M.A. or M.S. in Related Field)		7	9.72
	Other (M.A. or M.S. in Unrelated Field)		2	2.78

(Table Continued)

Variable	Level	*M* (*SD*)	*n*	%
Time in Current Program	2 semesters	7.36 (3.12)	4	5.56
	3 – 6 semesters		26	36.11
	7 – 10 semesters		23	31.94
	> 10 semesters		19	26.39
Clinical Experience	≤ 2 semesters	5.94 (3.09)	13	18.06
	3 – 4 semesters		9	12.50
	5 – 6 semesters		19	26.39
	≥ 7 semesters		24	33.33
Theoretical Orientation[a]	Cognitive-Behavioral		78	68.42
	Interpersonal		40	35.09
	Acceptance and Commitment		35	30.70
	Feminist		28	24.56
	Psychodynamic/Psychoanalytic		25	21.93
	Multicultural		24	21.05
	Emotion-Focused		14	12.28
	Positive		13	11.40
	Relational-Cultural		7	6.14
	Dialectical-Behavioral		5	4.39
	Eclectic/Integrative		2	1.75
	Motivational Interviewing		2	1.75
	Gestalt		1	0.88
	Systemic		1	0.88
	Affirmative		1	0.88
	Existential		1	0.88

[a] Totals exceed 100% because participants were able to choose more than one race/ethnicity and theoretical orientation.

Program Characteristics

Of participants who completed the program characteristics portion of the survey (*n* = 57; 18 training directors and 39 doctoral students), the majority reported that their programs were in the U.S. (94.74%), identified with a scientist-practitioner model of

training (66.67%), and had been accredited for more than 16 years (56.15%). The programs were approximately equally representative of counseling (49.12%) and clinical psychology programs (50.88%). A minority of programs offered specialty areas of focus/tracks (38.60%) with a small subset (5.26%) explicitly focusing on multicultural/social justice considerations. While a diverse range of theoretical orientations were represented across faculty in the programs surveyed, CBT (89.47%), Psychodynamic/Psychoanalytic (64.91%), and Multicultural Theory (64.91%) were the most represented. For additional information regarding program demographics, see Table 3 below. It is important to note that, given limitations accompanying the recruiting process, it is possible that training director and/or student participants from the same program responded and as a result, the program characteristics may not represent discrete programs.

Table 3

Program Demographics

Variable	Level	*n*	%
Region	Midwest	12	21.05
	Northeast	10	17.54
	Southeast	12	21.05
	Southwest	5	8.77
	West	15	26.32
	Canada	3	5.26

(Table Continued)

Variable	Level	*n*	%
Degree	Ph.D. Counseling Psychology	23	40.35
	Psy.D. Counseling Psychology	5	8.77
	Ph.D. Clinical Psychology	14	24.56
	Psy.D. Clinical Psychology	15	26.32
Time Accredited	≤ 5 years	4	7.02
	6 – 10 years	8	14.04
	11 – 15 years	4	7.02
	16 – 20 years	8	14.04
	> 20 years	24	42.11
	Unsure	9	15.77
Training Model	Scientist-Practitioner	38	66.67
	Practitioner-Scientist	4	7.02
	Scholar-Practitioner	2	3.51
	Practitioner-Scholar	11	19.30
	Local Clinical Scientist	1	1.75
	Unsure	1	1.75
Specialty Track	Multicultural/Social Justice	3	5.26
	Health	10	17.54
	Other (e.g., Forensic)	9	15.79
Theories Represented[a]	Cognitive-Behavioral	51	89.47
	Psychodynamic/Psychoanalytic	37	64.91
	Multicultural	37	64.91
	Interpersonal	32	56.14
	Feminist	26	45.61
	Acceptance and Commitment	24	42.11
	Systemic	21	36.84
	Emotion-Focused	16	28.07
	Relational-Cultural	8	14.04
	Positive	6	10.53
	Dialectical-Behavioral	2	3.51
	Affirmative	1	1.75
	Gestalt	1	1.75

[a] Totals exceed 100% because participants were able to choose more than one theoretical orientation.

Procedure

Eligible programs (N = 339) were identified through the APA website database in conjunction with the CPA website. The researcher used program websites to gather email addresses for current training directors. All listed training directors were contacted through email with a request for their participation and a request to share a formal invitation to eligible students within their respective programs (see Appendix A). Training directors were contacted in two additional follow-up requests in 2-week intervals following the initial request. As an incentive, participants were provided with the option to be entered in a drawing for the chance to win one of two $50 Amazon gift cards. Participants interested in being entered in the drawing were given the opportunity to provide their preferred email address at the completion of the study, which was stored in a separate database from the participants' responses.

The survey's instruments were posted online via PsychData, a secure data-collection website that utilizes several forms of security to protect participants' confidentiality including encryption of stored data. Prior to completing the survey, participants were directed to an informed consent page (see Appendix B) where they were told about the procedure for the study, including risks and resources to access in case of emotional distress, and completed a screening document to ensure their eligibility. Eligibility was based on being a current training director or being a current doctoral student with (a) a minimum of 1 year of enrollment in the current doctoral program and (b) a minimum of one completed semester of doctoral-level practicum. Following the

completion of these items, eligible participants were presented with each of the following measures in a randomized sequence to minimize order effects.

Measures

Demographic Information

Participants completed a brief questionnaire (see Appendices C and D for the questionnaire for training directors and students, respectively). Both doctoral students and training directors answered questions pertaining to the type of program (counseling or clinical psychology), age, ability, race/ethnicity, gender, and sexual orientation. Additionally, doctoral students provided information regarding time in the program and semesters of clinical experience to determine eligibility, highest level of education, and area of specialty if applicable. Training directors were asked to provide information regarding time serving as a director and general information regarding their programs including specialty tracks, training model, and predominant theories endorsed by faculty.

Training and Education

Through a review of the two leading handbooks in body image theory, research, and practice (Cash & Pruzinsky, 2002; Cash & Smolak, 2011), the researcher developed a survey to assess the inclusion of body image topics in graduate curriculum (see Appendix E). The survey consisted of four sections with 23 items: awareness (2 items), knowledge (12 items), skills (7 items), and other training experiences (2 items). While no known previous researcher has explored or provided a comprehensive framework for assessing clinician competence in working with topics of body image, cultural

competence has historically been conceptualized and measured as consisting of practitioner self-awareness, knowledge, and skills (Pederson, 1997). Examples of items included, "How well do you think your program encourages self-reflection of students' own body image and its impact in practice?" and "How comfortable do you feel broaching body image in session?" Most items are measured on 5-point Likert scales measuring how well programs cover topics (ranging from 1-*not well at all* to 5-*exceptionally well*). Of the 23 items included in the survey, 7 were free response and included an 8,000-character limit response frame.

Pathological topics were assessed through the summation of the endorsement of survey items 4a, 4c, 4d, 4e, 4f, 4h, 10a, 11a, 11b, 13a, 13b, 13c, 13e, and 13f, consisting of the following topics: body dissatisfaction, body distortion, objectification, self-objectification, size perception accuracy, body surveillance/body scanning, risk factors for development of negative body image, dieting, exercise, measures of size perception accuracy, measures of eating disorder behaviors/criteria for diagnosis, measures of body dissatisfaction, measures of body preoccupation, and weight bias/anti-fat bias. Positive and celebratory topics were assessed through the summation of the endorsement of survey items 4g, 4j, 4k, 9d, 10b, and 13d, consisting of the following topics: body satisfaction, body acceptance, body appreciation, the Health at Every Size movement (Bacon, 2010), protective factors encouraging development of positive body image, and measures of body acceptance, appreciation, and/or positivity. Pathological and positive/celebratory items were coded as 0 (no endorsement) or 1 (endorsement).

The researcher utilized the proportion of items endorsed within each of the two categories to compare inclusion of pathological topics to inclusion of positive and celebratory topics. Size perception accuracy was assessed through endorsement of survey item 4a. Medical presentations were assessed through survey item 6, consisting of neurodegenerative disorders, disfigurement, cancer, skin concerns, cosmetic surgery, congenital conditions, depression, anxiety, pregnancy, anorexia nervosa, bulimia nervosa, body dysmorphic disorder, and binge-eating disorder. Topics of size as a cultural variable, assessed through survey item 5, included body image and race/ethnicity, gender, ability status, age, sexual orientation, and size; size as a cultural identity; men and the muscular ideal; women and the thin ideal; steroid use and body image; hormone use and body image; sizeism and weight bias; and the effects of sizeism on larger-bodied individuals.

Weight Bias

Weight bias, self-perceived competence and preparedness, and participants' willingness to work with larger-bodied individuals were assessed through a modification of the Attitudes about Treating Obese Patients Scale (Puhl, Latner, et al., 2014; see Appendix F), an 18-item self-report measure consisting of two subscales: negative attitudes toward larger-bodied patients (12 items) and frustrations in working with larger-bodied patients (6 items). Items are rated on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Examples of items include, "I feel prepared to effectively treat larger-bodied clients/patients," and "I often feel frustrated with larger-

bodied clients/patients." For the purposes of the current study, the researcher, with permission of the scale's authors, modified the full 22-item version of the measure to be more applicable to a sample of professionals within the field of psychology by using less medicalized language (e.g., changing "patients" to "clients/patients" and changing "obese" to "larger-bodied"). The measure demonstrated good levels of internal consistency in the current study, as determined by Cronbach's alpha: negative attitudes toward larger-bodied clients/patients (α = .80) and frustrations in working with larger-bodied clients/patients (α = .89).

Body Esteem

The Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS; Brown et al., 1990) was used to assess participant body esteem, perceived control in body size, and body preoccupation (see Appendix G). The MBSRQ-AS is a 34-item self-report measure comprised of the following scales: Appearance Evaluation (7 items), Appearance Orientation (12 items), Overweight Preoccupation (4 items), Self-Classified Weight (2 items), and the Body Areas Satisfaction (9 items) subscales of the extended MBSRQ. Through a review of previous examinations, Cash (2000) demonstrated the consistently good reliability of the measure across each of the subscales for men and women: Appearance Evaluation (α = .88 for men; α = .88 for women), Appearance Orientation (α = .88 for men; α = .85 for women), Overweight Preoccupation (α = .73 for men; α = .76 for women), Self-Classified Weight (α = .70 for men; α = .89 for women), and the Body Areas Satisfaction (α = .77 for men; α = .73 for women). Each

item is rated on a 5-point Likert scale measuring satisfaction (1 = *very dissatisfied* to 5 = *very satisfied*), frequency (1 = *never* to 5 = *very often*), and agreement (1 = *definitely disagree* to 5 = *definitely agree*) with the exception of the Self-Classified Weight Scale which is a self-assessment measure ranging from 1 (*very underweight*) to 5 (*very overweight*). Examples of items include, "I like my looks just the way they are," "I am in control of my health," and "I never think about my appearance." The MBSRQ-AS has demonstrated good internal consistency, discriminant validity, and test-retest reliability in Greek (Argyrides & Kkeli, 2013), Spanish (Roncero, Perpiñá, Marco, & Sánchez-Reales, 2015), French (Untas, Koleck, Rascle, & Borteyrou, 2009), and German translations (Vossbeck-Elsebusch et al., 2014) and good convergent validity compared to other measures of body image (e.g., the Body Image Questionnaire; Cash & Szymanski, 1995).

The norms for the questionnaire were developed from a sample of 996 men and 1,070 women with subscale reliability ranging from α = .73 to α = .89 for women and α = .70 to α = .88 for men, and subscale test-retest reliabilities of r_{tt} = .74 to r_{tt} = .91 for women and r_{tt} = .79 to r_{tt} = .89 for men (Cash, 2000). Given the constricting norms utilized in the development of the MBSRQ, which mirror the field's historical endorsement of the gender binary and omittance of non-binary populations (Westbrook & Saperstein, 2015), data non-binary populations' responses are unavailable. The MBSRQ-AS generally demonstrated good internal reliability in the current study, with the exception of Overweight Preoccupation, as reflected by their respective Cronbach's alpha: Appearance Evaluation (α = .90), Appearance Orientation (α = .87), Overweight

Preoccupation (α = .65), Self-Classified Weight (α = .86), and the Body Areas Satisfaction (α = .83).

CHAPTER IV

RESULTS

Descriptive Analyses

The researcher reviewed the data and used the pairwise deletion method to address missing data (Peugh & Enders, 2004). The researcher conducted descriptive analyses to examine age, gender, race/ethnicity, sexual orientation, ability status, theoretical orientation, and experience (time in current position for training directors and highest level of education, time in program, and clinical experience for doctoral students). Additionally, the researcher ran descriptive analyses to examine program characteristics including region, type of program (e.g., Ph.D. or Psy.D. and clinical or counseling psychology), years accredited, training model, specialty track or emphasis, and theoretical orientations represented among faculty. The researcher assessed interval and ratio variables for skewness and kurtosis to ensure that they were normally distributed. Years of accreditation scores were normally distributed with a skewness of 0.81 (*SE* = 0.34) and kurtosis of -0.85 (*SE* = 0.67). Semesters in current program and semesters of clinical experience were also normally distributed with a skewness of 0.22 (*SE* = 0.29) and 0.17 (*SE* = 0.30) and a kurtosis of -0.87 (*SE* = 0.57) and -0.99 (*SE* = 0.58), respectively. Age and time serving as training director were not normally distributed with a skewness of 2.29 (*SE* = 0.21) and 1.82 (*SE* = 0.50) and a kurtosis of 4.85 (*SE* = 0.41) and 4.18 (*SE* = 0.97), respectively.

The researcher reviewed outliers, defined as data points that were three standard deviations above or below the mean for the present study (Dixon, 1953). The researcher conducted and observed analyses with and without the outliers to determine degree of influence. If the results indicated discrepancies in significance, the researcher included analyses of results with and without outliers.

Additionally, to address the previously identified limitation of the binary norming of the MBSRQ (Brown et al., 1990), the researcher conducted exploratory descriptive analyses on the entirety of the sample and on a subset of the sample including only participants in the binary categories. It is important to note that these results should be considered with caution given the limitations evident in the sample size of men (n = 16) and non-binary identified participants (n = 3). See Table 4 depicting the scores of participants identifying as female, male, and non-binary as well as the norming data for each of the five subscales. An outlier in the form of one data point more three standard deviations below the mean was evident on the Self-Classified Weight scale. The researcher conducted analyses with and without the outlier to determine degree of influence.

Table 4

Gender and the MBSRQ-AS Subscales

Subscale	Norm Females[a] *M (SD)*	Norm Males[a] *M (SD)*	Females *M (SD)*	Males *M (SD)*	Non-Binary[a] *M (SD)*
Appearance Evaluation	3.36 (0.87)	3.49 (0.83)	3.39 (0.83)	3.40 (0.62)	3.43 (1.17)
Appearance Orientation	3.91 (0.60)	3.60 (0.68)	3.26 (0.58)	2.91 (0.84)	3.25 (0.58)
Body Areas Satisfaction	3.23 (0.74)	3.50 (0.63)	3.40 (0.66)	3.35 (0.49)	3.78 (0.89)
Overweight Preoccupation	3.03 (0.96)	2.47 (0.92)	2.54 (0.79)	2.42 (0.91)	2.00 (0.66)
Self-Classified Weight	3.57 (0.73)	2.96 (0.62)	3.20 (0.66)	3.16 (0.40)	3.00 (0.50)

Note. Each item is rated on a 5-point Likert scale. Higher scores indicate more body satisfaction (Appearance Evaluation and Body Areas Satisfaction with the latter assessing specific aspects), investment in appearance (Appearance Orientation), preoccupation with gaining weight and weight control behaviors (Overweight Preoccupation), and perception of being "overweight" (Self-Classified Weight).

[a] The norming data provided is based on the findings outlined in the MBSRQ manual (Cash, 2000).

Primary Analyses

Prior to conducting the statistical analyses for each of the hypotheses outlined, the researcher utilized preliminary analyses to examine the assumptions accompanying each test. The researcher has presented the results for the preliminary tests of assumptions and the subsequent statistical analyses for each of the hypotheses.

Hypothesis 1 Preliminary Analyses

Following descriptive analyses, the researcher utilized a correlated groups t-test to test the following hypothesis:

> (H1) It was hypothesized that graduate curriculum and training opportunities would cover pathological topics more frequently than positive and celebratory topics.

Prior to conducting the correlated groups t-test, the assumption of normality was assessed using the One-Sample Kolmogorov-Smirnov test (Field, 2013). The proportion of pathological topics scores, $D(114) = 0.20$, $p < .05$, and the proportion of positive and celebratory topics scores, $D(114) = 0.36$, $p < .05$, both significantly deviated from normality. Due to the robustness of the t-test (Field, 2013), the researcher conducted the analyses despite the assumption of normality being violated. Two outliers were detected in proportion of positive and celebratory topics scores, as assessed by inspection of a boxplot. Removal of the outliers did not significantly alter the normality of the data.

Hypothesis 1 Primary Analyses

The proportion of pathological topics included in training and education elicited a statistically significant increase in inclusion of body image topics compared to positive

and celebratory topics, $t(113) = 2.95$, $p < 0.005$, $d = 0.28$. Participants were exposed to a slightly higher proportion of pathological topics pertaining to body image ($M = 0.16$, $SD = 0.19$) compared to positive and celebratory topics pertaining to body image ($M = 0.12$, $SD = 0.21$). The proportion of pathological topics elicited a mean increase of 0.04 topics included in training, 95% CI [0.01, 0.07] compared to positive and celebratory topics. There was a statistically significant difference between means ($p < .005$) and as a result, the null hypothesis was rejected, and the alternative hypothesis was accepted as student participants reported a significantly higher rate of exposure to pathological topics in body image compared to celebratory and positive topics pertaining to body image. For an overview of inclusion of body image topics in training and education, see Table 5.

Table 5

Students' Reports of Breadth of Body Image Training Inclusion

Training Category	Focus	*N*	%
Concepts	Body esteem	13	13.40
	Embodiment	7	7.22
	Body dissatisfaction	17	17.53
	Body distortion	24	24.74
	Objectification	25	25.77
	Self-objectification	15	15.46
	Body surveillance/scanning	19	19.59
	Size perception accuracy	8	8.25
	Body satisfaction	16	16.49
	Body acceptance	17	17.53
	Body appreciation	9	9.28
	No training	18	18.56
Cultural Considerations	Body image and race/ethnicity	25	25.77
	Body image and gender	39	40.21
	Body image and ability status	8	8.25
	Body image and age	8	8.25
	Body image and sexual orientation	12	12.37
	Body image and size	12	12.37
	Size as a cultural identity	14	14.43
	Men and the muscular ideal	27	27.84
	Women and the thin ideal	47	48.45

(Table Continued)

Training Category	Focus	*N*	%
Cultural Considerations Continued	Steroid use and body image	4	4.12
	Hormone use and body image	6	6.19
	Sizeism and weight bias	22	22.68
	The effects of sizeism on larger-bodied individuals	9	9.28
	No training	20	20.62
Health/Mental Health Processes	Body image and neurodegenerative disorders	2	2.06
	Body image and disfigurement	3	3.09
	Body image and cancer	1	1.03
	Body image and skin concerns (e.g., burns, skin disorders, and discoloration)	2	2.06
	Body image and cosmetic surgery	1	1.03
	Body image and congenital conditions	2	2.06
	Body image and depression	21	21.65
	Body image and anxiety	19	19.59
	Body image and pregnancy	4	4.12
	Body image and anorexia nervosa	59	60.82
	Body image and bulimia nervosa	56	57.73
	Body image and body dysmorphic disorder	48	49.48
	Body image and binge-eating disorder	48	49.48
	No Training	19	19.59
Functionality	Body image and social functioning	12	12.37
	Body image and sexual functioning	6	6.19
	No training	45	46.39

(Table Continued)

Training Category	Focus	*N*	%
Theoretical Perspectives of Body Image	Sociocultural	19	19.59
	Feminist	20	20.62
	Evolutionary	4	4.12
	Cognitive-Behavioral	18	18.56
	Positive Psychology	3	3.09
	No training	28	28.87
Research	History of body image research	3	3.09
	Empirically based critiques of use of Body Mass Index (BMI)	16	16.49
	Empirically based critiques of dieting as a recommended treatment	9	9.28
	Health at Every Size research	7	7.22
	No training	52	53.61
Developmental Considerations	Risk factors for development of negative body image	28	28.87
	Protective factors encouraging development of positive body image	23	23.71
	Body image development in childhood	16	16.49
	Body image development in adolescence	21	21.65
	Body image development in adulthood	11	11.34
	Body image development in late adulthood (geriatric populations)	3	3.09
	The impact of media on body image development	42	43.30
	No training	28	28.87

(Table Continued)

Training Category	Focus	*N*	%
Approaches to Treatment	Psychotherapy approaches to dieting	21	21.65
	Psychotherapy approaches to exercise	30	30.93
	Integrating expressive components (e.g., art, music, dance) into psychotherapy	8	8.25
	Media literacy and protective filtering	9	9.28
	Referral to physician, nutritionist, and/or dietician	44	45.36
	No training	22	22.68
Assessment	Measures of size perception accuracy	2	2.06
	Measures of eating disorder behaviors/criteria for diagnoses	39	40.21
	Measures of body dissatisfaction	16	16.49
	Measures of body acceptance, appreciation, and/or positivity	8	8.25
	Measures of body preoccupation	6	6.19
	Measures of weight bias and/or anti-fat bias	5	5.15
	No training	31	31.96

Note. Percentages are representative of a subset of the sample consisting of 97 of the total 114 student participants due to missing responses.

Hypothesis 2 Preliminary Analyses

The researcher conducted a correlated groups t-test to test the following hypothesis:

(H2) Of the topics covered, it was hypothesized that, paralleling the focus of body image research, size perception accuracy would be covered more frequently than body image as it pertained to medical presentations.

Prior to conducting the correlated groups t-test, the assumption of normality was assessed using the One-Sample Kolmogorov-Smirnov test (Field, 2013). The medical presentation scores, $D(114) = 0.26$, $p < .05$, and the size perception accuracy scores, $D(114) = 0.54$, $p < .05$, were both significantly non-normal. Due to the robustness of the t-test (Field, 2013), the researcher conducted the analyses despite the assumption of normality being violated.

Hypothesis 2 Primary Analyses

The proportion of health and mental health processes topics covered elicited a statistically significant increase in inclusion of body image topics compared to size perception accuracy, $t(96) = 4.22$, $p < 0.001$, $d = 0.43$. Student participants were exposed to a higher proportion of topics pertaining to body image and health and mental health processes ($M = 0.21$, $SD = 0.19$) compared to size perception accuracy ($M = 0.08$, $SD = 0.28$). The proportion of health and mental health processes topics elicited a mean increase of 0.14 topics included in training, 95% CI [0.07, 0.19] compared to size perception accuracy. There was a statistically significant difference between means ($p < .001$) and as a result, the null hypothesis was rejected, and the alternative hypothesis was

accepted. Student participants reported a significantly higher rate of exposure to health and mental health processes related to body image compared to size perception accuracy.

Hypothesis 3 Preliminary Analyses

An independent sample t-test and measures of effect size (e.g., Cohen's *d* and eta squared) were utilized to test the following hypothesis:

> (H3) Given the foundational tenants of social justice and multiculturalism evident in the field of counseling psychology, it is hypothesized that counseling psychology programs will cover topics of size as a cultural variable more frequently compared to clinical psychology programs.

Prior to conducting the independent t-tests, the researcher assessed the assumptions of normality and homogeneity of variance using the One-Sample Kolmogorov-Smirnov test and Levene's Test for the Equality of Error Variances to ensure all assumptions were fulfilled (Field, 2013). No outliers were evident in the data, as assessed through an inspection of a boxplot. The scores for inclusion of size as a cultural variable significantly deviated from normality for both counseling, $D(28) = 0.24$, $p < .05$ and clinical psychology programs, $D(29) = 0.25$, $p < .05$. For the proportion of size as a cultural variable scores, the variances were equal for the two groups, $F(1, 55) = 0.41$, $p < .05$. Although the assumption of normality was violated, the assumption of homogeneity was fulfilled. As independent samples t-tests are fairly robust to deviations from normality (e.g., Lumley, Diehr, Emerson, & Chen, 2002) and the sample sizes were comparable for counseling and clinical psychology programs, the researcher conducted

the independent t-test to determine if there were differences in inclusion of topics of size as a cultural variable between counseling psychology and clinical psychology programs.

Hypothesis 3 Primary Analyses

Of the student and faculty participants who specified their discipline, 28 indicated counseling psychology and 29 indicated clinical psychology. Accordingly, 57 total participants were included in the analyses. Although a difference in inclusion of topics of size as a cultural variable was evident, the difference was not statistically significant, $t(55) = 0.38$, $p = .71$, and therefore, the researcher failed to reject the null hypothesis and was unable to accept the alternative hypothesis. Topics of size as a cultural variable were covered more in counseling ($M = 2.68$, $SD = 3.10$) than in clinical psychology programs ($M = 2.38$, $SD = 2.85$) with counseling psychology programs' inclusion of size as a cultural variable being 0 .30 ($SE = 0.79$) higher than the inclusion score of clinical psychology programs. There was homogeneity of variances, as assessed through Levene's test for equality of variances ($p = .52$).

Hypothesis 4 Preliminary Analyses

An independent sample t-test and measures of effect size (e.g., Cohen's *d* and eta squared) were utilized to test the following hypothesis:

> (H4) Programs directors who identify their respective programs as having a focus in social justice and/or multiculturalism will cover body image and size more frequently as assessed through the training and education survey.

Prior to conducting the independent t-tests, the assumptions of normality and homogeneity of variance were assessed using the One-Sample Kolmogorov-Smirnov test

and Levene's Test for the Equality of Error Variances to ensure all assumptions were fulfilled (Field, 2013). The scores for inclusion of body image and size topics significantly deviated from normality for programs with a specialty in Multiculturalism/Social Justice, $D(50) = 0.50$, $p < .05$, and without a specialty in Multiculturalism/Social Justice, $D(3) = 0.39$, $p < .05$. For inclusion of body image and size, the variances were equal for the two groups, $F(50, 3) = 1.04$, *ns*. Although the assumption of normality was violated, the assumption of homogeneity was fulfilled. Due to the previously identified robustness of independent t-tests to deviations from normality, the researcher conducted the test to determine if there were differences in inclusion body image and size between programs identifying with a Multiculturalism/Social Justice focus and those that did not.

Hypothesis 4 Primary Analyses

According to the program demographics information provided, 3 programs explicitly identified as having a Multiculturalism/Social Justice focus and 50 programs identified without a focus/specialty or with an unrelated focus/specialty. Although a difference in inclusion of body image and size was evident, the difference was not statistically significant, $t(51) = -0.65$, $p = .52$, and therefore, the researcher failed to reject the null hypothesis and was unable to accept the alternative hypothesis. The intersectionality of body image and size was covered more in programs with a Multiculturalism/Social Justice focus ($M = 0.33$, $SD = 0.58$) than in programs without a Multiculturalism/Social Justice focus ($M = 0.18$, $SD = 0.39$). There was homogeneity of variances, as assessed through Levene's test for equality of variances ($p = .31$). Programs

without a Multiculturalism/Social Justice focus had a mean inclusion score 0.15 lower than programs with this focus.

Hypothesis 5 Primary Analyses

A Pearson correlation was selected to test the following hypothesis given the continuous nature of the variables. Cohen's standard was utilized to examine the correlation coefficient.

> (H5) Trainees with more exposure to education and training in topics of body image would endorse less weight bias and frustrations when working with larger-bodied individuals.

The researcher ran a Pearson's correlation to assess the relationship between students' exposure to education and training in topics of body image and students' endorsement of weight bias and frustrations when working with larger-bodied individuals. Preliminary analyses revealed the relationship to be linear with not all variables normally distributed, as assessed by Shapiro-Wilk's test ($p < .05$). No outliers were identified. No correlation was evident between exposure to education and training in topics of body image and endorsement of weight bias and frustrations when working with larger-bodied individuals, $r(91) = -0.06$, $p > .05$. With consideration of non-normality, the researcher also conducted a non-parametric test in the form of Spearman's rank-order correlation test. Again, no correlation was evident between exposure to training and education and perceptions when working with larger-bodied individuals, $r_s(91) = -0.04$, $p > .05$, and therefore, the researcher failed to reject the null hypothesis and was unable to accept the alternative hypothesis.

Hypothesis 6 Primary Analyses

The final hypothesis outlined below was tested using a Pearson correlation. Cohen's standard was utilized to examine the correlation coefficient.

(H6) Trainees with higher body esteem would endorse less weight bias and frustrations when working with larger-bodied individuals compared to trainees with lower body esteem.

The researcher ran a Pearson's correlation to assess the relationship between students' body esteem and students' endorsement of weight bias and frustrations when working with larger-bodied individuals. Preliminary analyses revealed the relationship to be linear with not all variables normally distributed, as assessed by Shapiro-Wilk's test ($p < .05$). No outliers were identified. No correlation was evident between body esteem and endorsement of weight bias and frustrations when working with larger-bodied individuals, $r(91) = -0.07$, $p > .05$. With consideration of non-normality, the researcher also conducted a non-parametric test in the form of Spearman's rank-order correlation test. Again, no correlation was evident between body esteem and perceptions when working with larger-bodied individuals, $r_s(91) = -0.16$, $p > .05$, and therefore, the researcher failed to reject the null hypothesis and was unable to accept the alternative hypothesis. To review student participants' endorsement of weight bias items, see Table 6, which provides an overview of student participants' and training director participants' endorsement on each of the items on the Attitudes about Treating Larger-Bodied Clients/Patients Scale.

Table 6

Student and Training Directors' Perspectives Regarding Work with Larger-Bodied Clients/Patients

Item	% Student Endorsement	% Director Endorsement
Attitudes toward larger-bodied clients		
I would rather treat a client/patient who is not larger-bodied than a larger-bodied client/patient.	7.53	5.88
Treating a larger-bodied client/patient repulses me.	1.08	0.00
Treating a larger-bodied client/patient is more stressful than treating a client/patient who is not larger-bodied.	2.15	5.88
Treating a larger-bodied client/patient is more emotionally draining than treating a client who is not larger-bodied.	0.00	5.88
It is difficult to feel empathy for a larger-bodied client/patient.	0.00	5.88
I feel disgust when treating a larger-bodied client/patient.	2.15	0.00
I feel more irritated when I am treating a larger-bodied client/patient than a client/patient who is not larger-bodied.	3.23	5.88
Treating a larger-bodied client/patient is more frustrating that treating a client/patient who is not larger-bodied.	3.23	5.88

(Table Continued)

Item	% Student Endorsement	% Director Endorsement
Larger-bodied clients/patients tend to be lazy.	2.15	0.00
Treating larger-bodied clients/patients is professionally rewarding.	48.39	41.18
I feel that larger-bodied clients/patients lack motivation to make lifestyle changes.	2.15	5.88
I dislike treating larger-bodied clients/patients.	1.08	5.88
I feel that it is important to treat larger-bodied clients/patients with compassion and respect.	96.77	88.24
Larger-bodied clients/patients can be difficult to deal with.	3.23	11.76
I often feel frustrated with clients/patients who are larger-bodied.	3.23	0.00
I feel that larger-bodied clients/patients are often non-compliant with treatment recommendations.	0.00	5.88
Perceived competence		
I feel professionally prepared to effectively treat larger-bodied clients/patients.	55.91	64.71
I feel confident that I provide quality care to larger-bodied clients/patients.	72.04	70.59

(Table Continued)

Item	% Student Endorsement	% Director Endorsement
Perceived acceptability of weight bias in field		
Other health providers in my field often have negative stereotypes toward larger-bodied clients/patients.	49.46	64.71
I have heard/witnessed other professionals in my field make negative comments about larger-bodied clients/patients.	41.94	47.06
My colleagues tend to have negative attitudes toward larger-bodied clients/patients.	10.75	5.88
Health care providers feel uncomfortable when caring for larger-bodied clients/patients.	35.48	17.65

Note. Percentages are representative of a subset of the sample consisting of 93 of the total 114 student participants and 17 of the total 21 director participants due to missing responses.

Exploratory Analyses

The researcher conducted exploratory descriptive analyses to examine participants' perceptions of the importance of training in topics of body image, integration of body image considerations in the culture of the program (i.e., terminology used to refer to larger-bodied individuals and encouragement of self-reflection pertaining to topics of body image), and student experiences in clinical practice. Regarding perceived importance of body image in graduate psychology training, the majority of student and faculty participants (62.96%) considered body image inclusion to be important ("somewhat important" or "important") with a minority of participants considering body image to be "not important" (5.93%). Additionally, nearly one-third of student and faculty participants (31.11%) considered body image training to be "very important"/"essential." When asked how well participants believe their program encourages and offers the awareness, knowledge, and skills needed to work effectively and competently with body image in practice, a minority of faculty participants (16.67%) reported that their program does this well ("well" or "exceptional").

Program Integration

When asked about terminology used to refer to larger bodies within their programs, the vast majority of the faculty and student sample (71.30%) reported that "overweight" is the term used to refer to larger bodies while the following terms were reported by the minority of the sample: "fat" (5.22%), "obese" (34.78%), "people of size" (7.83%), "larger-bodied" (18.26%), and "heavier/bigger" (0.87%). Additionally, 12.17%

of the sample reported that "bodies are not discussed at all" or there is no term used to refer to larger bodies within their program. Nearly half of student participants (49.48%) rated their program's encouragement of student's exploration of personal biases and assumptions of larger-bodied individuals to be poor ("not well at all"). The majority of students (58.76% and 61.86%, respectively) similarly rated their program's encouragement of self-reflection of personal size as a cultural identity and self-reflection of the impact of students' own body image on practice as poor ("not well at all").

Student Clinical Experience

Although most students (80%) reported having experience working with at least one client during their current program (in practica or on internship) who presented with concerns pertaining to body image in therapy, the majority of students estimated that the prevalence of body image concerns across their caseload was relatively small. When asked to estimate the number of clients with body image concerns whom students have seen in practica to date, the majority of student participants (67.27%) estimated 30% or fewer of the clients they have seen thus far have had or are currently experiencing body image-related concerns. Of the student participants who reported having experience working with clients presenting with body image concerns, the majority (55.81%) of the sample reported working with ≤ approximately 3 clients. One-fifth of the sample (20.93%) reported working with 10 or more clients with body image concerns.

When considering clients with whom they have worked while enrolled in their programs, the majority of students (67.27%) reported that they discuss body image with

10% or less of their clients. A minority of students (10.91%) reported discussing body image with 50% or more of their clients. The majority of student participants (58.18%) reported feeling comfortable (49.09% "somewhat comfortable" and 9.09% "very comfortable") broaching body image in session. However, approximately half of student participants (49.09%) reported feeling incompetent working with body image in session and only 9.09% of student participants felt above average competence addressing this topic in session. See Table 7 for an overview of forms of training received by student participants.

Table 7

Form of Body Image Training Received by Student Participants

Category	*n*	%
Internal		
Courses[a]	23	38.33
Multicultural	9	15.00
Practicum	13	21.67
Psychopathology	24	40.00
Practica	18	30.00
Conferences	2	3.33
Activism	3	5.00
Research	10	16.67
External		
Courses	6	10.00
Workshops	8	13.33
Conferences	11	18.33
Activism	8	13.33
Research	9	15.00

(Table Continued)

Category	*n*	%
No training	17	28.33

Note. Internal refers to training received within the student's current program while external refers to training received/sought outside the student's current program.
[a] Specific course endorsement exceed general course endorsement as participants were able to choose more than one course.

Qualitative Analysis

As a component of the training and education survey developed for the purposes of the study, the researcher asked the doctoral students about the following components of their training, education, and practice: their relationship with their own bodies; factors increasing and decreasing the likelihood that they would integrate considerations of body image into practice; recommendations they generally make for clients presenting with body image concerns; comments (e.g., compliments or critiques) they have heard pertaining to their bodies from clients, faculty members, or students within their program; and how bodies (e.g., weight, size, and ability status) are discussed within their programs by students, faculty members, and staff with an opportunity to provide examples. The researcher downloaded the responses from the online survey format into a de-identified Microsoft Excel document. Following a careful review and correction of responses to address any spelling errors that would have impeded analyses, the responses were subsequently analyzed using the Linguistic Inquiry and Word Count (LIWC; Pennebaker, Boyd, Jordan, & Blackburn, 2015) program, a computerized text analysis software.

The LIWC consists of a processing and dictionary component. The software processes each word in the text provided and, through comparison with the software

dictionary consisting of nearly 6,400 words, provides a 90-variable output analysis including linguistic dimensions (e.g., confidence and negations), grammatical considerations (e.g., use of quantifiers and comparisons), and psychological processes (e.g., use of positive and negative emotion words). The output analysis provides the percentages for inclusion of words from each category. For example, if a participant in the proposed study provided a 100-word response that included 3 affective process words (e.g., negative emotion, such as "hurt") and 5 cognitive process words (e.g., tentative, such as "maybe"), the output would reflect a 3% rating for affective processes and a 5% rating for cognitive processes. Due to the exploratory nature of the present study, all categories were included in the output with a specific focus on the categories outlined in Table 8 and Table 9.

Table 8

LIWC Text Analyses of Students' Body Image and Experiences of Body Discussion in Their Programs

Category	Description/ Examples	Personal *M (SD)*	Program I *M (SD)*	Program II *M (SD)*
Linguistic Dimensions				
Clout (Clout)	-	19.14 (24.35)	20.98 (33.50)	12.80 (26.19)
Prepositions (prep)	to, with, above	8.69 (8.97)	4.94 (7.82)	3.37 (5.70)
Common adverbs (adverb)	very, really	3.20 (4.50)	3.80 (7.69)	2.32 (5.91)
Conjunctions (conj)	and, but, whereas	5.03 (5.24)	2.14 (4.22)	2.33 (4.91)
Negations (negate)	no, not, never	2.45 (7.95)	2.96 (8.22)	8.14 (25.14)
Other Grammar				
Comparisons (compare)	greater, best, after	2.06 (4.12)	0.54 (1.60)	0.67 (2.25)
Quantifiers (quant)	few, many, much	2.93 (12.25)	0.86 (3.44)	0.45 (1.45)
Psychological Processes				
Affective processes (affect)	happy, cried	21.63 (31.87)	0.96 (2.31)	1.38 (2.98)
Positive emotion (posemo)	love, nice, sweet	18.81 (31.81)	0.67 (2.04)	0.88 (2.23)
Negative emotion (negemo)	hurt, ugly, nasty	2.69 (9.34)	0.24 (0.91)	0.48 (1.66)
Anxiety (anx)	worried, fearful	0.64 (2.60)	0.05 (0.32)	0.05 (0.35)
Anger (anger)	hate, kill, annoyed	0.94 (8.61)	0.03 (0.33)	0.11 (0.59)
Sadness (sad)	crying, grief, sad	0.17 (0.87)	0.09 (0.53)	0.25 (1.39)

(Table Continued)

Category	Description/ Examples	Personal *M (SD)*	Program I *M (SD)*	Program II *M (SD)*
Cognitive processes (cogproc)	cause, know, ought	15.74 (21.75)	7.16 (12.77)	4.81 (9.03)
Insight (insight)	think, know	3.95 (12.68)	0.97 (2.64)	0.94 (2.98)
Causation (cause)	because, effect	0.90 (1.93)	0.19 (0.79)	0.39 (1.56)
Discrepancy (discrep)	should, would	0.76 (1.69)	0.33 (1.48)	0.22 (1.19)
Tentative (tentat)	maybe, perhaps	3.01 (5.85)	1.61 (4.28)	1.08 (2.82)
Certainty (certain)	always, never	4.08 (16.89)	0.74 (2.76)	0.83 (4.54)
Differentiation (differ)	hasn't, but, else	3.64 (7.46)	3.74 (9.64)	1.85 (4.36)
Drives (drives)	-	12.55 (21.64)	2.88 (5.37)	2.27 (4.55)
Achievement (achieve)	win, success, better	2.97 (10.01)	0.45 (1.53)	0.41 (1.66)
Power (power)	superior, bully	1.28 (3.29)	1.20 (2.74)	1.08 (2.68)
Reward (reward)	take, prize, benefit	7.17 (19.96)	0.12 (0.68)	0.28 (1.10)
Risk (risk)	danger, doubt	0.70 (2.43)	0.23 (1.39)	0.11 (0.72)
Time orientations (TimeOrient)	-			
Past focus (focuspast)	ago, did, talked	1.37 (2.59)	1.12 (3.27)	2.43 (6.02)
Present focus (focuspresent)	today, is, now	8.07 (8.24)	4.82 (9.04)	3.21 (6.76)
Future focus (focusfuture)	may, will, soon	0.20 (0.63)	0.26 (1.44)	0.08 (0.43)
Informal language (informal)	-	2.45 (14.68)	0.08 (0.59)	0.51 (1.99)
Fillers (filler)	Imean, youknow	0.73 (8.54)	0.00 (0.00)	0.00 (0.00)

Note. Examples provided are from Pennebaker et al.'s (2015) Language Manual. For the purposes of this table, "Personal" refers to participants' descriptions of their relationships with their own bodies. "Program I" refers to participants' responses regarding how bodies (e.g., weight, size, and ability status) are discussed within their programs by students, faculty members, and staff while "Program II" refers to participants' responses to comments (e.g., compliments or critiques) participants may have heard pertaining to their bodies from clients, faculty members, or students within their program.

Table 9

LIWC Text Analyses of Student Integration of Body Image in Practice

Category	Description/ Examples	Factors I *M (SD)*	Factors II *M (SD)*	Treatment *M (SD)*
Linguistic Dimensions				
Clout (Clout)	-	4.48 (14.98)	14.22 (27.10)	19.57 (34.24)
Prepositions (prep)	to, with, above	2.99 (6.06)	4.21 (7.38)	3.33 (7.22)
Common adverbs (adverb)	very, really	0.79 (2.90)	1.24 (3.78)	0.71 (2.34)
Conjunctions (conj)	and, but, whereas	2.03 (4.79)	3.58 (6.68)	1.68 (4.22)
Negations (negate)	no, not, never	4.14 (13.05)	0.09 (0.59)	0.14 (0.88)
Other Grammar				
Comparisons (compare)	greater, best, after	0.47 (1.90)	0.69 (2.67)	0.54 (1.80)
Quantifiers (quant)	few, many, much	1.94 (12.37)	0.49 (1.73)	0.36 (1.39)
Psychological Processes				
Affective processes (affect)	happy, cried	0.68 (3.03)	0.82 (2.64)	2.61 (6.41)
Positive emotion (posemo)	love, nice, sweet	0.23 (1.62)	0.23 (1.23)	1.98 (5.17)
Negative emotion (negemo)	hurt, ugly, nasty	0.38 (2.42)	0.58 (2.33)	0.48 (2.20)
Anxiety (anx)	worried, fearful	0.06 (0.71)	0.23 (1.74)	0.12 (1.01)
Anger (anger)	hate, kill, annoyed	0.00 (0.00)	0.08 (0.72)	0.00 (0.00)
Sadness (sad)	crying, grief, sad	0.00 (0.00)	0.05 (0.44)	0.06 (0.54)

(Table Continued)

Category	Description/ Examples	Factors I *M (SD)*	Factors II *M (SD)*	Treatment *M (SD)*
Cognitive processes (cogproc)	cause, know, ought	4.59 (9.40)	4.30 (8.38)	4.03 (8.54)
Insight (insight)	think, know	0.64 (2.31)	0.63 (2.40)	1.93 (4.67)
Causation (cause)	because, effect	0.12 (0.76)	0.31 (1.38)	0.48 (1.83)
Discrepancy (discrep)	should, would	1.12 (3.41)	1.62 (4.37)	0.40 (1.75)
Tentative (tentat)	maybe, perhaps	1.33 (3.41)	2.46 (5.09)	0.51 (2.14)
Certainty (certain)	always, never	0.20 (1.23)	0.20 (1.07)	0.64 (2.86)
Differentiation (differ)	hasn't, but, else	2.90 (6.27)	2.39 (5.04)	0.59 (1.96)
Drives (drives)	-	2.35 (5.81)	2.79 (6.39)	2.95 (6.84)
Achievement (achieve)	win, success, better	0.11 (0.70)	0.29 (1.74)	1.38 (4.43)
Power (power)	superior, bully	1.04 (3.84)	1.40 (5.39)	0.29 (1.56)
Reward (reward)	take, prize, benefit	0.15 (1.44)	0.25 (1.61)	0.91 (3.12)
Risk (risk)	danger, doubt	1.00 (3.48)	0.87 (2.57)	0.19 (1.21)
Time orientations (TimeOrient)	-			
Past focus (focuspast)	ago, did, talked	0.10 (0.82)	0.27 (1.17)	0.69 (2.73)
Present focus (focuspresent)	today, is, now	3.24 (6.92)	1.91 (4.36)	1.05 (3.35)
Future focus (focusfuture)	may, will, soon	0.21 (1.13)	0.13 (1.17)	0.06 (0.49)
Informal language (informal)	-	0.02 (0.26)	0.18 (1.37)	0.00 (0.00)
Fillers (filler)	Imean, youknow	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)

Note. Examples provided are from Pennebaker et al.'s (2015) Language Manual. For the purposes of this table, "Factors I" refers to participants' descriptions of factors increasing the likelihood that they will incorporate body image considerations into practice while "Factors II" refers to participants' descriptions of factors decreasing the likelihood that they will incorporate body image considerations into practice. "Treatment" refers to participants' descriptions of treatment recommendations they commonly utilize when working with body image in practice.

Following the computerized text analysis, the researcher conducted content analyses in accordance with the recommendations of Patton (2015) to address limitations identified with the LIWC (e.g., consideration of context and viewing content thematically; Tausczik & Pennebaker, 2010). Participants were asked to characterize their relationships with their own bodies. Through a content analysis, responses were categorized as "positive" (e.g., "I have a very positive relationship with my body. Taking care of my body, feeling in-tune with my physical nature, and doing body-affirming self-care practices are very important to me."), "mixed" (e.g., "I have good and bad days"), or "negative" (e.g., "It is a struggle"). The sample was fairly evenly distributed with 29.57% of the sample reporting a generally positive relationship with their bodies, 41.74% reporting a mixed relationship, and 28.70% reporting a negative relationship.

The primary factor identified by most participants (82.98%) as influential in increasing the likelihood of incorporating body image considerations into practice was client identification of body image as a concern (e.g., "If a client brings it up"). Additional considerations included characteristics of disordered eating (36.17%), gender with students noting that they are more likely to incorporate body image as a consideration with women (12.77%), perception of clients as "overweight" or "underweight" (8.51% with 2.50% identifying perception of the client as "thin" as a factor decreasing their likelihood to incorporate body image into practice), and students' training/sense of expertise (6.38%). When identifying factors that decrease their likelihood of incorporating body image considerations into practice, 10% of the sample

explicitly identified insufficient training as impactful. When examining treatment recommendations commonly made by students while working with clients with body image-related presentations, 21.05% of the sample reported utilizing referrals (e.g., to an "appropriately trained professional," dieticians, physicians, eating disorder specialists, and nutritionists). Nearly a quarter of participants (23.68%) reported regularly including exercise and diet in treatment recommendations.

Regarding discussion of bodies within participants' programs, approximately half of participants (49.12%) reported receiving appearance-based compliments from others within their programs (clients, students, and professors). When examining how bodies are discussed within their programs (e.g., weight, size, ability status, etc.), most participants (76.27%) noted that bodies are either discussed "rarely" or not discussed at all within their programs (e.g., "it is an area that is largely avoided").

CHAPTER V

DISCUSSION

Summary of Findings

In the present investigation, the researcher sought to address limitations in the current body image literature through the development of a foundational understanding of the current state of body image training in clinical and counseling psychology doctoral programs. The present study represents the first known overview of doctoral-level curricula in APA-accredited and CPA-accredited programs in Canada and the U.S. related to body image topics. Several significant findings were observed. As predicted, participants were exposed to pathological topics pertaining to body image at a higher rate compared to positive and celebratory topics pertaining to body image. The topics participants reported most frequently being exposed to during their training generally related to pathology (e.g., disordered eating diagnoses), women (e.g., women and the thin ideal), referrals (e.g., to physicians, nutritionists, and/or dieticians), and media influence (i.e., the impact of media on body image development). By contrast, the topics least covered generally regarded health and mental health processes (e.g., body image and neurodegenerative disorders, disfigurement, and skin concerns) and positive considerations (e.g., positive theory as it applies to body image; measures of body acceptance, appreciation, and/or positivity; Health at Every Size research; and body appreciation). Additionally, contrary to the initial prediction, health and mental health

processes were covered more than size perception accuracy. Higher rates of inclusion of health and mental health processes may be attributable to the pathological focus most participants reported were more typically characteristic of their programs' curricula. As predicted, body image related to health processes was rarely included in participants' training. Pathological components of mental health processes (e.g., body image in relation to depression, anxiety, and disordered eating) were among the topics most commonly endorsed.

Although the remaining hypotheses were not significant, these lines of inquiry are novel and noteworthy as a foundation for further exploration. It is important to consider that the lack of statistical significance may be attributable to the small sample size in the current investigation. For instance, although the topic of size as a cultural variable was covered more in counseling than clinical psychology programs as predicted, this finding failed to reach statistical significance. Similarly, while a difference in inclusion of body image and size was evident with programs identifying with a Social Justice/Multicultural focus more than programs without this focus, the difference was not statistically significant. Additional exploration is warranted to determine if insignificance in these avenues of exploration may have occurred due to the small sample size.

Contrary to predictions, no relationship was evident between exposure to training and education or practitioner's own body esteem and perceptions of working with larger-bodied individuals. When completing self-report measures pertaining to socially sensitive questions, such as endorsement of personal biases, the risk of social desirability

bias increases, potentially obscuring results (King & Bruner, 2000). Accordingly, participants may have underreported weight bias, which may have resulted in the lack of observed relationship. Social desirability may help account for the discrepancy between participants' endorsement of items pertaining to weight bias among other practitioners and their self-reported bias, such that participants reported observing bias among other practitioners at notably higher rates than personal bias.

Integration with the Literature

The present study offers insight into the current state of doctoral-level training in topics of body image. Previous investigations are rare and have been limited to inferences based on site visits (McHugh & Kasardo, 2012), reviews of course syllabi (Pieterse et al., 2009), and reviews of undergraduate textbooks (Goodwin et al., 2003; Touster, 2000) or have focused exclusively on pathological topics (e.g., training in eating disorders; Worthington-White, 2001). The present study contributes to the existing literature through a review of the experiences of doctoral-level students who have also engaged in doctoral-level clinical practice from their perspectives. Additionally, in contrast to the evident focus on undergraduate and medical student samples in the existing literature, this study is the first known study to review this breadth of body image considerations among a counseling and clinical psychology graduate trainee and training director sample.

Although there is no known research reviewing inclusion of positive and celebratory body image topics in training, the finding that current training encompasses pathological topics at higher rates than celebratory topics is consistent with trends in the literature (Cash &

Pruzinsky, 2002). Similarly, body image has historically been oversimplified in research, theory, and practice to topics of women and the thin ideal, generally linked to topics of disordered eating. This oversimplification has occurred at the expense of the breadth of body image considerations and representation of diverse populations, most notably men and non-binary populations (Jones et al., 2016; Mishkind et al., 1986). The current findings demonstrated similar exclusion of the breadth of body image considerations across diverse populations in training and education. The underlying pathological lens through which body image is integrated, combined with practitioners' identification of body image work as an area of discomfort (Turner et al., 2014), may contribute to the prevalence of training and education in referrals to physicians, nutritionists, and/or dieticians.

Examinations of weight bias among graduate students have predominantly been confined to medical students (Miller et al., 2013; Puhl, Latner, et al., 2014; Wear et al., 2006). Findings in the current investigation revealed that participants' confidence in their ability to provide quality care to clients/patients of size was comparable to those observed in medical samples (Puhl, Latner, et al., 2014). However, participants in the current study endorsed less weight bias than in previous findings and were more likely to view working with larger-bodied clients/patients as professionally rewarding. While these findings support previous research indicating that weight bias may be less prevalent among graduate students in mental health compared to medical students (e.g., Young & Powell, 1985), the methodology in the present investigation did not provide an opportunity for examination of qualifiers regarding weight bias, which may have provided more insight into potential implicit biases.

Regarding the perceived acceptability of weight bias in the field, participants reported rates of prejudicial beliefs and comments that correspond with previous examinations of medical students (Wear et al., 2006). Interestingly, while endorsement of perceived acceptability of weight bias was generally lower in the present study compared to previous findings (across hearing/witnessing other professionals making negative comments, perceptions of discomfort among practitioners working with larger-bodied patients/clients, and perceptions of negative attitudes among colleagues; Puhl, Latner, et al., 2014), endorsement of practitioners within the field holding negative stereotypes of larger-bodied patients/clients was distinctly higher in the current investigation. Consistent with previous findings, both student and faculty participants endorsed bias within the field at notably higher rates than personal bias (Puhl, Latner, et al., 2014). As Puhl, Latner, and colleagues (2014) noted, higher endorsement of bias within the field may be due in part to social desirability bias in responses.

Implications for Theory

Across the domains of theory, practice, research, and training, the researcher joins with the pioneering efforts in the body positivity literature to advocate for a paradigm shift from a pathological view of body image to a focus on fostering body positivity with an appreciation and celebration of body diversity as a cultural variable (Abakoui & Simmons, 2010; Bergen & Mollen, in press; Touster, 2000). Sociocultural theory is among the leading approaches to understanding body image and has made substantial contributions to the discourse regarding social and cultural influences on the development

of negative body image and the perpetuation of the thin and muscular ideals (Cash & Smolak, 2011). However, through advancements in the field's understanding of body image, researchers are continuously challenging predominant theoretical approaches to body image to encompass a broader definition of body image across more diverse and representative populations (Cash & Smolak, 2011).

Furthermore, existing theories offer significant implications for positive approaches to body image. For example, in an examination of the relationship between how bodies are discussed within families and the development of positive body image, Webb, Rogers, Etzel, and Padro (2018) provided an illustration of how sociocultural theory can be applied not only to the identification of risk factors for the development of negative body image, but also to the identification of protective factors for the development of positive body image. Similarly, researchers are in the nascent stages of applying diverse theories to fostering body positivity including Cognitive-Behavioral Theory (CBT; e.g., Cassone, Lewis, & Crisp, 2016), Positive Psychology (Tylka, 2011), Acceptance and Commitment Theory (ACT; e.g., Smith, 2018), and Relational-Cultural Theory (RCT; e.g., Trepal, Boie, & Kress, 2012).

Although the most commonly used approaches to body image within the field of psychology aid in case conceptualization and treatment planning with a focus on the client (e.g., Sociocultural and Cognitive-Behavioral theories, Cash & Smolak, 2011), the integral relationship between the client and practitioner with a consideration of practitioner variables is largely overlooked or underutilized. Practitioners' relationships

with their own bodies, values, and potential biases often go unexamined. In a growing body of literature, researchers have explored the contributions of RCT to fostering body positivity, which, with a consideration of the present findings, offers promising areas for future examination through the inclusion of clinician factors.

An essential component of RCT, mutuality, refers to a shared vulnerability, authenticity, and openness to being impacted within the therapeutic alliance (Miller & Stiver, 1997). Saftner, Ryan, and Pierce (2009) found that mutuality is predictive of body satisfaction, such that low mutuality in relationships is linked to body dissatisfaction. This is particularly important when considering researchers' identification of the therapeutic alliance as a model for the development of external relationships (Trepal et al., 2012). In a review of the Health at Every Size movement, Brady, Gingras, and Aphramor (2013) advocated for inclusion of core tenets of relational-cultural approaches, suggesting that mutuality shifts from viewing the client as "the other" to viewing the client as a "person-in-relation" (p. 351). Furthermore, relational-cultural approaches to psychotherapy foster mutual growth, encouraging practitioners to engage in self-reflection regarding their own values with food, eating, and bodies (Brady et al., 2013). In an examination of RCT applied to the prevention of disordered eating, Trepal and colleagues provided an outline applicable to fostering body positivity consisting of psychoeducation (e.g., pertaining to media literacy and societal influences), encouraging body positivity while integrating cultural identities, and promoting counterdialogue to challenge harmful cultural narratives (Trepal et al., 2012).

Conceptualizing body image as a cultural variable creates new avenues for theoretical exploration through which many of the concepts applied to other aspects of diversity can strengthen theory and practice pertaining to the construct of body image. For the purposes of the present discussion, the researcher has drawn from the literature examining cultural differences in psychotherapy pertaining to race and ethnicity as no known research has empirically examined the impact of practitioners' body image on body image work with clients; commonalities between symbolic racism and sizeism have been previously identified (e.g., Crandall, 1994). It is important to note that historically, race and ethnicity were among the first cultural variables critically examined within the field and as such, they have provided the framework for subsequent applications (e.g., Sue et al., 1992).

As Cash and Smolak (2011) recommended, a more comprehensive and holistic approach to the field's understanding of body image requires an integration across the contributions of prominent theories, such as Sociocultural, Evolutionary, Feminist, Positive, and Cognitive-Behavioral theories. The slow movement toward a paradigm shift evident in the work of a minority of researchers has been founded in positive and feminist theories (Murnen & Seabrook, 2012; Tylka, 2011; Tylka & Wood-Barcalow, 2015; Worrell, 2001). The contributions of these theories (e.g., systemic considerations, the phenomena of objectification and self-objectification, and positive body image as a unique construct requiring additional research; Cash & Smolak, 2011) in conjunction with RCT's essential inclusion of clinician variables can help address current theoretical

limitations and provide clients with what Gaztambide (2012) deemed a "corrective *cultural* experience" (p. 186, emphasis in original), an approach that has been found to be more effective than approaches lacking integration of cultural considerations (Benish, Quintana, & Wampold, 2011). With consideration of the widespread stigmatizing of diverse bodies and accompanying experience of body shame, researchers have examined positive and affirming approaches to body image in practice as having the potential to be influential corrective cultural experiences (Sanftner & Tantillo, 2011). Proponents of RCT emphasize that new experiences within relationships, such as the therapeutic alliance, can expand relational frameworks to challenge controlling cultural images (e.g., that clients must adhere to societal ideals of beauty to be worthy of investment; Trepal et al., 2012).

Implications for Practice

The findings of the current study offer several implications for practice. In particular, results have implications for multiculturally competent practice. Multicultural counseling competence consists of self-awareness regarding personal biases and limitations, knowledge pertaining to multicultural considerations, and the ability to apply evidence-based skills when working with diverse populations (Pederson, 1997; Sue et al., 1992). In addition to the need for incorporation of clinician variables in theoretical conceptualizations including an awareness of personal biases, values, and areas for growth, findings indicate implications for the areas of knowledge and skills as well.

First, clinician variables related to topics of body image may be overlooked in training and education and as a result subsequently, in practice. Researchers have found robust empirical support for the integral role of the therapeutic alliance as the foundation for efficacious treatment (Horvath, Del Re, Fluckiger, & Symonds, 2011), such that weak alliances predict attrition (Sharf, Primavera, & Diener, 2010) and clinician bias, specifically in the form of weight bias, predicts client diagnosis and prognosis (Abakoui, 1998; Agell & Rothblum, 1991; Davis, 1998; Davis-Coelho et al., 2000; Young & Powell, 1985). Despite robust support for the importance of the therapeutic alliance, specifically in the treatment of larger-bodied clients, the majority of trainees in the current study reported that self-reflection in topics of body image was not sufficiently encouraged in their training. Additionally, only a minority of trainees in the current study expressed having a positive relationship with their own bodies and trainees as well as directors endorsed areas of weight bias in practice. Trainees' limited exposure to training and education encouraging self-reflection is particularly concerning as researchers have identified the impactful role of self-awareness in effective practice (Knapp, Gottlieb, & Handelsman, 2017).

Recently, there has been a shift toward cultural humility in practice with a recognition that the traditionally endorsed tripartite model of multicultural competence (awareness, knowledge, and skills) poses notable limitations (e.g., possibility for harmful generalizations and restraints in application to intersectionality; Mosher et al., 2017). Cultural humility consists of (1) self-reflection pertaining to one's worldview and cultural

identities, (2) engaging with clients as a "curious learner" in topics of clients' experiences as a cultural being, (3) seeking to foster relationships characterized by respect and collaboration, and (4) being open to the lifelong nature of growth (Mosher et al., 2017, p. 230). Congruent with relational-cultural implications for theory, proponents of a cultural humility approach argue for its invaluable inclusion of clinician factors with an emphasis on "ways of *being with* clients" (Mosher et al., 2017, p. 222, emphasis in original). Incorporating cultural humility in practice is especially applicable considering the present findings as this approach emphasizes self-reflection pertaining to personal values and fosters practitioners' comfort and confidence in integrating these considerations in practice (Mosher et al., 2017). Employing a cultural humility approach, Davis and colleagues (2018) offered recommendations for the integration of cultural considerations throughout the therapeutic process from explicit conversations orienting clients to the therapeutic process as a cultural experience at intake to inviting clients to be a collaborative and empowered agent in the treatment planning process.

Second, findings suggest that doctoral-level trainees may underestimate the prevalence of body image concerns and as a result, their relevance to clinical presentations and the therapeutic process. In addition to identifying client initiation as influential in trainees' decisions to integrate body image considerations in practice, several student participants added that this initiation must be marked by an acknowledgement that body image is problematic for the client, a clear connection to the presenting concerns of the client, and that the trainee is particularly attuned to these

indications during the intake; however, students suggested that they may be less attuned to these considerations following the intake. Most student participants in the current study estimated that 30% or less of the clients they have worked with were experiencing body image-related concerns at the time they were seen or had experienced body image-related concerns previously. However, robust findings have largely supported the prevalence of body dissatisfaction across clinical and non-clinical samples with most individuals experiencing some degree of body dissatisfaction (Bedford & Johnson, 2006; Fiske et al., 2014; Garner, 1997; Hurd, 2000).

More than 30 years ago, Rodin and colleagues' (1985) proposal that the phenomenon of body dissatisfaction is "normative" remains relevant; however, it has expanded beyond the researchers' original focus on women to broader aspects of body image and more diverse populations (p. 267). Beyond body dissatisfaction among women, researchers have found that body image concerns are relevant in consideration of phase of life (e.g., Halliwell & Dittmar, 2003), medical presentations (e.g., oncology populations; Burg, 2016), across intersecting identities (e.g., social class and size; Swami, 2015), and as a potential protective factor (e.g., race and the development of disordered eating; Capodilupo & Kim, 2014). Notably, however, in a recent examination of body dissatisfaction research, Karazsia, Murnen, and Tylka (2017) found novel evidence suggesting that body dissatisfaction, although prevalent, varies across diversity variables, components of body dissatisfaction, and time. Examining hundreds of studies that captured data of thousands of participants over 3 decades, Karazsia and colleagues (2017)

identified a relationship among time, gender, and body dissatisfaction, such that girls and women continue to demonstrate higher levels of body dissatisfaction compared to boys and men; however, this dissatisfaction lessened over time for girls and women. Additionally, boys and men demonstrated more body dissatisfaction than girls and women when examining muscularity-related dissatisfaction (Karazsia et al., 2017). While results regarding girls' and women's decreased body dissatisfaction over time is encouraging, additional research is needed to further investigate body dissatisfaction trends over time with a consideration of diverse samples and components.

Underestimation of significance may result in decreased intervention, as may be evident in trainees' reports that most reported discussing body image with 10% or less of their clients. This is particularly significant when considering student participants identified client initiation of body image discussions (in the form of identifying body image as problematic or related to their presenting concern) as the primary factor determining whether they addressed body image in their practice. Researchers have found that clinician initiation, especially pertaining to sensitive topics, such as sex (e.g., Cruz, Greenwald, & Sandil, 2017), is essential to ethical and comprehensive practice.

Although most student participants expressed feeling comfortable broaching the topic of body image in session, nearly half of the participants in the current study reported feeling some degree of incompetence pertaining to their ability to work with body image in practice. According to previous findings that medical and mental health practitioners tend to overestimate competence (Knapp et al., 2017), it is possible that

trainee competence is even lower than reported. This finding is analogous with previous research identifying practitioners' lack of comfort with body image work as a primary impediment for practitioners' use of evidenced-based approaches to disordered eating behaviors (Turner et al., 2014). Lack of perceived competence may be impactful in clinician initiation of body image discussions in practice.

Third, when topics related to body image are broached in session, it is important not only to reflect on underlying values (e.g., pathological perspectives versus positive perspectives), but also to seek to utilize interventions grounded in current literature. When examining treatment recommendations commonly made by participants while working with clients with body image-related presentations, a sizeable minority of participants reported regularly including exercise and diet in treatment recommendations. Despite evidence suggesting that these recommendations are linked to detrimental physical and mental health outcomes (see McFarlane et al., 1999, for a review) and considerations regarding scope of practice (e.g., awareness of limitations of competence and the benefits of interprofessional collaboration), exercise and dieting remain the gold standard for treatment recommendations when working with larger-bodied individuals (Mann et al., 2007). A shift toward positive and growth-fostering approaches to body image entails replacing harmful practices with affirmative interventions. Piran (2015) recommended an alternative approach to body image that emphasizes positive embodiment through the encouragement of positive ways of clients experiencing their bodies. Winter (2016) found a relationship between negative self-objectification,

specifically among women, and body dissatisfaction and shame. Based on her findings, Winter (2016) identified self-objectification as an intervention point in the development of positive body image in practice, such that clinicians, through the incorporation of relational-cultural strategies, can foster positive embodiment. Embodiment has been linked to promising findings in efficacious treatment approaches to maladaptive self-body perceptions and mental representations (e.g., Muller-Pinget et al., 2012).

Fourth, as is the case across other identity variables, practice can be strengthened through an examination of body image considerations within a multicultural framework. In the present study, participants' biases impacted consideration of body image in treatment planning with students expressing a decreased likelihood of discussing body image with men and clients they perceive as thin. As most of the sample reported having a negative or mixed relationship with their own bodies, it is important to consider how these factors impact practice and the therapeutic alliance. Sue (2006) provided the following examples of questions clinicians can utilize to further develop self-awareness as an integral component in multicultural competence, most notably when the values or identities of the clinician differ from those of their client:

> Why am I uncomfortable with this client at this time? Is the client doing something that I don't understand or value? What kinds of cultural differences are being portrayed? How can I use the discomfort to understand myself and the client as well as to more effectively help the client? (p. 243)

Through their research contributing to recent advances in the field's understanding of cultural humility, Davis and colleagues (2018) offered additional recommendations for addressing value conflicts in practice such as identifying the essence of the value conflict (e.g., salient cultural identities of the practitioner and the potential role of morality), seeking consultation and supervision with colleagues from both comparable and differing identities/worldviews, and determining if it is clinically indicated to discuss the conflict with the client.

Lastly, conceptualizing body image as a cultural variable necessitates the development of comprehensive and affirmative guidelines for practice. While some components of body image are incorporated across existing practice guidelines (e.g., *Guidelines for Practice with Transgender and Gender Nonconforming People*; APA, 2015), pathologizing and harmful guidelines continue to be developed (e.g., *Clinical Practice Guideline for the Behavioral Treatment of Obesity and Overweight in Children and Adolescents*; APA, 2017a) and no comprehensive and affirmative guidelines for addressing the breadth of body image considerations in practice have been proposed. The *Guidelines for Practice with Girls and Women* (APA, 2007) provide an example of the progression evident within the field while simultaneously highlighting the need for further expansion of practice considerations. In these guidelines, the APA recognizes body size as a social identity to be considered in practice with girls and women and explicitly encourages practitioners to integrate interventions that foster positive body image as a protective factor. While this recognition and integration has yet to be fully

realized, other facets of body image remain excluded and interestingly, the concept of body image is not explicitly addressed in the proposed *Guidelines for Psychological Practice with Boys and Men* (APA, 2016b). As guidelines and standards serve to set the framework for research, theory, practice, and training for professionals within the field of psychology, the need for the development of guidelines representative of the clinical populations with which practitioners are working is vital to shifting the existing paradigm.

Implications for Research

The exploratory nature of the current study offers many avenues for further research. As Cash and Pruzinsky (2002) noted, misuse of body image terminology and oversimplification of the inherently complex construct of body image have resulted in a fragmented body of literature that is difficult to view holistically. As a result, future researchers should seek first to develop the field's understanding of the construct of body image with an awareness of cultural considerations, the breadth of the components of body image, and existing theory. An essential aspect in broadening the field's understanding of body image requires replication of existing findings across diverse samples pertaining to gender identity, ability status, medical presentations, and age as these considerations have largely been overlooked with a historical focus on White, able-bodied women and girls (Cash & Smolak, 2011).

A broader definition of body image also requires the development of new measures to assess constructs such as bias and affirmative approaches to practice. While

measures assessing specific forms of bias involving aspects of body image including sizeist and ableist perspectives are in the early stages of development (e.g., measures of the experience of receiving ableist microaggressions; Conover, Israel, & Nylund-Gibson, 2017), there is no known measure of a comprehensive assessment of potential bias across multiple aspects of body image. Similarly, although there are measures assessing affirmative approaches to work with diverse populations (e.g., the Gay Affirmative Practice Scale [GAP]; Crisp, 2006), no known measure assesses affirmative practice with clients with diverse body image considerations.

With consideration of the potential influence of social desirability bias, future researchers should seek to include measures of implicit (e.g., the Simple Implicit Procedure; O'Shea, Watson, & Brown, 2016) and explicit bias. Through a qualitative investigation, Adams (2008) found that although no explicit weight bias was evident, practitioners expressed implicit weight bias through the use of qualifiers, particularly pertaining to conditions of client success and willingness to work with clients. In an examination of implicit weight bias among Asian women, researchers replicated this finding of implicit bias in the absence of explicit bias and demonstrated the role of implicit bias in predicting behavioral intention (e.g., discriminatory behaviors toward larger-bodied individuals; Jiang, Tan, & Fassnacht, 2017). Jiang and colleagues (2017) suggested that future researchers should integrate cultural considerations in explorations of implicit biases (e.g., the socially acceptability of expressing bias). Additionally, as implicit bias has been found to increase in response to stereotypical portrayals of larger-

bodied individuals (Carels et al., 2013; Hinman, Burmeister, Kiefner, Borushok, & Carels, 2015), future researchers should examine the potential relationship between portrayals of larger-bodied individuals in training and education and implicit biases among trainees. Recently, researchers have identified a decline in weight bias among medical students over the course of the first 2 years of their training, which the researchers attributed to decreased implicit biases (Baker et al., 2017). Future researchers should examine factors contributing to decreased bias in medical school training and explore the applicability of these findings to graduate psychology students as they may offer fruitful implications for training and education.

Additional research is also needed to determine if the findings evident in the present study can be replicated across a larger sample of graduate students and training directors. Similarly, while researchers have begun to examine the role of clinician variables in body image practice (e.g., Carrizales, 2015), this body of literature remains scarce. Accordingly, findings regarding practitioner comfort, perceived competence, and factors impacting inclusion of body image considerations should be investigated in samples of practicing clinicians to determine if these trends extend beyond clinicians in training. While the present investigation is the first known exploration of these factors, analyses were limited by the small sample size. Accordingly, future researchers studying larger samples may be better equipped to speak to possible differences across region, specialty, and position (e.g., training directors compared to doctoral students). Furthermore, future researchers may want to study students' and practitioners' dominant

theoretical orientation to allow for exploration of potential relationships between theory and weight bias as the current investigation was limited in providing participants with the option to select multiple theories which prohibited conducting this analysis.

Implications for Training

The findings of this study provide several implications for training. Although the majority of student and training director participants identified body image training to be important, only a minority of participants considered their programs' coverage of the awareness, knowledge, and skills to work effectively and competently with body image in practice to be "well" or "exceptional." This finding is particularly significant considering 1 out of every 10 trainee participants explicitly identified insufficient training as decreasing their likelihood to incorporate body image considerations in practice.

The most common avenue for training in topics of body image was through courses offered in participants' current programs and practica with internal psychopathology courses the most widely endorsed form. Participants expressed more exposure to pathological topics in training and education compared to positive and celebratory topics. Accredited programs are expected to consist of education and training that is "based on the existing and evolving body of general knowledge and methods in the science and practice of psychology" (APA, 2015, p. 4). Furthermore, education has been identified as one of the primary mediums through which multicultural competence can be fostered across a myriad of diversity variables including size (Brownell & Rodin, 1994). The findings of the current study suggest

that evidence-based approaches and considerations relevant to some aspects of the populations with whom clinicians work remain largely excluded from trainees' experience.

The absence of positive and celebratory approaches to body image and representation of diverse body image considerations may result in harmful biases in practice. For example, participants identified gender as influential in determining whether they discuss body image in session with some participants endorsing that they would be less likely to explore body image with men. Consistent with the exclusion of men and boys from body image literature based on the belief that men and boys do not experience body image concerns (see Burlew & Shurts, 2013 for a review), findings indicate that trainers and educators may focus on body image pertaining to women (e.g., women and the thin ideal) at higher rates than body image as it pertains to men (e.g., men and muscularity). Exposure to the relevance of topics, such as body image, across diverse populations may be impactful in trainees' consideration of these factors in clinical work.

In addition to implications for training and education provided through formal curriculum, findings revealed implications for graduate programs as training environments as well. Despite researchers' recognition of terminology as influential in perpetuating pathologizing perspectives (Abakoui & Simmons, 2010), most of the sample identified "overweight" as the most common term used to refer to larger bodies within their programs. Furthermore, when examining how bodies are discussed within programs (e.g., weight, size, ability status, etc.), the vast majority of trainees reported that bodies are either discussed "rarely" or not at all with some participants identifying what they

perceived to be an "avoidance" of the topic. By contrast, approximately half of participants reported receiving appearance-based compliments from others within their programs (clients, students, and professors). Findings suggest that a paradox may exist in which bodies are discussed more frequently in the form of appearance-based compliments than within educational curriculum or as an intentional opportunity for modeling affirmative perspectives. The finding that appearance-based compliments were experienced by nearly half of the sample is noteworthy, particularly with a consideration of researchers who have identified the detrimental effects of appearance-based compliments related to self-objectification, body satisfaction, and body surveillance (Calogero, Herbozo, & Thompson, 2009).

Most trainees identified their program's encouragement of self-reflection pertaining to the influential role of their own body image in practice to be poor. While trainees identified encouragement of self-reflection across other body image considerations to be poor as well, personal body image is noteworthy as only one-third of the sample expressed having a positive relationship with their own bodies. Researchers have identified clinician's own body image and particularly potential body shame as an important area for self-reflection when working with body image in practice, noting that clinicians may communicate discomfort with the topic nonverbally (Carrizales, 2015; Sanftner & Tantillo, 2011). In the case of the present findings, this discomfort may also be communicated by avoidance of the topic in session unless posed by clients with most of the sample identifying client initiation of topics of body image as essential in their

inclusion of these considerations in practice. Additionally, researchers identified clinician body positivity as an impactful factor contributing to the development of client body positivity (e.g., through modeling of comfort with one's own body and discussions of body image; Sanftner & Tantillo, 2011). In conjunction with previous findings, results from the current investigation suggest that developing approaches to training and education that foster trainee self-awareness pertaining to topics of body image (i.e., personal values, biases, and relationships with their own bodies) may be warranted.

Regarding practice as a component of doctoral-level training, the significance of the topic of body image is evident with most students reporting working with at least one client who presented with concerns pertaining to body image in therapy. However, as outlined in the implications for practice, half of students feel incompetent working with body image in session and many may underestimate the prevalence of these concerns across their caseloads. The findings of this study support previous findings indicating that body image considerations continue to be predominantly excluded from discourse, particularly of cultural variables and multicultural practice (Bergen & Mollen, in press), which may be to the detriment of trainees' competence.

Strengths

With an exploratory focus, the greatest strength of the present investigation is its contribution to a scarce body of literature, offering yet another voice advocating for affirmative and growth-fostering practice. The current study is the first known investigation of graduate psychology training and education in topics of body image

across the breadth of topics included from the perspectives of graduate students as well as training directors in APA- and CPA-accredited programs. The mixed-method approach of the current study serves as another strength, providing student participants with the opportunity to share their unique experiences and perceptions pertaining not only to clinical practice and training, but also to their relationships with their own bodies. Prior to the current investigation, literature examining graduate education in psychology in topics of body image was scarce (e.g., McHugh & Kasardo, 2012; Pieterse et al., 2009) with most limited to examinations of undergraduate textbook and syllabi content (e.g., Goodwin et al., 2003; Touster, 2000). The present study offers novel contributions across a range of graduate-level training and education within the field of psychology (e.g., internal and external practicum, workshops, and conferences).

Additionally, the current study offers one of the first known applications and discussions of the Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS; Brown et al., 1990) beyond the traditional gender binary (see also Testa, Rider, Haug, Balsam, & Freedland, 2017; van de Grift et al., 2016b). Although the sample predominantly consisted of White, heterosexual, able-bodied women, notable diversity was evident across race/ethnicity, sexual orientation, gender, and ability status. The present investigation provides a framework for future examinations across a broader range of aspects of body image and including a more diverse sample.

Limitations

Although the current investigation offers novel contributions to the existing literature and provides a foundation upon which future research can be developed, numerous limitations are noteworthy and should be considered when evaluating the generalizability of these findings. First, the sample size for the present study was relatively small (N = 135) with a particularly low representation of training directors as well as students. Accordingly, caution should be taken in the interpretation of the study's findings.

Inherent to the sampling process, which included intermediaries in the form of training directors, the researcher is unable to calculate the total number of students solicited, preventing the calculation of a response rate. Furthermore, ensuring the confidentiality of training directors prohibited the researcher's ability to examine program representation. As a result, it is feasible that multiple training director and/or student participants may have responded from one program, limiting the ability to know whether the reported data capture discrete or overlapping programmatic information. Future research should seek to address these limitations and to provide a more representative overview of doctoral training within the U.S. and Canada.

Secondly, the present investigation is limited by participants' completion of the incorrect form of the survey (i.e., student participants completing the director form). Although several components were consistent across the student and training director forms, completion of the incorrect form resulted in the missing data evident across

multiple scales and eliminated the opportunity for those student participants to complete the qualitative portion of the survey. Additionally, the low reliability as assessed by Cronbach's alpha on the Overweight Preoccupation subscale of the MSBRQ-AS is a limitation; accordingly, results from the analyses using the subscale should be interpreted with caution.

Finally, as noted previously, social desirability may have impacted participant responses, as is characteristic of self-report measures assessing socially sensitive topics (King & Bruner, 2000). The potential impact of social desirability is of particular importance when considering participant endorsement of weight bias. In spite of the relative lack of reported weight bias in the current sample, it is possible that weight bias among graduate trainees and training directors occurs at rates similar to those previously reported (Adams, 2008; Jackson, 2014; Puhl, Latner, et al., 2014). Future researchers may improve upon the current investigation with an incorporation of a social desirability measure to address this limitation (van de Mortel, 2008).

Conclusion

Although most trainees and training directors report considering inclusion of topics of body image in graduate training to be important, body image training continues to be limited in nature. Most trainees experience their program's encouragement of self-reflection in topics of body image to be poor. Resembling trends in the history of body image literature, trainees report exposure to training and education in pathological topics of body image at higher rates than positive and celebratory topics. Participants reported

receiving limited training in topics of body image related to health processes, and low rates of incorporating body image considerations into their clinical work. Although the majority of trainees feel comfortable broaching the topic of body image in session, half of trainees reported feeling incompetent working with this topic in therapy. This finding suggests that trainee discomfort may not be the result of an inherent sensitivity to the topic of body image, but rather a discomfort with their own ability to work with the topic effectively in practice. Additionally, the leading predictor of trainee incorporation of body image in practice is client identification of body image which is problematic as it relies on clients to initiate sensitive discussions about size which may be arduous given pervasive negative attitudes toward people of size in the U.S. Beyond providing a foundation for further exploration in doctoral-level training in topics of body image, the researcher hopes the present study will serve as a springboard for advocating a more holistic and growth-fostering approach to body image. Further research is needed to examine psychologists' competence in topics of body image and develop guidelines and measurements for affirmative practice across the range of body diversity.

REFERENCES

Abakoui, R. A. (1998). *Effects of weight status and gender on psychologists' diagnosis and treatment planning* (Unpublished doctoral dissertation). University of North Texas, Denton, TX.

Abakoui, R., & Simmons, R. E. (2010). Sizeism: An unrecognized prejudice. In J. E. Cornish, B. A. Schreier, L. I. Nadkarni, L. H. Metzger, & E. R. Rodolfa (Eds.), *Handbook of multicultural counseling competencies* (pp. 317-349). Hoboken, NJ: John Wiley & Sons Inc.

Adams, L. G. (2008). *Weight bias among counselors-in-training: A qualitative inquiry* (Unpublished doctoral dissertation). Auburn University, Auburn, AL.

Agell, G., & Rothblum, E. D. (1991). Effects of clients' obesity and gender on the therapy judgments of psychologists. *Professional Psychology: Research and Practice, 22,* 223-229. doi: 10.1037/0735.7028.22.3.223

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

American Psychological Association. (2007). *Guidelines for Psychological Practice with Girls and Women*. Retrieved from http://www.apa.org/practice/guidelines/girls-and-women.aspx

American Psychological Association. (2009). *APA resolution on promotion of healthy active lifestyles and prevention of obesity and unhealthy weight control behaviors in children and youth.* Retrieved from http://www.apa.org/about/policy/chapter-12b.aspx#active-lifestyle

American Psychological Association. (2015). *Standards of accreditation for health service psychology.* Retrieved from https://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

American Psychological Association. (2016a). *Ethical principles of psychologists and code of conduct.* Retrieved from https://www.apa.org/ethics/code/ethics-code-2017.pdf

American Psychological Association. (2016b). *Proposed Guidelines for Psychological Practice with Boys and Men: Call for Comments.* Retrieved from http://division51.net/homepage-slider/proposed-guidelines-for-psychological-practice-with-boys-and-men-call-for-comments/

American Psychological Association. (2017a). *Clinical practice guideline for the behavioral treatment of obesity and overweight in children and adolescents.* Retrieved from http://apacustomout.apa.org/commentPracGuidelines/Practice/Full%20Obesity%20Guideline%20Draft%20comment%20version.pdf

American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality.* Retrieved from http://www.apa.org/about/policy/multicultural-guidelines.PDF

American Psychological Association. (2017c). *Seeking comments on draft APA clinical practice guideline for the behavioral treatment of obesity and overweight in children and adolescents.* Retrieved from http://apacustomout.apa.org/commentPracGuidelines/Comment.aspx?siteCode=3

American Psychological Association. (2018). *Database of APA-Accredited psychology programs.* Retrieved from http://www.apa.org/ed/accreditation/programs/using-database.aspx

Amy, N. K., Aalborg, A., Lyons, P., & Keranen, L. (2006). Barriers to routine gynecological cancer screening for White and African American obese women. *International Journal of Obesity, 30,* 147-155. doi:10.1038/sj.ijo.0803105

Andre, J. (1994). Respect for bodies. In M. G. Winkler & L. B. Cole (Eds.), *The good body: Asceticism in contemporary culture* (pp. 9-22). New Haven, CT: Yale University Press.

Argyrides, M., & Kkeli, N. (2013). Multidimensional body-self relations questionnaire-appearance scales: Psychometric properties of the Greek version. *Psychological Reports, 113,* 885-897. doi: 10.2466/03.07.PR0.113x29z6

Aronson, D. (1997). No laughing matter: Young people who are overweight can face a lifetime of discrimination. *Teaching Tolerance, 6*(2), 21-23. Retrieved from https://www.tolerance.org/magazine/fall-2004/no-laughing-matter

Avalos, L., Tylka, T. L., & Wood-Barcalow, N. (2005). The Body Appreciation Scale: Development and psychometric evaluation. *Body Image, 2,* 285-297. doi: 10.1016/j.bodyim.2005.06.002

Bacon, L. (2010). *Health at every size.* Dallas, TX: BenBella Books, Inc.

Baker, T. K., Smith, G. S., Jacobs, N. N., Houmanfar, R., Tolles, R., Kuhls, D., & Piasecki, M. (2017). A deeper look at implicit weight bias in medical students. *Advances in Health Sciences Education, 22,* 889-900. doi: 10.1007/s10459-016-9718-1

Bedford, J. L., & Johnson, C. S. (2006). Societal influences on body image dissatisfaction in younger and older women. *Journal of Women & Aging, 18*(1), 41-55. doi:10.1300/J074v18n01_04

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct comparison meta-analysis. *Journal of Counseling Psychology, 58,* 279-289. doi: 10.1037/a0023626

Bergen, M.F., & Mollen, D. (2012, August). Attitudes toward menopause and self-objectification in midlife and beyond. Poster presented at the 120th annual meeting of the American Psychological Association. Orlando, FL.

Bergen, M., & Mollen, D. (2017, in press). Teaching sizeism: Integrating size into multicultural education and clinical training. *Women & Therapy.*

Brady, J., Gingras, J., & Aphramor, L. (2013). Theorizing health at every size as a relational-cultural endeavor. *Critical Public Health, 23*, 345-355. doi: 10.1080/09581596.2013.797565

Brems, C., & Johnson, M. E. (1996). Comparison of Ph.D. programs in clinical and counseling psychology. *Journal of Psychology, 130,* 485-498. doi: 10.1080/00223980.1996.9915016

Brown, T. A., Cash, T. F., & Mikulka, P. J. (1990). Attitudinal body image assessment: Factor analysis of the body-self relations questionnaire. *Journal of Personality Assessment, 55,* 135–144. doi: 10.1080/00223891.1990.9674053

Brownell, K., & Rodin, J. (1994). The dieting maelstrom: Is it possible and advisable to lose weight? *The American Psychologist, 49,* 781-791. doi: 10.1037/0003-066X.49.9.781

Burg, A. J. (2016). Body image and the female adolescent oncology patient. *Journal of Pediatric Oncology Nursing, 33*(1), 18-24. doi: 10.1177/1043454214563759

Burlew, L. D., & Shurts, W. M. (2013). Men and body image: Current issues and counseling implications. *Journal of Counseling & Development, 91,* 428-435. doi: 10.1002/j.1556-6676.2013.00114.x

Calogero, R.M., Herbozo, S., & Thompson, J.K. (2009). Complimentary weightism: The potential costs of appearance-related commentary for women's self-objectification. *Psychology of Women Quarterly, 33,* 120-132. doi: 10.1111/j.1471-6402.2008.01479.x

Caplan, P. J. (2011). Should obesity be called a mental illness? *Psychology Today,* Retrieved from https://www.psychologytoday.com/blog/science-isnt-golden/201105/should-obesity-be-called-mental-illness

Capodilupo, C. M., & Kim, S. (2014). Gender *and* race matter: The importance of considering intersections in Black women's body image. *Journal of Counseling Psychology, 61*(1), 37-49. doi: 10.1037/a0034597

Carels, R. A., Hinman, N. G., Burmeister, J. M., Hoffmann, D. A., Ashrafioun, L., & Koball, A. M. (2013). Stereotypical images and implicit weight bias in overweight/obese people. *Eating and Weight Disorders, 18,* 441-445. doi: 10.1007/s40519-013-0072-5

Carrizales, S. (2015). *What are the experiences of obese, Latina therapists: A qualitative study* (Unpublished doctoral dissertation). Texas Woman's University, Denton, TX.

Cash, T. F. (2000). *MBSRQ User's Manual* (3rd ed.). Retrieved from http://www.body-images.com/assessments/mbsrq.html

Cash, T. F. (2008). *The body image workbook: An eight-step program for learning to like your looks* (2nd ed.). Oakland, CA: New Harbinger Publications, Inc.

Cash, T. F. (2012). *Encyclopedia of body image and human appearance.* Boston, MA: Elsevier Inc.

Cash, T. F., & Fleming, E. C. (2002). The impact of body image experiences: Development of the Body Image Quality of Life Inventory. *International Journal of Eating Disorders, 31,* 455-460. doi: 10.1002/eat.10033

Cash, T. F., Gillen, B., & Burns, D. S. (1977). Sexism and "beautyism" in personnel consultant decision making. *Journal of Applied Psychology, 62,* 301-310. doi: 10.1037/0021-9010.62.3.301

Cash, T. F., & Pruzinsky, T. (1990). *Body images: Development, deviance, and change.* New York, NY: Guilford Press.

Cash, T. F, & Pruzinsky, T. (2002). *Body image: A handbook of theory, research, and clinical practice.* New York: Guilford Press.

Cash, T. F., & Smolak, L. (2011). *Body image: A handbook of science, practice, and prevention* (2nd ed.). New York, NY: Guildford Press.

Cash, T. F., & Szymanski, M. L. (1995). The development and validation of the Body-Image Ideals Questionnaire. *Journal of Personality Assessment, 64,* 466-477. doi: 10.1207/s15327752jpa6403_6

Cash, T. F., Thériault, J., & Annis, N. M. (2004). Body image in an interpersonal context: Adult attachment, fear of intimacy, and social anxiety. *Journal of Social and Clinical Psychology, 23*(1), 89-103. https://doi.org/10.1521/jscp.23.1.89.26987

Cash, T. F., Winstead, B. A., & Janda, L. H. (1986). Body image survey report: The great American shape-up. *Psychology Today, 20*(4), 30-37.

Cassone, S., Lewis, V., & Crisp, D. A. (2016). Enhancing positive body image: An evaluation of a cognitive behavioral therapy intervention and an exploration of the role of body shame. *Eating Disorders, 24,* 469-474. doi: 10.1080/10640266.2016.1198202

Castonguay, A. L., Gilchrist, J. D., Mack, D. E., & Sabiston, C. M. (2013). Body-related pride in young adults: An exploration of the triggers, contexts, outcomes and attributions. *Body Image, 10,* 335-343. doi: 10.1016/j.bodyim.2013.03.001

Chrisler, J. C., & Barney, A. (2017). Sizeism is a health hazard. *Fat Studies, 6*(1), 38-53. doi: 10.1080/21604851.2016.1213066

Chrisler, J. C., & Ghiz, L. (1993). Body image issues of older women. In N. D. Davis, E. Cole, & E. D. Rothblum (Eds.), *Faces of women and aging* (pp. 67-75). New York, NY: Harrington Park.

Clifford, D., Ozier, A., Bundros, J., Moore, J., Kreiser, A., & Morris, M. N. (2015). Impact of non-diet approaches on attitudes, behaviors, and health outcomes: A systematic review. *Journal of Nutrition Education and Behavior, 47,* 143-155. doi: 10.1016/j.jneb.2014.12.002

Cohen, J., Collins, R., Darkes, J., & Gwartney, D. (2007). A league of their own: Demographics, motivations and patterns of use of 1,955 male adult non-medical anabolic steroid users in the United States. *Journal of the International Society of Sports Nutrition, 4*(12), 1-12. doi: 10.1186/1550-2783-4-12

Conover, K. J., Israel, T., & Nylund-Gibson, K. (2017). Development and validation of the Ableist Microaggressions Scale. *The Counseling Psychologist, 45,* 570-599. doi: 10.1177/0011000017715317

Cope, C., Michalski, D. S., & Fowler, G. A. (2016). *Summary report: Student demographics.* Retrieved from http://www.apa.org/education/grad/survey-data/2017-student-demographics.aspx

Crandall, C. S. (1994). Prejudice against fat people: Ideology and self-interest. *Journal of Personality and Social Psychology, 66,* 882-894. doi: 10.1037/0022-3514.66.5.882

Crisp, C. (2006). The Gay Affirmative Practice scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work, 51*(2), 115-126.

Cruz, C., Greenwald, E., & Sandil, R. (2017). Let's talk about sex: Integrating sex positivity in counseling psychology practice. *The Counseling Psychologist, 45,* 547-569. doi: 10.1177/0011000017714763

Daníelsdóttir, S., O'Brien, K. S., Ciao, A. (2010). Anti-fat prejudice reduction: A review of published studies. *Obesity Facts: The European Journal of Obesity, 3*(1), 47-58. doi: 10.1159/000277067

Davis, K. (1998). *Fat bias among psychologists: Impact of client weight on clinical judgments and treatment planning* (Unpublished doctoral dissertation). University of Montana, Missoula, MT.

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, Elise, …Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy, 55,* 89-100. doi: 10.1037/pst0000160

Davis-Coelho, K., Waltz, J., & Davis-Coelho, B. (2000). Awareness and prevention of bias against fat clients in psychotherapy. *Professional Psychology: Research and Practice, 31,* 682-684. doi: 10.1037/0735-7028.31.6.682

De Vries, A. L. C., Mcguire, J. K., Steensma, T. D., Eva, C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134*(4), 1–9. doi: 10.1542/peds.2013-2958

De Vries, A. L. C., Steensma, T. D., Doreleijers, T. a H., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine, 8,* 2276–2283. http://dx.doi.org/10.1111/j.1743-6109.2010.01943.x

Dixon, W. J. (1953). Processing data for outliers. *International Biometric Society, 9*(1), 74-89. doi: 10.2307/3001634

Dye, H. (2015). Are there differences in gender, race, and age regarding body dissatisfaction? *Journal of Human Behavior in the Social Environment,* 1-10. doi: 10.1080/10911359.2015.1091240

Eisenberg, M. E., Neumark-Sztainer, D., & Story, M. (2003). Associations of weight-based teasing and emotional well-being among adolescents. *Archives of*

Pediatrics and Adolescent Medicine, 157, 733-738. doi: 00022363-200308000-00008

Fallon, A. E., & Rozin, P. (1985). Sex differences in perceptions of desirable body shape. *Journal of Abnormal Psychology, 94,* 102-105. doi: 10.1037/0021-843X.94.1.102

Farrar, S., Stopa, L., & Turner, H. (2015). Self-imagery in individuals with high body dissatisfaction: The effect of positive and negative self-imagery on aspects of the self-concept. *Journal of Behavior Therapy and Experimental Psychiatry, 46,* 8-13. doi: 10.1016/j.jbtep.2014.07.011

Field, A. (2013). *Discovering statistics using SPSS* (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Fikkan, J. L., & Rothblum, E. D. (2012). Is fat a feminist issue? Exploring the gendered nature of weight bias. *Sex Roles, 66,* 575-592. doi: 10.1007/s11199-011-0022-5

Fisher, S. (1990). The evolution of psychological concepts about the body. In T. F. Cash & T. Pruzinsky (Eds.), *Body images: Development, deviance, and change* (pp. 3-20). New York, NY: Guildford Press.

Fiske, L., Fallon, E. A., Blissmer, B., & Redding, C. A. (2014). Prevalence of body image dissatisfaction among United States adults: Review and recommendations for future research. *Eating Behaviors, 15,* 357-365. doi: 10.1016/j.eatbeh.2014.04.010

Fredrickson, B. L., & Roberts, T. A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly, 21*(2), 173-206. doi: 10.1111/j.1471-6402.1997.tb00108.x

Frisén, A., & Holmqvist, K. (2010). What characterizes early adolescents with a positive body image? A qualitative investigation of Swedish girls and boys. *Body Image, 7,* 205-212. doi: 10.1016/j.bodyim.2010.04.001

Fryar, C. D., Carroll, M. D., & Ogden, C. L. (2014). *Prevalence of overweight, obesity, and extreme obesity among adults aged 20 and over: United States, 1960-1962 through 2013-2014.* Retrieved from https://www.cdc.gov/nchs/data/hestat/obesity_ adult_13_14.htm

Fuller-Tyszkiewicz, M., Skouteris, H., Watson, B. E., & Hill, B. (2013). Body dissatisfaction during pregnancy: A systematic review of cross-sectional and prospective correlates. *Journal of Health Psychology, 18,* 1411-1421. doi: 10.1177/1359105312462437

Gapinski, K., Brownell, K., & LaFrance, M. (2003). Body objectification and "fat talk": Effects on emotion, motivation, and cognitive performance. *Sex Roles, 48,* 377-388. doi: 10.1023/A:1023516209973

Garner, D. M. (1997). The 1997 body image survey results. *Psychology Today, 30*(1), 30-44. Retrieved from http://ezp.twu.edu/docview/214474038?accountid=7102

Gaztambide, D. J. (2012). Addresses cultural impasses with rupture resolution strategies: A proposal and recommendations. *Professional Psychology: Research and Practice, 43,* 183-189. doi: 10.1037/a0026911

Gillen, B. (1981). Physical attractiveness: A determinant of two types of goodness. *Personality and Social Psychology Bulletin, 7,* 277-281.

Goldsmith, D., & Thompson, J. K. (1989). The effect of mirror confrontation and size estimation accuracy feedback on perceptual inaccuracy in normal females who overestimate body size. *International Journal of Eating Disorders, 8,* 437-444. doi: 10.1002/1098-108X(198907)8:4<437::AID-EAT2260080407>3.0.CO;2-L

Goodwin, B. J., McHugh, M. C., & Touster, L. O. (2003). Who is the woman in the psychology of women? In P. Bronstein & K. Quina (Eds.), *Teaching gender and multicultural awareness* (pp. 137-152). Washington, D. C.: American Psychological Association.

Gottheil, E., Backup, C. E., & Cornelison, F. S. (1969). Denial and self-image confrontation in a case of anorexia nervosa. *The Journal of Nervous and Mental Disease, 148,* 238-250.

Haines, J., Neumark-Sztainer, D., Eisenberg, M. E., & Hannan, P. J. (2006). Weight teasing and disordered eating behaviors in adolescents: Longitudinal findings from Project EAT (Eating Among Teens). *Pediatrics, 117,* e209-e215. doi: 10.1542/peds.2005-1242

Halliwell, E. (2015). Future directions for positive body image research. *Body Image, 14,* 177-189. doi: 10.1016/j.bodyim.2015.03.003

Halliwell, E., & Dittmar, H. (2003). A qualitative investigation of women's and men's body image concerns and their attitudes toward aging. *Sex Roles, 49,* 675-684. doi: 10.1023/B:SERS.0000003137.71080.97

Heilman, M. E., & Saruwatari, L. R. (1979). When beauty is beastly: The effects of appearance and sex on evaluations of job applicants for managerial and nonmanagerial jobs. *Organizational Behavior, 23,* 360-372. doi: 10.1016/0030-5073(79)90003-5

Hesse-Biber, S., Clayton-Matthews, A., & Downey, J. A. (1988). The differential importance of weight and body image among college men and women. *Genetic, Social, and General Psychology Monographs, 114,* 511-528.

Hill, J., D'Urso-Fischer, E., McDonald, L., Weinstein, D., Kaiser-Froehlke, J., & Burr, V. (2004). Every body's different: A conference on new approaches to health for children and adolescents of all sizes. *Journal of American Dietetic Association, 104*(2), p. 23. doi: 10.1016/j.jada.2004.05.067

Hinman, N. G., Burmeister, J. M., Kiefner, A. E., Borushok, J., & Carels, R. A. (2015). Stereotypical portrayals of obesity and the expression of implicit weight bias. *Body Image, 12,* 32-35. Retrieved from http://dx.doi.org/10.1016/j.bodyim.2014.09.002

Homan, K. J., & Boyatzis, C. J. (2010). The protective role of attachment to God against eating disorder risk factors: concurrent and prospective evidence. *Eating Disorders, 18,* 239-258. doi: 10.1080/10640261003719534

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9–16. doi: 10.1037/a0022186

Hurd, L. C. (2000). Older women's body image and embodied experience: An exploration. *Journal of Women & Aging, 12*(3-4), 77-97. doi: 10.1300/J074v12n03_06

Hutchinson, M. G. (1985). *Transforming body image: Learning to love the body you have.* Berkeley, CA: The Crossing Press.

Ip, E. J., Barnett, M., J., Tenerowicz, M. J., & Perry, P. J. (2011). The anabolic 500 survey: Characteristics of male users versus nonusers of anabolic-androgenic steroids for strength training. *Pharmacotherapy, 31,* 757-766. doi: 10.1592/phco.31.8.757

Jackson, S. (2014). *Pre-service school psychologists' racial and weight-related biases and the relationship that taking diversity courses has on these biases* (Unpublished doctoral dissertation). Illinois State University, Normal, Illinois.

Jiang, W., Tan, J., & Fassnacht, D. B. (2017). Implicit and explicit anti-fat bias among Asian females. *Eating and Weight Disorders, 22,* 457-465. doi: 10.1007/s40519-016-0290-8

Jones, B. A., Haycraft, E., Murjan, S., & Arcelus, J. (2016). Body dissatisfaction and disordered eating in trans people: A systematic review of the literature. *International Review of Psychiatry, 28*(1), 81-94. Retrieved from http://dx.doi.org/10.3109/09540261.2015.1089217

Karazsia, B. T., Murnen, S. K., & Tylka, T. L. (2017). Is body dissatisfaction changing across time? A cross-temporal meta-analysis. *Psychological Bulletin, 143,* 293-320. Retrieved from http://dx.doi.org/10.1037/bul0000081

King, M., & Bruner, G. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology and Marketing, 17*(2), 79–103. doi: 10.1002/(SICI)1520-6793(200002)17:2<79::AID-MAR2>3.0.CO;2-0

Knapp, S., Gottlieb, M. C., & Handelsman, M. M. (2017). Self-awareness questions for effective psychotherapists: Helping good psychotherapists become even better. *Practice Innovations, 2,* 1-10. Retrieved from http://dx.doi.org/10.1037/pri0000051

Korman, M. (1974). National conference on levels and patterns of professional training in psychology. *American Psychologist, 29,* 441-449. doi: 10.1037/h0036469

Kornilaki, E. N. (2011). The obesity stigma and its consequences on children's social and emotional functioning: A literature review. *Psychology: The Journal of the Hellenic Psychological Society, 18,* 176-191.

Kostanski, M., & Gullone, E. (1998). Adolescent body image dissatisfaction: Relationships with self-esteem, anxiety, and depression controlling for body mass.

Journal of Child Psychology and Psychiatry, 39, 255-262. doi: 10.1111/1469-7610.00319

Lokken, K., Ferraro, R. F., Kirchner, T., & Bowling, M. (2003). Gender differences in body size dissatisfaction among individuals with low, medium, or high levels of body focus. *The Journal of General Psychology, 130,* 305-310. doi: 10.1080/00221300309601161

Lumley, T., Diehr, P., Emerson, S. & Chen, L. (2002). The importance of the normality assumption in large public health data sets. *Annual Review of Public Health, 23,* 151-169. doi: 10.1146/annurev.publheath.23.100901.140546

Mann, T., Tomiyama, A. J., Westling, E., Lew, A. M., Samuels, B., & Chatman, J. (2007). Medicare's search for effective obesity treatments: Diets are not the answer. *American Psychologist, 62,* 220-233. doi: 10.1037/0003066x.62.3.220

Mazur, A. (1986). U.S. trends in feminine beauty and overadaptation. *Journal of Sex Research, 22,* 281-303. doi: 10.1080/00224498609551309

McFarlane, T., Polivy, J., & McCabe, R. E. (1999). Help, not harm: Psychological foundation for a nondieting approach toward health. *Journal of Social Issues, 55,* 261-276. doi: 10.1111/0022-4537.00115

McGuire, J. K., Doty, J. L., Catalpa, J. M., & Ola, C. (2016). Body image in transgender young people: Findings from a qualitative, community based study. *Body Image, 18,* 96-107. doi: 10.1016/j.bodyim.2016.06.004

McHugh, M. C., & Kasardo, A. E. (2012). Anti-fat prejudice: The role of psychology in explication, education and eradication. *Sex Roles, 66,* 617-627. doi: 10.1007/s11199-011-0099-x

Mendelson, B. K., Mendelson, M. J., & White, D. R. (2001). Body esteem scale for adolescents and adults. *Journal of Personality Assessment, 76*(1), 90-106. doi: 10.1207/S15327752JPA7601_6

Miller, Jr., D. P., Spangler, J. G., Vitolins, M. Z., Davis, S. W., Ip, E. H., Marion, G. S., & Crandall, S. J. (2013). Are medical students aware of their anti-obesity bias? *Academic Medicine, 88,* 978-982. doi: 10.1097/ACM.0b013e318294f817

Miller, J. B., & Stiver, I. P. (1997). *The healing connection.* Boston, MA: Beacon.

Mishkind, M. E., Rodin, J., Silberstein, L. R., & Striegel–Moore, R. H. (1986). The embodiment of masculinity: Cultural, psychological, and behavioral dimensions. *American Behavioral Scientist, 29,* 545–562. doi:10.1177/000276486029005004

Montani, J. P., Schutz, Y., & Dulloo, A. G. (2015). Dieting and weight cycling as risk factors for cardiometabolic diseases: Who is really at risk? *Obesity Reviews, 16*(1), 7-18. doi: 10.1111/obr.12251

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations, 2,* 221-233. doi: 10.1037/pri0000055

Muennig, P. (2008). The body politic: The relationship between stigma and obesity-associated disease. *BMC Public Health, 8,* 128-138. doi: 10.1186/1471-2458-8-128

Muller-Pinget, S., Carrard, I., Ybarra, J., & Golay, A. (2012). Dance therapy improves self-body image among obese patients. *Patient Education and Counseling, 89,* 525-528. doi: 10.1016/j.pec.2012.07.008

Murnen, S. K., & Seabrook, R. (2012). Feminist perspectives on body image and physical appearance. In T. Cash (Ed.), *Enxyclopedia of body image and human appearance* (pp. 438-443). Cambridge, MA: Academic Press.

Murray, S. B., Griffiths, S., Mond, J. M., Kean, J., & Blashill, A. J. (2016). Anabolic steroid use and body image psychopathology in men: Delineating between appearance- versus performance-driven motivations. *Drug and Alcohol Dependence, 165,* 198-202. https://doi.org/10.1016/j.drugalcdep.2016.06.008

Nielson, A. C. (1979). *Who is dieting and why?* Chicago, IL: Nielson Company, Research Department.

Norris, D. L. (1984). The effects of mirror confrontation on self-estimation of body dimensions in anorexia nervosa, bulimia, and two control groups. *Psychological Medicine, 14,* 835-842.

O'Shea, B., Watson, D. G., & Brown, G. D. A. (2016). Measuring implicit attitudes: A positive framing bias flaw in the Implicit Relational Assessment Procedure (IRAP). *Psychological Assessment, 28,* 158-170. doi: 10.1037/pas0000172

Parent, M. C. (2013). Clinical considerations in etiology, assessment, and treatment of men's muscularity-focused body image disturbance. *Psychology of Men & Masculinity, 14*(1), 88-100. doi: 10.1037/a0025644

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Pederson, P. B. (1997). The cultural context of the American Counseling Association Code of Ethics. *Journal of Counseling & Development, 76*, 23-28. doi: 10.1002/j.1556-6676.1997.tb02372.x

Pennebaker, J.W., Boyd, R.L., Jordan, K., & Blackburn, K. (2015). *The development and psychometric properties of LIWC2015*. Austin, TX: University of Texas at Austin. Retrieved from https://repositories.lib.utexas.edu/bitstream/handle/2152/31333/LIWC2015_LanguageManual.pdf

Peugh, J. L., & Enders, C. K. (2004). Missing data in educational research: A review of reporting practices and suggestions for improvement. *Review of Educational Research, 74,* 525-556. http://dx.doi.org/10.3102/00346543074004525

Pierloot, R. A., & Houben, M. E. (1978). Estimation of body dimensions in anorexia nervosa. *Psychological Medicine, 8*, 317-324.

Pieterse, A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education. *The Counseling Psychologist, 37*(1), 93-115. doi: 10.1177/0011000008319986

Pingitore, R., Spring, B., & Garfield, D. (1997). Gender differences in body satisfaction. *Obesity Research, 5*, 402-409. doi: 10.1002/j.1550-8528.1997.tb00662.x

Piran, N. (2015). New possibilities in the prevention of eating disorders: The introduction of positive body image measures. *Body Image, 14*, 146-157. doi: 10.1016/j.bodyim.2015.03.008

Puhl, R. M., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research, 9*, 788-805. http://dx.doi.org/10.1038/oby.2001.108

Puhl, R. M., Latner, J. D., King, K. M., & Luedicke, J. (2014). Weight bias among professionals treating eating disorders: Attitudes about treatment and perceived patient outcomes. *International Journal of Eating Disorders, 47*(1), 65-75. doi: 10.1002/eat.22186

Puhl, R. M., Luedicke, J., & Grilo, C. M. (2014). Obesity bias in training: Attitudes, beliefs, and observations among advanced trainees in professional health disciplines. *Obesity, 22*, 1008-1015. doi: 10.1002/oby.20637

Renck Jalongo, M. (1999). Matters of size: Obesity as a diversity issue in the field of early childhood. *Early Childhood Education Journal*, *27*(2), 95-103. doi: 10.1023/A:1026048227491

Rodin, J., Silberstein, L. R., & Striegel-Moore, R. H. (1985). Women and weight: A normative discontent. In T. B. Sonderegger (Ed.), *Psychology and Gender* (pp. 267-307). Lincoln, NE: University of Nebraska Press.

Roncero, M., Perpiñá, C., Marco, J. H., & Sánchez-Reales, S. (2015). Confirmatory factor analysis and psychometric properties of the Spanish version of the Multidimensional Body-Self Relations Questionnaire-Appearance Scales. *Body Image, 14,* 47-53. doi: 10.1016/j.bodyim.2015.03.005

Sanftner, J. L., Ryan, W. J., & Pierce, P. (2009). Application of a relational model to understanding body image in college women and men. *Journal of College Student Psychotherapy, 23,* 262-280. doi: 10.1080/87568220903167182

Sanftner, J., & Tantillo, M. (2011). Body image and eating disorders: A compelling source of shame for women. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 277-303). Washington, DC: American Psychological Association.

Schafer, M. H., & Ferraro, K. F. (2011). The stigma of obesity: Does perceived weight discrimination affect identity and physical health? *Social Psychology Quarterly, 74*(1), 76-97. doi: 10.1177/0190272511398197

Schofield, W. (1966). Clinical and counseling psychology: Some perspectives. *American Psychologist, 21*(2), 122-131. doi: 10.1037/h0023301

Schwartz, M., O'Neal Chambliss, H., Brownell, K., Blair, S., & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research, 11,* 1033-1039. doi: 10.1038/oby.2003.142

Secord, P. F., & Jourard, S. M. (1953). The appraisal of body-cathexis: Body-cathexis and the self. *Journal of Consulting Psychology, 17*, 343-347. doi: 10.1037/h0060689

Senkowski, D., & Heinz, A. (2016). Chronic pain and distorted body image: Implications for multisensory feedback interventions. *Neuroscience and Biobehavioral Reviews, 69,* 252-259. https://doi.org/10.1016/j.neubiorev.2016.08.009

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy, 47,* 637–645. doi:10.1037/a0021175

Silberstein, L. R., Striegel-Moore, R. H., & Rodin, J. (1987). Feeling fat: A woman's shame. In H. B. Lewis (Ed.), *The role of shame in symptom formation*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Smith, A. (2018). *Female genital image self-consciousness: Using Acceptance and Commitment Therapy in a group setting with college-aged women* (Unpublished doctoral dissertation). Widener University, Chester, PA.

Striegel-Moore, R. H. (1993). Etiology of binge-eating: A developmental perspective. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge-eating: Nature, assessment, and treatment* (pp. 144-172). New York, NY: Guilford Press.

Striegel-Moore, R. H., & Cachelin, F. M. (1999). Body image concerns and disordered eating in adolescent girls: Risk and protective factors. In R. H. Striegel-Moore &

F. M. Cachelin (Eds.), *Beyond appearance: A new look at adolescent girls* (pp. 85-108). Washington, DC: American Psychological Association.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486. doi: 10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J., Durran, M., Feinberg, L., Pedersen, P., Smith, E., et al. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45-52. doi: 10.1177/0011000082102008

Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology, 34*, 237-245. doi: 10.1002/jcop.20095

Sujoldžić, A., & De Lucia, A. (2007). A cross-cultural study of adolescents—BMI, body image and psychological well-being. *Collegium Anthropologicum, 31*(1), 123-130. Retrieved from http://hrcak.srce.hr/index.php?show=clanak&id_clanak_jezik=431 88

Swami, V. (2015). Cultural influences on body size ideals: Unpacking the impact of westernization and modernization. *European Psychologist*, *20*(1), 44-51. http://dx.doi.org.ezp.twu.edu/10.1027/1016-9040/a000150

Swami, V., Airs, N., Chouhan, B., Leon, M. A. P., & Towell, T. (2009). Are there ethnic differences in positive body image among female British undergraduates? *European Psychologist, 14*, 288-296. doi: 10.1027/1016-9040.14.4.288

Tatangelo, G., Connaughton, C., McCabe, M., & Mellor, D. (2017). Preadolescent boys' investment in masculine gender norms and their use of body change strategies. *Psychology of Men & Masculinity,* 1-8. doi: 10.1037/men0000087

Tausczik, Y. R., & Pennebaker, J. W. (2010). The psychological meaning of words: LIWC and computerized text analysis methods. *Journal of Language and Social Psychology, 29*(1), 24-54. doi: 10.1177/0261927X09351676

Teachman, B. A., & Brownell, K. D. (2001). Implicit anti-fat bias among health professionals: Is anyone immune? *International Journal of Obesity, 25,* 1525-1531. doi: 10.1038/sj.ijo.0801745

Testa, R. J., Rider, G. N., Haug, N. A., Balsam, K. F., & Freedland, K. E. (2017). Gender confirming medical interventions and eating disorder symptoms among transgender individuals. *Health Psychology, 36,* 927-936. doi: 10.1037/hea0000497

Thompson, J. K. (1990). *Body image disturbance: Assessment and treatment.* Elmsford, NY: Pergamon Press, Inc.

Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance.* Washington DC, US: American Psychological Association. Retrieved from http://dx.doi.org/10.1037/10312-000

Tierney, S. (2012). Body image and cystic fibrosis: A critical review. *Body Image, 9*(1), 12-19. doi: 10.1016/j.bodyim.2011.09.001

Tiggemann, M. (2001). The impact of adolescent girls' life concerns and leisure activities on body dissatisfaction, disordered eating, and self-esteem. *The Journal of Genetic Psychology, 162*(2), 133-142. doi: 10.1080/00221320109597955

Tiggemann, M. (2015). Considerations of positive body image across various social identities and specific populations. *Body Image, 14,* 168-176. https://doi.org/10.1016/j.bodyim.2015.03.002

Tiggemann, M., Lynch, J. E., & Dannemiller, J. L. (2001). Body image across the lifespan in adult women: The role of self-objectification. *Developmental Psychology, 37,* 243-253. doi: 10.1037/0012-1649.37.2.243

Tiggemann, M., & Stevens, C. (1999). Weight concern across the life-span: Relationship to self-esteem and feminist identity. *International Journal of Eating Disorders, 26*(1), 103-106. doi: 10.1002/(SICI)1098108X(199907)26:1<103::AIDEAT14>3.0.CO;2-0

Tomiyama, A. J., Ahlstrom, B., & Mann, T. (2013). Long-term effects of dieting: Is weight loss related to health? *Social and Personality Psychology Compass, 7,* 861-877. doi: 10.1111/spc3.12076

Tomiyama, J. A., Finch, L. E., Belsky, A. C. I., Buss, J., Finley, C., Schwartz, M. B., & Daubenmier, J. (2015). Weight bias in 2001 versus 2013: Contradictory attitudes among obesity researchers and health professionals. *Obesity, 23*(1), 46-53. doi: 10.1002/oby.20910

Touster, L. (2000). *Fat oppression: The complicity of psychology* (Unpublished doctoral dissertation). Indiana University of Pennsylvania, Indiana, Pennsylvania.

Trepal, H. C., Boie, I., & Kress, V. E. (2012). A relational-cultural approach to working with clients with eating disorders. *Journal of Counseling & Development, 90,* 346-356.

Turner, H., Tatham, M., Lant, M., Mountford, V. A., & Waller, G. (2014). Clinicians' concerns about delivering cognitive behavioural therapy for eating disorders. *Behaviour Research and Therapy, 57,* 38-42. doi: 10.1016/j.brat.2014.04.003 http://ezproxy.twu.edu:3361/science/article/pii/S0005796714000576

Tylka, T. L. (2011). Positive psychology perspectives on body image, In T. F. Cash & L. Smolak (Eds.), *Body image: A handbook of science, practice, and prevention* (2nd ed., pp. 56-64). New York, NY: Guilford Press.

Tylka, T. L., & Wood-Barcalow, N. L. (2015). What is and what is not positive body image? Conceptual foundations and construct definition. *Body Image, 14,* 118-129. doi: 10.1016/j.bodyim.2015.04.001

Unger, R. K. (1985). Personal appearance and social control. In M. Safir, M. Mednick, I. Dafna, & J. Bernard (Eds.), *Women's worlds: From the new scholarship* (pp. 142-151). New York, NY: Praeger.

Untas, A., Koleck, M., Rascle, N., & Borteyrou, X. (2009). Psychometric properties of the French adaptation of the Multidimensional Body Self Relations

Questionnaire-Appearance Scales. *Psychological Reports, 105,* 461-471. doi: 10.2466/PR0.105.2.461-471

van de Grift, T. C., Cohen-Kettenis, P. T., Elaut, E., De Cuypere, G., Richter-Appelt, H., Haraldsen, I. R., & Kreukels, B. P. C. (2016). A network analysis of body satisfaction of people with gender dysphoria. *Body Image, 17,* 184-190. http://dx.doi.org/10.1016/j.bodyim.2016.04.002

van de Grift, T. C., Kreukels, B. P., Elfering, L., Özer, M., Bouman, M. B., Buncamper, M. E., … Mullender, M. G. (2016). Body image in transmen: Multidimensional measurement and the effects of mastectomy. *The Journal of Sexual Medicine, 13*, 1778-1786. doi: 10.1016/j.jsxm.2016.09.003

van de Mortel, T. F. (2008). Faking it: Social desirability response bias in self-report research. *Australian Journal of Advanced Nursing, 25*(4), 40-48. Retrieved from https://epubs.scu.edu.au/cgi/viewcontent.cgi?article=1001&context=hahs_pubs

van Diemen, T., van Leeuwen, C., van Nes, I., Geertzen, J., & Post, M. (2017). Body image in patients with spinal cord injury during inpatient rehabilitation. *Archives of Physical Medicine and Rehabilitation, 98,* 1126-1131. doi: 10.1016/j.apmr.2016.10.015

Vossbeck-Elsebusch, A. N., Waldorf, M., Legenbauer, T., Bauer, A., Cordes, M., & Vocks, S. (2014). German version of the Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS): Confirmatory factor analysis and validation. *Body Image, 11,* 191-200. doi: 10.1016/j.bodyim.2014.02.002

Wadden, T. A., Webb, V. L., Moran, C. H., & Bailer, B. A. (2012). Lifestyle modification for obesity: New developments in diet, physical activity, and behavior therapy. *Circulation, 125,* 1157-1170. doi: 10.1161/CIRCULATIONAHA.111.039453

Walters-Brown, B., & Hall, J. M. (2012). Women's body image: Implications for mental health nursing interventions. *Issues in Mental Health Nursing, 33,* 553-559. doi: 10.3109/01612840.2012.663459

Watkins, C. E., Jr. (1990). Reflections on uncomplemented philosophies, integrated curriculums, and words that bind and separate in clinical and counseling psychology. *Counseling Psychology Quarterly, 3,* 101-108. doi: 10.1080/09515079008254237

Watts, K., & Cranney, J. (2009). The nature and implications of implicit weight bias. *Current Psychiatric Reviews, 5,* 110-126. doi: 10.2174/157340009788167338

Wear, D., Aultman, J. M., Varley, J. D., & Zarconi, J. (2006). Making fun of patients: Medical students' perceptions and use of derogatory and cynical humor in clinical settings. *Academic Medicine, 81,* 454-462. doi: 10.1097/01.ACM.0000222277.21200.a1

Webb, J. B., Rogers, C. B., Etzel, L., & Padro, M. P. (2018). "Mom, quit fat talking—I'm trying to eat (mindfully) here!": Evaluating a sociocultural model of family fat talk, positive body image, and mindful eating in college women. *Appetite, 126,* 169-175. doi: 10.1016/j.appet.2018.04.003

Webb, J. B., Wood-Barcalow, N. L., & Tylka, T. L. (2015). Assessing positive body image: Contemporary approaches and future directions. *Body Image, 14,* 130-145. http://dx.doi.org/10.1016/j.bodyim.2015.03.010

Westbrook, L., & Saperstein, A. (2015). New categories are not enough: Rethinking the measurement of sex and gender in social surveys. *Gender & Society, 29,* 534-560. Retrieved from http://dx.doi.org/10.1177/0891243215584758

White, B. F. C. (2013). *Multicultural training of clinical and counseling psychology doctoral students: Ideals vs. practice* (Unpublished doctoral dissertation). University of Rhode Island, Kingston, RI.

Winter, V. R. (2016). Toward a relational understanding of objectification, body image, and preventative sexual health. *Journal of Sex Research, 54,* 341-350. doi: 10.1080/00224499.2016.1190807

Woertman, L., & Van Den Brink, F. (2012). Body image and female sexual functioning and behavior: A review. *Journal of Sex Research, 49,* 184-211. doi: 10.1080/00224499.2012.658586

Wood-Barcalow, N. L., Tylka, T. L., & Augustus-Horvath, C. L. (2010). But I like my body: Positive body image characteristics and a holistic model for young-adult women. *Body Image, 7,* 106-116. doi: 10.1016/j.bodyim.2010.01.001

Wooley, S. C., & Wooley, O. W. (1984). Feeling fat in a thin society. *Glamour,* 198-252.

Worrell, J. (2001). Feminist interventions: Accountability beyond symptom reduction. *Psychology of Women Quarterly, 25,* 335-343. doi: 10.1111/1471-6402.00033

Worthington-White, S. I. (2001). *Knowledge of and attitudes to eating disorders amongst educational psychology graduate students* (Unpublished master's thesis). University of Alberta, Edmonton, Alberta.

Young, L. M., & Powell, B. (1985). The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behavior, 26,* 233-246. http://ezproxy.twu.edu:2069/stable/2136755

APPENDIX A

Introductory Email to Training Directors

Dear (Training Director Name),

My name is Samantha Lee and I am a doctoral student in counseling psychology at Texas Woman's University conducting my dissertation under the direction of Dr. Debra Mollen. I invite you to participate in a study approved by the Institutional Review Board at Texas Woman's University. The study will be examining current doctoral clinical and counseling psychology training and education pertaining to body image topics.

The survey will take approximately 30 minutes to complete and will provide us with information regarding current body image training and education in APA-accredited graduate psychology programs. To be eligible to participate, you must be a current training or program director of an APA-accredited counseling psychology or clinical psychology program.

To participate, please click on the link below:

URL

Students are also eligible to participate in the study to provide insight into the experiences of doctoral clinical and counseling psychology students in APA-accredited programs. Please share the following email and link with students in your program.

Dear Doctoral Student,

My name is Samantha Lee and I am a doctoral student in counseling psychology at Texas Woman's University conducting my dissertation under the direction of Dr. Debra Mollen. I invite you to participate in a study approved by the Institutional Review Board at Texas Woman's University. The study will be examining current doctoral clinical and counseling psychology training and education pertaining to body image topics.

The survey will take approximately 45 minutes and will provide us with information regarding graduate students' training and education in areas of body image and their self-rated competency working with individuals presenting with body image concerns. To be eligible to participate, you must have been in your current doctoral program for a minimum of one academic year and have completed a minimum of one semester of clinical experience in the field of psychology.

If you have questions or concerns about this research, please feel free to contact Samantha Lee at SLee18@twu.edu.

To participate, please click on the link below:

URL

Kindly,

Samantha Lee, M.S.
Doctoral Candidate
Texas Woman's University
SLee18@twu.edu

APPENDIX B

Informed Consent

CONSENT TO PARTICIPATE IN RESEARCH

Investigator and Advisors: Samantha Lee…….……..……..SLee18@twu.edu
Debra Mollen, PhD (Advisor)…….…….DMollen@twu.edu
(940)-898-2317

Explanation and Purpose of the Research

You are being asked to participate in a study being conducted under the supervision of Debra Mollen, Ph.D. at Texas Woman's University. Participation consists of completing an online survey. The purpose of this study is to explore graduate training and education in counseling psychology and clinical psychology programs in body image topics.

Description of Procedure

For this study, you will be asked to spend approximately 30 to 45 minutes of your time; due to additional questions for trainees, students may expect to spend more time than training directors. Participation will include online completion of a demographics form and survey. Participation will be voluntary and responses will be confidential. Following completion of the study, participants will be provided with the option to submit contact information to receive results of the study via email and/or to be entered in a drawing for a chance to win one of two $50 Amazon gift cards. Identifying information will not be connected to responses provided.

Potential Risks

The investigator will try to prevent risks through precautionary measures to the best of her ability. Potential risks in the current study include loss of confidentiality, potential emotional distress, and loss of personal time. Confidentiality will be protected to the extent that is allowed by law. There is a risk of loss of confidentiality in all email, downloading, and internet transactions.

There is a potential risk for loss of time and fatigue as the interview and questionnaire will require approximately 30 to 45 minutes of your time. To alleviate the risk of loss of time and fatigue, you can take a break at any time. Your participation is also voluntary; therefore, you can also discontinue participation at any time without penalty.

Given the nature of the material being assessed, there is a potential risk of emotional distress. In the event you experience emotional discomfort, you may choose to speak with a professional counselor or psychologist. Sources to obtain counseling include:

http://locator.apa.org/; https://findtreatment.samhsa.gov/; https://therapists.psychologytoday.com/rms/; http://www.findapsychologist.org/

Please contact the investigator if you experience technological difficulties while completing the study.

Participation and Benefits

Your involvement in this study is completely voluntary and you may discontinue your participation in this study at any time without penalty. Your participation is greatly appreciated and will contribute to a better understanding of current graduate training and education in APA-accredited clinical and counseling psychology programs. As previously mentioned, your responses will be anonymous and not connected with the identifying information you supply should you decide to participate in the drawing for the gift card and/or request the results of the study.

Questions Regarding the Study

If you have any questions about this research study you may ask the primary investigator, Samantha Lee, whose email address is at the top of this form.

By clicking the "continue" option below you are consenting to the aforementioned information. To withdrawal your participation, you may exit out of the survey by closing your web browser.

APPENDIX C

Training Director Demographic Form

1. What is your age? _____

2. What is your gender?
    a. Female
    b. Male
    c. Non-binary/third gender
    d. Prefer to self-describe: _____

3. What is your race/ethnicity (select all that apply)?
    a. American Indian or Alaska Native
    b. White
    c. Latino(a)(x)/Hispanic
    d. Middle Eastern/North African
    e. Black or African American
    f. Asian or Pacific Islander
    g. Bi- or multi-racial/multi-ethnic. List all: _____
    h. Other: _____

4. What is your sexual orientation?
    a. Gay
    b. Lesbian
    c. Bisexual
    d. Heterosexual
    e. Queer
    f. Questioning
    g. Pansexual
    h. Demi-sexual
    i. Asexual
    j. Prefer to self-describe: _____

5. What is your ability status? _____

6. How many years have you served as a training director in your current program? _____ years _____ months

7. What is your professional area of expertise in research (if applicable)? _____

8. What is your professional area of expertise in clinical practice (if applicable)? _____

9. What is your theoretical orientation (select all that apply)?

a. Cognitive-Behavioral (CBT)
b. Psychodynamic/psychoanalytic
c. Positive
d. Multicultural
e. Feminist
f. Interpersonal
g. Emotion-Focused (EFT)
h. Relational Cultural (RCT)
i. Acceptance and Commitment (ACT)
j. Other: _____

10. How important do you think it is for graduate psychology training to include body image in the curriculum?
    a. Not important
    b. Somewhat important
    c. Important
    d. Very Important
    e. Essential

The following questions refer to your program.

1. In which region is your program located?
    a. Midwest (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI)
    b. Northeast (CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT)
    c. Southeast (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV)
    d. Southwest (AZ, NM, OK, TX)
    e. West (AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY)
    f. Canada

2. Which of the following best describes your program?
    a. Ph.D. Counseling Psychology
    b. Psy.D. Counseling Psychology
    c. Ph.D. Clinical Psychology
    d. Psy.D. Clinical Psychology
    e. Combined Program (Specify: _____)
    f. Other: _____

3. How long has your program been APA-accredited?
    _____ years _____ months

4. Which of the following training models most aligns with your program?
    a. Scientist-Practitioner

b. Practitioner-Scientist
c. Scholar-Practitioner
d. Practitioner-Scholar
e. Practitioner
f. Local Clinical Scientist
g. Not sure

5. Does your program have a specialty track or emphasis (e.g., Child Clinical, Family Systems, Multiculturalism)?
    a. Yes
    b. No

6. If your program does have a specialty track or emphasis, please specify:
    _____

7. Which of the following theories are represented among the doctoral psychology faculty (select all that apply):
    a. Cognitive-Behavioral (CBT)
    b. Psychodynamic/psychoanalytic
    c. Positive
    d. Multicultural
    e. Feminist
    f. Interpersonal
    g. Emotion-Focused (EFT)
    h. Relational Cultural (RCT)
    i. Acceptance and Commitment (ACT)
    j. Humanistic/Existential
    k. Systemic
    l. Integrative
    m. Other: _____

8. Compared with other programs in applied psychology, how well do you think your program encourages and offers the awareness, knowledge, and skills needed for graduate students to work effectively and competently with clients on body image topics?
    a. Poor
    b. Average
    c. Well
    d. Exceptional

APPENDIX D

Doctoral Student Demographic Form

1. What is your age? _____

2. What is your gender?
    a. Female
    b. Male
    c. Non-binary/third gender
    d. Prefer to self-describe: _____

3. What is your race (select all that apply)?
    a. American Indian or Alaska Native
    b. White
    c. Latino(a)(x)/Hispanic
    d. Middle Eastern/North African
    e. Black or African American
    f. Asian or Pacific Islander
    g. Bi- or multi-racial/multi-ethnic. List all: _____
    h. Other: _____

4. What is your sexual orientation?
    a. Gay
    b. Lesbian
    c. Bisexual
    d. Heterosexual
    e. Queer
    f. Questioning
    g. Pansexual
    h. Demi-sexual
    i. Asexual
    j. Prefer to self-describe: _____

5. What is your ability status? _____

6. What is your highest level of education?
    a. Bachelor's degree in psychology or related field
    b. Bachelor's degree in an unrelated field
    c. M.A. or M.S. in Clinical Psychology
    d. M.A. or M.S. in Counseling Psychology
    e. Other: _____

7. How long have you been in your current program?
    _____ years _____ months

8. How many semesters of clinical experience do you have? _____

9. What is your professional area of expertise in research (if applicable)?
   _____

10. What is your professional area of expertise in clinical practice (if applicable)?
    _____

11. What is your theoretical orientation (select all that apply)?
    a. Cognitive-Behavioral (CBT)
    b. Psychodynamic/psychoanalytic
    c. Positive
    d. Multicultural
    e. Feminist
    f. Interpersonal
    g. Emotion-Focused (EFT)
    h. Relational Cultural (RCT)
    i. Acceptance and Commitment (ACT)
    j. Humanistic/Existential
    k. Systems
    l. Integrative
    m. Other: _____

12. How important do you think it is for graduate psychology training to include body image in the curriculum?
    a. Not important
    b. Somewhat important
    c. Important
    d. Very Important
    e. Essential

APPENDIX E

Training and Education Survey

Bold items will be included on the student survey only.

1. Are you a training director in an APA-accredited Counseling or Clinical Psychology program or a student in such a program who is beyond your first year in training?

    a. Yes, I am a training director in an APA-accredited Counseling or Clinical Psychology program.
    b. Yes, I am a student in an APA-accredited Counseling or Clinical Psychology program with a minimum of one year in the program and one semester of clinical experience (clinical experience can be from a previous program).
    c. No, I do not meet either of the criteria listed above.

Please answer the following questions pertaining to your current doctoral program.

Awareness

2. Compared to other programs, how well do you think your program:

    a. encourages student's exploration of personal biases and assumptions of larger-bodied individuals (i.e., people described as fat, larger-bodied, overweight, or obese)?
        i. Not well at all
        ii. Somewhat well
        iii. Average (comparable to other programs)
        iv. Above average
        v. Exceptionally well

    b. encourages self-reflection of personal size as a cultural identity?
        i. Not well at all
        ii. Somewhat well
        iii. Average (comparable to other programs)
        iv. Above average
        v. Exceptionally well

    c. encourages self-reflection of student's own body image and its impact in practice?
        i. Not well at all
        ii. Somewhat well
        iii. Average (comparable to other programs)
        iv. Above average

v. Exceptionally well

3. How would you characterize your own relationship with your body?

Knowledge

4. In which of the following body image concepts does your program provide training?
    a. Body dissatisfaction
    b. Body esteem
    c. Body distortion
    d. Objectification
    e. Self-objectification
    f. Size perception accuracy
    g. Body satisfaction
    h. Body surveillance/scanning
    i. Embodiment
    j. Body acceptance
    k. Body appreciation
    l. I am unsure if these topics are covered.
    m. None of these topics are covered in our program.

5. In which of the following cultural considerations does your program provide training?
    a. Body image and race/ethnicity
    b. Body image and gender
    c. Body image and ability status
    d. Body image and age
    e. Body image and sexual orientation
    f. Body image and size
    g. Size as a cultural identity
    h. Men and the muscular ideal
    i. Women and the thin ideal
    j. Steroid use and body image
    k. Hormone use and body image
    l. Sizeism and weight bias
    m. The effects of sizeism on larger-bodied individuals
    n. I am unsure if these topics are covered.
    o. None of these topics are covered in our program.

6. In which of the following health/mental health processes related to body image does your program provide training?
    a. Body image and neurodegenerative disorders
    b. Body image and disfigurement
    c. Body image and cancer
    d. Body image and skin concerns (e.g., burns, skin disorders, and discoloration)
    e. Body image and cosmetic surgery
    f. Body image and congenital conditions
    g. Body image and depression
    h. Body image and anxiety
    i. Body image and pregnancy
    j. Body image and Anorexia Nervosa
    k. Body image and Bulimia Nervosa
    l. Body image and Body Dysmorphic Disorder
    m. Body image and Binge-Eating Disorder
    n. I am unsure if these topics are covered.
    o. None of these topics are covered in our program.

7. In which of the following areas of functioning does your program provide training?
    a. Body image and social functioning
    b. Body image and sexual functioning
    c. I am unsure if these topics are covered.
    d. None of these topics are covered in our program.

8. In which of the following areas pertaining to theory does your program provide training?
    a. Sociocultural perspectives of body image
    b. Feminist perspectives of body image
    c. Evolutionary perspectives of body image
    d. Cognitive-behavioral perspectives of body image
    e. Positive psychology perspectives of body image
    f. I am unsure if these topics are covered.
    g. None of these topics are covered in our program.

9. In which of the following areas pertaining to research does your program provide training?
    a. History of body image research
    b. Empirically based critiques of use of Body Mass Index (BMI)
    c. Empirically based critiques of dieting as a recommended treatment
    d. Health at Every Size research

e. I am unsure if these topics are covered.
f. None of these topics are covered in our program.

10. In which of the following areas of development of body image does your program provide training?
    a. Risk factors for development of negative body image
    b. Protective factors encouraging development of positive body image
    c. Body image development in childhood
    d. Body image development in adolescence
    e. Body image development in adulthood
    f. Body image development in late adulthood (geriatric populations)
    g. The impact of media on body image development
    h. I am unsure if these topics are covered.
    i. None of these topics are covered in our program.

11. In which of the following approaches to treatment does your program provide training related to body image in therapy?
    a. Psychotherapy approaches to dieting
    b. Psychotherapy approaches to exercise
    c. Integrating expressive components (e.g., art, music, dance) into psychotherapy
    d. Media literacy and protective filtering
    e. Referral to physician, nutritionist, and/or dietician
    f. I am unsure if these topics are covered.
    g. None of these topics are covered in our program.
    h. Other: _____

12. How are people with larger bodies generally referred to in your program? (check all that apply)
    a. Fat
    b. Overweight
    c. Obese
    d. People of size
    e. Large-bodied
    f. Other, specify:

13. In which of the following types of assessment does your program provide training?
    a. Measures of size perception accuracy
    b. Measures of eating disorder behaviors/criteria for diagnoses
    c. Measures of body dissatisfaction
    d. Measures of body acceptance, appreciation, and/or positivity

e. Measures of body preoccupation
f. Measures of weight bias and/or anti-fat bias
g. I am unsure if these topics are covered.
h. None of these topics are covered in our program.

14. In which settings have you had body image training? Please indicate if this experience was internal (a part of the program) or external (sought outside the program).
   a. Classes
   b. Practicum
   c. Workshops
   d. Conferences
   e. Activism
   f. Research
   g. None; I have not had body image training to date.

15. If you have received body image training as a component of a class in your doctoral program, in which courses did you receive training?
   a. Multicultural Course
   b. Practicum Course
   c. Psychopathology Course
   d. Other: _____

Skills

16. Have you worked with a client during your current program practica or on internship who had concerns about her/his/their body image in therapy?
   a. With approximately how many clients?
   b. What treatment recommendations do you generally make?

17. When conceptualizing cases, in approximately what percentage of clients do you include body image considerations?

18. With approximately what percentage of your clients do you discuss body image in practice?

19. When considering factors that impact inclusion of body image in practice,

   a. What factors increase the likelihood that you consider and integrate body image into practice?
   b. What factors decrease the likelihood that you consider and integrate body image into practice?

20. Among all the clients you have seen in practicum to date, what percentage do you estimate have or had body image concerns?

21. How comfortable do you feel broaching body image in session?

a. Not at all comfortable
b. Somewhat Uncomfortable
c. Neutral
d. Somewhat Comfortable
e. Very comfortable

22. How competent do you feel working with body image in session?

a. Not at all competent
b. Somewhat incompetent
c. Of average competence
d. Above average competence
e. Exceptionally competent

Other Training Experiences

23. Has anyone in your program (a client, professor, student) ever commented about your body, such as complimenting, critiquing, or noticing something about your body)? Please provide as much detail as you would like, including specific examples when possible.

24. How are bodies (e.g., weight, size, ability status, etc.) discussed in your program by students, faculty, and staff? Please share some examples.

APPENDIX F

Attitudes about Treating Larger-Bodied Clients/Patients Scale

Please indicate how much you agree or disagree with the following statements:

	Strongly Disagree	Disagree		Agree	Strongly Agree
1. I often feel frustrated with clients/patients who are larger-bodied.	1	2	3	4	5
2. Larger-bodied clients/patients can be difficult to deal with.	1	2	3	4	5
3. I feel that it is important to treat larger-bodied clients/patients with compassion and respect.	1	2	3	4	5
4. I dislike treating larger-bodied clients/patients.	1	2	3	4	5
5. I feel confident that I provide quality care to larger-bodied clients/patients.	1	2	3	4	5
6. I feel professionally prepared to effectively treat larger-bodied clients/patients.	1	2	3	4	5
7. I feel that larger-bodied clients/patients are often non-compliant with treatment recommendations.	1	2	3	4	5
8. I feel that larger-bodied clients/patients lack motivation to make lifestyle changes.	1	2	3	4	5
9. Treating larger-bodied clients/patients is professionally rewarding.	1	2	3	4	5
10. Larger-bodied clients/patients tend to be lazy.	1	2	3	4	5
11. Treating a larger-bodied client/patient is more frustrating that treating a client/patient who is not larger-bodied.	1	2	3	4	5
12. I feel more irritated when I am treating a larger-bodied client/patient than a client/patient who is not larger-bodied.	1	2	3	4	5
13. I feel disgust when treating a larger-bodied client/patient.	1	2	3	4	5
14. It is difficult to feel empathy for a larger-bodied client/patient.	1	2	3	4	5

15. Treating a larger-bodied client/patient is more emotionally draining than treating a client who is not larger-bodied.	1	2	3	4	5
16. Treating a larger-bodied client/patient is more stressful than treating a client/patient who is not larger-bodied.	1	2	3	4	5
17. Treating a larger-bodied client/patient repulses me.	1	2	3	4	5
18. I would rather treat a client/patient who is not larger-bodied than a larger-bodied client/patient.	1	2	3	4	5
19. Other health providers in my field often have negative stereotypes toward larger-bodied clients/patients.	1	2	3	4	5
20. I have heard/witnessed other professionals in my field make negative comments about larger-bodied clients/patients.	1	2	3	4	5
21. My colleagues tend to have negative attitudes toward larger-bodied clients/patients.	1	2	3	4	5
22. Health care providers feel uncomfortable when caring for larger-bodied clients/patients.	1	2	3	4	5

APPENDIX G

The Multidimensional Body-Self Relations Questionnaire-Appearance Scales

THE MBSRQ-AS

INSTRUCTIONS--PLEASE READ CAREFULLY

The following pages contain a series of statements about how people might think, feel, or behave. You are asked to indicate the extent to which each statement pertains to you personally.

Your answers to the items in the questionnaire are anonymous, so please do not write your name on any of the materials. In order to complete the questionnaire, read each statement carefully and decide how much it pertains to you personally. Using a scale like the one below, indicate your answer by entering it to the left of the number of the statement.

EXAMPLE:

_____ I am usually in a good mood.

In the blank space, enter a **1** if you **definitely disagree** with the statement;
enter a **2** if you **mostly disagree**;
enter a **3** if you **neither agree nor disagree**;
enter a **4** if you **mostly agree**;
or enter a **5** if you **definitely agree** with the statement.

There are no right or wrong answers. Just give the answer that is most accurate for you. Remember, your responses are confidential, so please be completely honest and answer all items.

1	2	3	4	5
Definitely Disagree	**Mostly Disagree**	**Neither Agree Nor Disagree**	**Mostly Agree**	**Definitely Agree**

_____ 1. Before going out in public, I always notice how I look.

_____ 2. I am careful to buy clothes that will make me look my best.

_____ 3. My body is sexually appealing.

_____ 4. I constantly worry about being or becoming fat.

_____ 5. I like my looks just the way they are.

_____ 6. I check my appearance in a mirror whenever I can.

_____ 7. Before going out, I usually spend a lot of time getting ready.

_____ 8. I am very conscious of even small changes in my weight.

_____ 9. Most people would consider me good-looking.

_____ 10. It is important that I always look good.

_____ 11. I use very few grooming products.

_____ 12. I like the way I look without my clothes on.

_____ 13. I am self-conscious if my grooming isn't right.

_____ 14. I usually wear whatever is handy without caring how it looks.

_____ 15. I like the way my clothes fit me.

_____ 16. I don't care what people think about my appearance.

_____ 17. I take special care with my hair grooming.

_____ 18. I dislike my physique.

continued on the next page

1	2	3	4	5
Definitely Disagree	**Mostly Disagree**	**Neither Agree Nor Disagree**	**Mostly Agree**	**Definitely Agree**

_____ 19. I am physically unattractive.

_____ 20. I never think about my appearance.

_____ 21. I am always trying to improve my physical appearance.

_____ 22. I am on a weight-loss diet.

For the remainder of the items use the response scale given with the item, and enter your answer in the space beside the item.

_____ 23. I have tried to lose weight by fasting or going on crash diets.

1. Never
2. Rarely
3. Sometimes
4. Often
5. Very Often

_____ 24. I think I am:

1. Very Underweight
2. Somewhat Underweight
3. Normal Weight
4. Somewhat Overweight
5. Very Overweight

_____ 25. From looking at me, most other people would think I am:

1. Very Underweight
2. Somewhat Underweight
3. Normal Weight
4. Somewhat Overweight
5. Very Overweight

continued on the next page

26-34. Use this 1 to 5 scale to indicate how dissatisfied or satisfied you are with each of the following areas or aspects of your body:

1	2	3	4	5
Very Dissatisfied	**Mostly Dissatisfied**	**Neither Satisfied Nor Dissatisfied**	**Mostly Satisfied**	**Very Satisfied**

_____ 26. Face (facial features, complexion)

_____ 27. Hair (color, thickness, texture)

_____ 28. Lower torso (buttocks, hips, thighs, legs)

_____ 29. Mid torso (waist, stomach)

_____ 30. Upper torso (chest or breasts, shoulders, arms)

_____ 31. Muscle tone

_____ 32. Weight

_____ 33. Height

_____ 34. Overall appearance
