

5-2022

Exploring Higher Weight Women's Experiences of Provider Weight Stigma

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Exploring Higher Weight Women's Experiences of Provider Weight Stigma

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Counselor Education and Supervision

by

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Abstract

The purpose of this phenomenological study is to explore the phenomena of weight stigma as experienced by higher weight women in mental health treatment who also engage in restrictive eating behaviors. Women in larger bodies who are emotionally or behaviorally restrictive in their eating behaviors face a unique set of challenges and barriers. These include challenges due the disordered eating behaviors themselves, along with barriers related to weight stigma perpetuated by the mental health providers treating them (Harrop, 2019). Distinct hurdles to proper treatment including delay of diagnosis, longer duration of symptoms, and increased distress related to eating and body image over a lifetime plague this subset of women (Sawyer et al., 2016). In addition, these clients experience greater delays in care than clients who are considered “normal” weight or underweight (Drury et al., 2002). This gap in care is perpetuated by provider weight stigma, (Lebow et al., 2015), along with societal barriers to care related to weight stigma (Cachelin et al., 2001). The goal of this study is to illuminate these women’s experiences, with the hope that the findings may contribute to the education of current and future counselors.

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Acknowledgements

First, I want to thank my committee members for all their encouragement, guidance, and help. Dr. Popejoy, thank you for believing in me throughout this process and for the many times that you provided encouragement when I was not sure if I could keep going. You are the embodiment of a professor and mentor that puts connection first. Your authenticity is truly your superpower, thank you for providing an example of what connection can bring in a mentorship. To Dr. Higgins, thank you for being a continuous source of motivation and for your ability to help me with the more detailed parts of this work along the way. To Dr. Horne, you have always challenged and supported me throughout my professional journey. I appreciate your willingness to be a part of my professional development, and I look up to you for your leadership in the college counseling field. To Dr. Williams, thank you for your perspective and caring guidance. I appreciate your willingness to join my committee and provide meaningful insight and some humor along the way.

I want to convey my true appreciation for all my mentors who have walked alongside me in this journey. First to Dr. Megan Little, thank you for being the first person to tell me that I could succeed in a doctoral program. I will never forget the ways that you helped me to believe that this was something I was capable of, and I hope to be that voice of encouragement to one of my students someday. To Kathryn, thank you for being the first supervisor to tell me that my own eating disorder history did not have to stop me from doing this work. During both my licensure and CEDS supervision you have provided a safe space for me to learn how to be kinder to myself and to speak up and use my voice with boldness and courage. Working alongside you as part of the eating disorder treatment team was a dream of mine for so many years and I continually feel encouraged and supported by you every single day. You embody all that I strive

to be as a supervisor, eating disorder specialist and leader and I am so thankful that you decided to invest in me in the ways that you have. To Dr. Stout, how far we have come since my intern days! Thank you for believing in the importance of the work that I do. You have given me the opportunity to share this knowledge with our training program, while always being a safe place to process how difficult this dissertation and professional development journey has been for me. To all my colleagues at CAPS and my doctoral cohort, thank you for the endless support, the late nights, the laughs, and the joy that comes from knowing you! You all bring yourselves to the world and to this work in a way that I admire and learn from every day. To my friends, what a journey this has been. I cannot thank you enough for your constant patience and for the many times that you allowed me to share my emotional process and provided comfort, safety, and understanding. Finally, to my parents this would not have been possible without your help and the sacrifices that you have made to help me achieve this dream. For allowing me to stay with you after some incredibly hard personal situations, for helping take care of Ellie, for bringing me meals, for providing a safe and comforting place of rest for me and most of all for your endless belief in me.

Dedication

This dissertation is dedicated to all the other people in larger bodies who are striving to have a healthy relationship with food and with our own bodies. It is endlessly exhausting to exist in a world that tells us we are too much and commands us to shrink ourselves. May we continue to grow, expand, and become boundless! Know that you deserve healing, pleasure, and joy in your life in the body that you have today. I am beyond thankful that each of the participants in my study were willing to share these stories in hopes that the study can bring awareness to the harms of weight stigma in mental health treatment. Each of you are incredibly brave and I am immensely inspired by you and honored that you shared your story with me.

To the other mental health professionals who recognize weight stigma and are working hard to bring this awareness to our field in a variety of ways, may you have energy to continue doing this amazing work! I hope that you never forget the importance of the work we do and that what you are doing is making a difference in the world and creating momentum for the next generation of mental health professionals. Lastly, I dedicate this dissertation to all the first-generation graduate students who question if this is something that you can do. Never stop working towards your dreams and know that you are worthy and capable.

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Chapter I Introduction

This chapter includes an introduction to the topic and problem being addressed by this study. In addition to an introduction of the study topic, the chapter includes a review of the purpose of this study, the research questions that guide the project and an overview of common terms that help the reader understand concepts discussed in subsequent chapters.

Introduction to Weight Stigma

Weight stigma can be defined as negative weight-related attitudes and beliefs that are manifested in stereotypes, rejection, and prejudice towards individuals because they are overweight or obese (Puhl, Moss-Racusin, et al., 2008). Weight stigma can be experienced by anyone regardless of body size; however, it is most common for those who are perceived to be “overweight” by modern societal standards, especially individuals who identify as women (Puhl, Andreyeva, et al., 2008). Weight stigmatization is well documented in research as a common cultural phenomenon (Crandall & Biernat, 1990; Puhl & Brownell, 2003) and occurs in a variety of domains such as educational institutions (Cameron, 2016), from medical and mental health providers (Kirk et al., 2014), in the workplace (Rudolph et al., 2009), in the media (Brochu et al., 2014), and from family members and friends (Puhl, Andreyeva, et al., 2008). Some examples of weight stigma include hurtful comments made by friends and family members, physical barriers such as waiting room and office chairs that are too small, negative assumptions made by others (e.g., those who are fat lack willpower), and being ignored or stared at in public (Puhl & Brownell, 2006).

Despite its rising rates, weight stigma is both pervasive and underrecognized in modern Western society. It is estimated that perceived weight-based discrimination has risen by over 66% in the last decade (Andreyeva et al., 2008), making it comparable to other types of societal

stigmatization (Puhl, Andreyeva, et al., 2008; Puhl & Heuer, 2010). Weight stigma has been recognized since the 1980's (Agell & Rothblum 1991; Brown, 1989; Chrisler, 1989; Young & Powell, 1985), however more research is needed to explore this phenomenon in mental health settings from the client's point of view. The fear and dislike of fat individuals is enveloped in our culture, making mental health providers susceptible to perpetuating this type of stigmatization even if it is not conscious. Research about weight stigma is lacking in counseling and counselor educator but work from correlating fields suggest that mental health providers hold negative beliefs about those in larger bodies (Pratt et al., 2016; Puhl et al., 2014).

This fear or dislike of fat people, along with other anti-fat attitudes and assumptions is referred to as fatphobia, and is inextricably tied to weight stigmatization (Monaghan, 2008). This inherent fear of fatness is the cognitive notion that often leads to acts of weight-based discrimination (Vartanian & Novak, 2011). In her book *You Have the Right to Remain Fat*, scholar and activist Virgie Tovar (2018) discusses the societal purpose of fatphobia by stating:

Fatphobia uses the treatment of fat people as a means of controlling the body size of all people. Fatphobia creates an environment of hostility towards larger bodied people, promotes a pathological relationship to food and movement, and places the burden on anti-fat bias on noncompliant individual- that is, fat people (p. 17)

Fatphobia may cause an individual to unconsciously treat a fat person poorly, as they themselves are afraid of becoming like this person, knowing how fat individuals are treated in society. This internalization of fatphobia is harmful to all parties involved and may be one of the reasons that providers often perpetuate weight stigma onto individuals that they are treating (Durso & Latner, 2008).

Statement of the Problem

Weight stigma is observable in a variety of settings and is prevalent in both medical and mental health treatment, referred to as *provider weight stigma* (Cowan et al., 1991; Young &

Powell, 1985). Provider weight stigma is pervasive but often subtle, going unrecognized or overlooked by medical and mental health professionals (Lebow et al., 2015; Sim et al., 2013). Specifically, in the world of eating disorder treatment, weight stigma is linked to a delay of treatment, along with misdiagnosis for women in larger bodies (Harrop, 2019). Women in a larger body are often advised or encouraged to lose weight as solution to disordered eating behaviors, while women in thinner bodies are advised to seek treatment for the restrictive behaviors (Burgard, 2004). Suggestions for weight loss for women with restrictive eating behaviors can be problematic and potentially harmful, as they perpetuate the dangerous consequences of disordered eating. The intentional pursuit of weight loss has been shown to be ineffective and even detrimental in multiple longitudinal health studies and may even be damaging to overall health in the long term (Cogan & Rothblum, 1992). In addition to its low success rate, suggesting dieting to an individual struggling with disordered eating is a potentially harmful practice that may cause an individual to progress from disordered eating to a diagnosable eating disorder, an unfortunate phenomenon that happens in up to 35% of chronic dieters (Aphramor, 2005, 2008; Bacon & Aphramor, 2011; Mann et al., 2007; National Institutes of Health [NIH], 1992).

Need for Study

Given the dangerous consequences of weight stigma, more research is needed to explore how Provider Weight Stigma (PWS) is experienced by higher weight women with restrictive eating behaviors (Puhl et al., 2014). Literature suggests that weight stigma is a negative factor in the treatment of eating disorders and is harmful to the therapeutic alliance, but little research is available from the client's perspective (Kinavey & Cool, 2019). To the writer's knowledge there is only one other study that focuses on the client's perceptions of weight stigma, and this study

focused on individuals diagnosed with binge eating disorder (BED), rather than women reporting restrictive behaviors with food (Ciepcieliński, 2016).

Along with being harmful and potentially traumatic, weight stigma is shown to affect accurate diagnosis and treatment in higher weight individuals (Harrop, 2019). Atypical Anorexia is an eating disorder diagnosis that fits under the umbrella of Other Specified Eating Disorder (OSFED) and is given to an individual when they meet all the diagnostic criteria for Anorexia Nervosa, but are not considered underweight. The weight requirements for such diagnoses serve to perpetuate weight stigma by including low body weight as a main criterion for a diagnosis of anorexia nervosa. According to Fairburn and Bohn (2005), because of the weight criteria set forth in the DSM clients in larger bodies are most often diagnosed with Other Specified Feeding or Eating Disorder (OSFED), and may be unable to receive insurance coverage for their treatment, as insurance companies do not always see OSFED as justification to cover treatment (Turner, 2019).

These diagnostic criteria create barriers to access and proper services for women in larger bodies who present with restrictive symptomology and may aid in the continuation of provider weight stigma and lack of access to proper care. This lack of access is alarming considering that eating disorders are the most fatal mental health diagnosis and can cause severe medical complications for clients of any size (National Eating Disorders Association [NEDA], 2018). According to recent prevalence statistics less than 6% of all people diagnosed with an eating disorder are considered underweight (Galmiche et., al., 2019; Hoek, 2016) and in a study of college aged women by Lipson and Sonnevile (2017), higher weight was in fact the most reliable predictor of eating disorder development later in life. Additional studies show that people in larger bodies are at a higher risk for developing eating disorders than those in more

societally acceptable bodies (Darby et. al., 2007; Lebow et., al., 2015; Sim et al., 2013;). The results of these studies challenge the dominant societal narrative that disordered eating is something that most often occurs in white, thin, able-bodied women, a myth that continues to prevent women in larger bodies from getting proper diagnosis and treatment (NEDA, 2018). The prevalence of disordered eating for women in larger bodies, along with the social portrayal of eating disorders as something that occurs in white, thin, cis-gender, heterosexual women make weight stigma an important phenomenon for counselors to address and research. (Kinavey & Cool, 2019).

Purpose of the Study

The purpose of this study is to increase understanding of client experiences of weight stigma perpetuated by mental health professionals. Qualitative in nature, the phenomena of weight stigma will be explored through a transcendental phenomenological methodology from the viewpoint of the client. The aim of the study is to explore this phenomenon from the client's perspective, specifically the perspective of higher weight women who report restrictive eating behaviors. Research shows that weight stigma is harmful and potentially traumatic to individuals seeking treatment (Kinavey & Cool, 2019) and that weigh stigmatization leads to a host of medical, physical, and emotional consequences as discussed in prior sections. Newer research points to the idea that health consequences that Western society contributes to "obesity" may instead be a result of weight stigmatization and discrimination (Sutin et al., 2015; Tomiyama et al., 2018). This demonstrates the need for mental health providers to increase their awareness of weight stigma, in order to avoid perpetuating this type of discrimination which may be harmful to their clients.

This study aims to highlight client experiences of weight stigma perpetrated by mental health professionals in the treatment of disordered eating and bring awareness to its negative effects of such stigma for clients in larger bodies. It is my hope that the study will bring attention to an important form of oppression that is often overlooked in the counseling profession. The data analysis procedures will be guided by the theoretical lenses of social constructivism as well as relational cultural theory, which will be explored in the methodology section of this study. These frameworks examine weight stigma through a social justice lens, providing justification for body size and shape to be seen as a dimension of diversity in counseling. While professional counselors are trained to be accepting and affirming to all clients, graduate programs do not currently address weight stigma (American Counseling Association [ACA], 2014; Kaplan & Gladding, 2011; Ratts et al., 2015). A gap in the literature demonstrates a need in the field of counselor education to develop critical consciousness around the topics of weight stigma and fatphobia and how they affect our work with clients of size, especially within the treatment of eating disorders and other disordered eating patterns involving restrictive behaviors.

Research Questions

Based upon the existing literature and the stated purpose of this study, I will ask the following research questions

RQ1: What are the lived experiences of higher weight women seeking mental health treatment?

RQ2: How do higher weight women perceive, and report experiences of weight stigma imposed by mental health professionals?

RQ3: How do these experiences of weight stigma influence the therapeutic alliance from the perspective of the client?

Assumptions

There are several common assumptions that underly qualitative research methodology. A foundation of the methodology is that reality is a social construct, and that researchers are part of this socially constructed world and hold their own biases and opinions (Creswell, 2013). I acknowledge my position as it pertains to the research and will take the necessary steps to bracket my own experience so that research bias will be minimized, but it is important to acknowledge that research is values based; and my own experiences and motives may affect the study. I assume that the participants will speak about their experience honestly during interviews and will be open to sharing their experiences of provider weight stigma. It can also be assumed that the researcher will collaborate with participants in ensuring the accuracy of derived themes, and will participate in member checks (Patton, 2002). Finally, I am making the assumption that this research study will provide insight and information that will be beneficial to mental health professionals working with clients in larger bodies.

Limitations

The study has a variety of limitations which are discussed in greater detail in subsequent chapters, however this section will provide a brief overview of the possible limitations present within the study. Much of the previous research on weight stigma centers the experiences of white women, leaving behind various differing identities including those with varying racial identities, members of the LGBTQ+ community and other intersecting identities (Gordon, 2019). This is limiting for a variety of reasons and decreases the ability for the results of studies to be applied to other groups. Because much of the prior research looks at a homogenous group, the intention is to obtain a more diverse sample for this study that can be stratified by race, ability and sexual orientation however it may not be achievable due to geographic location and available

participants. This lack of diversity could be a limitation as it would decrease the ability of this research to be inclusive of a variety of women with differing identities, overall limiting the influence of the results on current treatment paradigms and standards.

Another limitation is that very little demographic information will be collected about the participant's mental health provider. While questions about the provider's racial and other identities could potentially be included in the demographic questionnaire, the answers would rely on the memory and understanding of the research participant, as well as the amount to which the mental health provider disclosed their identities to the client/research participants.

Misidentification could potentially be even more harmful than not including these factors at all.

Researcher Position

In qualitative research, it is important for the researcher to discuss their own positionality in the research as part of a bracketing process. The bracketing process is a process wherein the researcher attempts to set aside their own biases and experiences to see the phenomena through the eyes of the participant (Creswell & Poth, 2018). While it is impossible to be free of bias, disclosing of the researcher's positionality is considered best practice as a part of a larger bracketing process. In this section, I will disclose some of my own identities and experiences which are salient to the research I am conducting.

I have worked with the Eating Disorder Treatment Team at a large southern university for the past two years and am passionate about the fields of eating disorder treatment, weight stigma, and weight inclusive treatment. I have developed and implemented a variety of weight inclusive outreaches and therapy groups on my campus and have trained interns and staff in these approaches. As someone in a larger body who has been in treatment for disordered eating myself and endured weight stigmatization from a variety of mental health providers, I have a growing

desire to change the way that mental health professionals view clients in higher weight bodies. I want other women who exist in larger bodies to be able to access appropriate and effective eating disorder treatment that is free of weight stigma and bias, as I know how important that is to the recovery process. I acknowledge that provider weight stigma is a common and pervasive problem that occurs in the therapeutic relationship and have experienced it in my own personal recovery and my work as a mental health provider. Given this personal perspective, I will strive to remain in my role as a researcher throughout my work, using a bracketing interview, personal journals and memos, and external audits by members of my research team. Although I understand that my lived experiences and biases cannot be completely erased, I remain open to hearing the experiences of my participants as they lived them and will work to separate their experience from my own.

As a higher weight woman, myself, I cannot exist in the world as anything else and I will be keenly aware of this as I conduct interviews—especially interviews where participants can see my body shape and size. While their knowledge of my shape and size may provide a form of solidarity, I also intend to avoid engaging in shaming other providers or asserting that my experience with weight stigma is the same as my participants. It is my intent to approach this study from a resilience and strengths-based perspective that I feel is congruent with my identity as a licensed counselor, as licensed counselors are interpersonal in nature and seek to empower the individuals that they work with. I want to encourage my participants in their process of healing and recovery, and I want them to know that they are deserving of stigma free care no matter their body shape or size.

Definition of Terms

For the purposes of this study, fat is used to describe individuals that society traditionally labels as “obese” or “overweight”. Words like “obese” and “overweight” medicalize diversity and perpetuate the assumption that there is one standard weight, rather than a natural range of weight diversity (Burgard, 2009). The word fat is used intentionally throughout the study as a neutral physical descriptor, to empower and affirm individuals in larger bodies, and move away from the stigmatization of larger bodies. The intentional use of the word fat in research studies and clinical environments is supported by the body liberation community as a way to decrease stigma related to body size and weight and is often used by researchers rooted in critical and feminist pedagogies (National Association to Advance Fat Acceptance [NAAFA], 2011). Below is a list of additional terms that are utilized throughout this paper and their definitions.

Diet culture: A system of beliefs that worships thinness and equates it to health and moral virtue, which means an individual can spend their whole life thinking they are irreparably broken just because they do not look like the impossibly thin “ideal”. This idea oppresses people who do not look like the supposed picture of health (Harrison, 2019).

Disordered Eating: Disordered eating is used to describe a range of irregular eating behaviors that do not necessarily warrant a specific eating disorder diagnosis. Disorders such as Anorexia Nervosa, and Binge Eating Disorder are diagnosed according to a specific and narrow criterion, excluding the majority of people suffering with disordered eating. Disordered eating may include things such as fasting, calorie counting, following specific fad diets, restricting food due to “feeling fat”, avoiding eating in front of others, and adhering to a strict diet focused on morally “good” or “clean” foods (Anderson, 2018).

Fat: For the purposes of this study, fat may be used to describe individuals who would be referred to as “obese” or “overweight” in modern society. While Fat may be considered a stigmatizing and/or triggering word by some, it is merely a description and it used In the Fat activism community to move away from medical terminology which further pathologize fat individuals (NAAFA, 2011)

Fatphobia: Fatphobia encapsulates negative or distasteful attitudes toward and stereotypes against fat people, especially that fat people may be “lazy, unhealthy, unmotivated, or unattractive” (Owen, 2012; Puhl et al., 2015; Swami & Monk, 2013; West, 2016)

Internalized weight bias: Internalized weight bias is the belief that negative stereotypes about weight apply to the self, it is a significant concern for women and has been linked to a range of physical and psychological issues including restrictive disordered eating (Puhl et al., 2007).

Mental health professionals (MHPs) can include licensed professional counselors, psychologists, substance abuse counselors, marriage and family therapists, and social workers.

Obese/obesity: “Obesity” is described in medical circles as a disease characterized by a BMI greater than 30 (Center for Disease Control, 2014) Fat activists and fat scholars often reject this term as they feel that it further stigmatizes fat bodies.

Provider weight stigma (PWS) refers to weight stigma and fatphobia exhibited by a large, overarching category of individuals: health professionals, mental health professionals, and more specifically, eating disorder professionals (Puhl et al., 2014).

Restrictive eating behaviors: Disordered eating behaviors of a restrictive nature may include frequent dieting, rigid rules around food, labeling foods as “good” and “bad,” restriction of calories and fasting. Although these may not be narrow enough to qualify someone for an eating

disorder, disordered eating is a complex and serious problem that requires specified treatment (Harrison, 2019)

Weight stigma: Often used interchangeably with fatphobia, weight stigma describes negative beliefs, thoughts, or behaviors towards others based on weight or body size. For the purposes of this study, weight stigma and fatphobia may be used interchangeably to describe negative body based microaggressions and stigma as experienced by the participants of this study (Puhl et al., 2008, p.347).

Brief Overview of the Study

This dissertation is organized in five separate chapters. Chapter one includes an introduction to weight stigma, its consequences, and the ethical imperative for mental health professionals to embrace weight inclusive treatment approaches. It also includes the research questions investigated in this study, discusses assumptions, limitations, and researcher position within the study. Chapter two provides an overview of the current research and defines the gap that exists in literature addressing weight stigma within restrictive eating disorder symptomology. This chapter provides current research on weight stigma, how it appears in the therapeutic alliance and how it prevents clients in larger bodies from accessing appropriate and effective mental health treatment. Chapter three outlines the research methodology and provides the reader with information on sampling procedures, participant inclusion criteria and selection, as well as detailing the theoretical underpinnings of the study. Chapter Four is a delineation of the study findings, and chapter five provides discussion surrounding the practical implications and suggestions for future research and clinical practice.

Chapter II Literature Review

This chapter includes a dissemination of the literature that is relevant to the current research study. Beginning with an overview and examination of weight stigma within modern Western Culture, the literature review also includes research in the areas of diet culture, appearance ideals, weight stigma within healthcare, and weight stigma within mental health treatment and eating disorder treatment. The literature review highlights the diagnostic and treatment delays and errors that often occur for women in larger bodies who present to treatment with restrictive disordered eating symptomology, building a case for more studies that focus on client experiences of provider weight stigma.

Weight Stigma in Western Culture

Weight stigma, which is also referred to as weight bias includes the negative weight-related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are overweight or obese (Puhl et al., 2008). The origins of weight stigmatization can be traced back to the cultural phenomena of the *appearance ideal* (Stice & Shaw, 1994). The appearance ideal is a collection of several societal standards that dictate acceptability and attractiveness. This ideal is a socially constructed phenomena that endorses white, thin, non-disabled bodies as being superior or ideal to others (Klaczynski et. al., 2009; Stice & Shaw, 1994). The appearance ideal is something that penetrates every aspect of our culture and plays a role in the development of disordered eating and eating disorders (Stice & Shaw, 1994). This pervasive ideal is not something that helping professionals are immune to; the appearance ideal is something that is presence for mental health professionals consciously or not. This prevalence of weight stigma in modern Western culture, and pervasiveness of the

appearance ideal may make mental health and other professionals susceptible to perpetuating this type of stigmatization. (Latner et al., 2008).

Weight stigma and its effects have been observed in a multitude of societal domains. The phenomenon of weight stigma was first studied and observed in the context of work environments. Roehling (1999) discovered a wage gap between working women based on their BMI, favoring women with a lower BMI. Roehling also found that weight often determines rate of promotion, and that employers may be more likely to see a higher weight employee as lazy or unmotivated regardless of their actual productivity values. Additionally, weight stigma has been observed in educational settings affecting grades for students with higher body mass indexes (BMI's) (Schwartz, et al., 2003). People of size are also less likely to gain acceptance into a variety of graduate programs even when their scores and academic achievements mirror those of their thin bodied peers (Burmeister et al., 2013). Weight stigma is also perpetrated by friends and family (Puhl & Brownell, 2001), by strangers (Puhl et al., 2008) and widely in the media (Pearl et al., 2012). Weight stigma is frequently reported in healthcare settings (Schwartz et al., 2003; Teachman & Brownell, 2001) and notably eating disorder treatment (Puhl et al., 2014).

As evidenced by the breadth of research discussed above, weight stigma is a phenomenon that effects individuals in Western society within a variety of professional and personal domains. It is important to understand the history of weight stigmatization in order to work towards combatting this type of stigma and oppression in the future. Beauty ideals are neither changeless, nor universal across all cultures. In Western culture, beauty is viewed as currently, especially within heteronormative structures which value the male gaze as a form of currency (Wolf, 2002). The following section provides a brief history of body ideals across time, orienting the reader to the origins and history of weight stigmatization and the appearance ideal.

Weight Stigma and the Appearance Ideal

Body ideals for American women are often dictated and created by the media and fashion industries and change frequently throughout history (Cash, 2002; Striegel-Moore et al., 1986). For beauty ideals and standards to be successful in controlling women, they must continually take on new forms throughout time. Feminist scholars believe that these beauty ideals serve to control and sedate women, and that they are intentionally shifting and changing so that the pursuit of such ideals becomes endless (Agell & Rothblum 1991; Brown, 1989; Chrisler, 1989; Young & Powell, 1985). By creating these ever-changing standards, women are kept subservient to fulfilling whatever image of beauty is more current during that time, and are unable to spend their time, money or energy on occupational and other social pursuits (Wolf, 2002). In her book *The Beauty Myth* (Wolf, 2002), researcher Naomi Wolf introduces body liberation as a feminist movement which co-occurred with the women's rights movement in the 1970s. She states that with the emergence of modern feminism, women pushing back against patriarchal standards of beauty such as the desire to be thin, white, and able-bodied. She asserts that these beauty standards were simply another way to keep women politically sedated, and a movement began to fight against these ideals. Wolf (2002) brings attention to the fact that over the past decade, images of the ideal woman became more pervasive and controlling in advertising, while at the same time eating disorder treatment became the most pursued medical specialty due to a high demand for services. This shows that these type of controlling images in the media are affecting the health and safety of women and putting women at a higher risk of developing disordered eating. Wolf argues that while women may have more political, economic, and personal power in the 20th century the increase of controlling images in the media serves as a violent backlash to the rise of feminism, becoming another tactic to keep women down economically draining

valuable resources of time, money, and energy. Wolf (2002) states, “A culture fixated on female thinness is not an obsession about female beauty, but an obsession about female obedience. Dieting is the most potent political sedative in women’s history; a quietly mad population is a tractable one” (p.11).

As women continued to fight for increased rights, the media reacted by introducing the image of the ugly feminist, portraying feminists as women who refused to fit in with beauty standards held by men. As Betty Friedan stated in the 1960s, “the unpleasant image of feminists today resembles less the feminists themselves than the image fostered by the interests who so bitterly opposed the vote for women in state after state” (Friedan, 1963). Third wave feminist scholars and activists emphasize the importance of women disconnecting from these images all together, and the importance of self-awareness and personal consciousness raising, rather than attempting to change the belief and practices of marketing agencies and the general public. In her book *Beauty Myth*, Wolf (2002) states, “The marketplace is not open to consciousness-raising. It is misplaced energy to attack the market’s images themselves given history they were bound to develop as they did. While we cannot directly affect the images, we can drain them of their power. We can turn away from them, look directly at one another and find alternative images of beauty” (p.277). While the media may not be willing to change the images, women can increase their own understanding and feel empowered to consume media more consciously and hopefully control the degree to which they are influenced by these quickly changing ideals. It is important to understand the origin and history of such beauty ideals, ideal which continue to shift and change throughout each new decade. In understanding these ideals, women can be empowered to find alternative images of beauty and avoid the harmful effects of internalized weight stigmatization.

Appearance Ideal Over Time

The appearance ideal is a set of standards which define beauty and are thought to be virtually unattainable for most women (Stice & Shaw, 1994). While the current ideals endorse thin, white, able-bodied, cisgendered bodies (Hoff & Hancock, 2022; Stice & Shaw, 1994) these ideals change over time and the world has not always valued thin bodies above other types. Beginning in the 17th century, women who were curvy or fat were idealized, this may be attributed to the fact that a larger body at that time was considered a sign of wealth and providence (Baker, 2014).

Moving into the 19th century, during the Victorian era; women became determined to change their shape and decrease waist size using corsets and other body binding undergarments (Ewing, 1989). According to Ewing (1989), this practice of waist binding was often done at the expense of physical and emotional health and at the time was seen as something that women were obligated to do to participate fully in society.

At the turn of the 20th century, women were urged through the media to hide their curves and dress in less shapely attire. This was accompanied by the emergence of the *flapper* in the 1920's, a fashion trend which encouraged chopped hair and bold makeup. As women moved towards social liberation, they began striving to be thinner and smaller, possibly to avoid other types of oppression and marginalization related to sex and gender. In the 1950's actress Marilyn Monroe was seen as the epitome of beauty, she possessed an hourglass figure and was somewhere around a modern-day size 12. It is important to note that clothing sizes have changed tremendously in the present decade, and it is possible that she would have been a smaller size in modern times, however it is still notable that she had a curvier body than the

famous women before her. Marilyn's hourglass waist became a hallmark fashion trend and beauty ideal that girls and women sought to attain.

Beginning in the 1960s and 1970s, Cher and Farrah Fawcett are often used as examples of the beauty ideal at the time which began prizing thin bodies over curvier women. This trend continued in the 1980s which brought about an era of aerobic exercise and the devaluation of larger bodies. In the 1990s, the appearance of the modern-day editorial model who is typically a size 00 or 0 was met with the aesthetic often coined as *heroin chic* again praising bones that were evident through clothing and extremely low body weight (Sypceck, Gray, Ahrens, 2004).

In the current era, the primary feature of the dominant beauty ideal is that of thinness (Herbozo, Tantleff-Dunn, Gokee-Larose, & Thompson, 2004). Achieving thinness is considered ideal because it is thought to be correlated with popularity and life satisfaction (Langlois et al, 2000). Pursuits of thinness are thought to be related to eating disorder (Spangler & Stice, 2001), body dissatisfaction (Tiggemann, 2006) and anti-fat attitudes (Lin & Reid, 2009). In a study of over ten thousand women, 89% of the women surveyed indicated that they were dissatisfied with their weight and wished they were thinner, and this belief begins as young as age ten (Swami et al., 2015). There is a pervasive belief in western culture that being thinner will bring us happiness, fulfillment, and worth. This belief serves the beauty and weight loss industries by keeping women trapped in an endless expense of mental, emotional, financial, and material resources (Wolf, 2002).

Along with being thin, another expectation placed on women is that their bodies should be firm or "toned." This thin, firm body is what is continually seen in mass marketing (Gill, 2007). Although it is often unattainable due to genetics and other social determinants of health, beauty ideals push women to believe that their bodies should not be soft in any way, but rather

that every muscle should be toned. Modern societal standards also expect women to be hairless and without skin imperfections (Darlow & Lobel, 2010). This demand for smoothness can lead women to a never-ending pursuit to erase every mark, pore, and imperfection. The problem with this is that when women are focused on microscopic imperfections, they are less likely to have time to engage in goals such as career building and pursuing higher education and leadership positions. Along with being thin, white, and without perfection the appearance ideal asserts that women need to remain youthful. This notion encourages individuals to undergo potentially dangerous cosmetic procedures to maintain younger facial features and avoid the natural effects of aging (Ganahl, Prinsen & Netsley, 2003).

These shifts and changes across time and culture, demonstrate that beauty ideals are something that change over time. These constant changes create a market in which women cannot possibly keep up, keeping women trapped in an endless cycle of spending their time money and energy attempting to meet unreachable standards. Beauty ideals also perpetuate the dominant cultural narrative of white, middle-class woman, rather than embracing the cultural differences that exist within weight stigma (Bordo, 1993; Wolf, 2002). It is presumed that every culture has its own unique beauty standards, although much of the research is focused on the beauty ideals of white women. Recent research highlights the lack of awareness surrounding body image in other cultures as a function of white supremacy, something that needs to be explored further in the context of weight stigma (Cox, 2020; Strings, 2019). To work towards body liberation which includes the eradication of weight stigma, it is critical that weight stigma be examined alongside other types of oppression such as racism, sexism, homophobia, transphobia, xenophobia and others (Paredes, 2018). To embrace body liberation as a form of

activism, it is important to understand the origins of weight stigma and fatphobia and to investigate how its origin are rooted in racism (Strings, 2019).

Origins of The Appearance Ideal and Weight Stigma

The beginnings of modern weight stigma can be traced back to the arrival of slaves in the United States, a time where white women became afraid to gain weight because of the association between curvier figures and Black women (Strings, 2019). In her book *Fearing the Black Body*, Strings (2019) goes on to explain that white women began worshipping the idea of thinness when fatness became associated with Black women and racial un-assimilability. This history is largely omitted from the narrative about fat phobia; however, it is important to address that these systems of oppression are inextricably tied together. Therefore, weight stigmatization is often thought to be the result of Eurocentric beauty standards which society associates with acceptability and attractiveness. This Eurocentric “appearance ideal” perpetuates weight-based oppression by endorsing white, thin, non-disabled bodies as superior or ideal (Stice & Shaw, 1994). The narrative that “good” bodies are thin is an assertion of white supremacy and should be addressed as such (Patton, 2006). Fatphobia, then, is the result of beauty standards typically associated with higher class white women, leading to weight stigmatization of those who do not fit into that description. While early research was critical in examining the phenomena of fat phobia, it focuses on the experiences of white, often middle-class women. If weight stigma is to be examined from a truly critical lens, we need to take a closer look at the role of white supremacy in fat phobia and anti-fat attitudes which have yet to be explored.

The Myth of Controllability

Beauty ideals are particularly dangerous in America, given that the culture has made claim that beauty is an ethical and moral ideal and obligation, and historically women were given

value based on how well they aligned with beauty standards (Tiggemann, 2004). As beauty is connected with thinness, this has created the emergence of healthism which focuses on the way that someone looks rather than actual markers of health (Crawford, 2006). Within this framework, thin is “good” and fat is “bad” and being fat is seen as a measure of failure and personal responsibility.

Fat individuals are often viewed as emotionally impaired, selfish, lazy and lacking in willpower based on the distorted notion that being overweight is controllable, and therefore must be the result of personal flaw (Sikorski et al., 2013). The social acceptance of weight-based oppression stems from this distorted idea that weight is always a result of personal responsibility. This is one of the controlling images that is ever presence for women living in a culture that values thinness and often denigrates larger bodies. Our culture projects images of what individuals should be, a concept known as controlling images for practitioners of Relational-Cultural Theory (RCT), which is one of the theoretical foundations of this study. Controlling images are ideas, images, and stereotypes that are defined by greater society and the media and often serve to further oppress individuals belonging to marginalized groups (Jordan, 2008). In modern media, fat individuals are often portrayed as lazy or lacking in self-discipline. This harmful controlling image makes it ways into the minds of the public, furthering diving the power differential between thin and larger bodied women. Fat characters in movie and television series have plot lines that are centered around their weight rather than their wholeness as a person. It is extremely difficult to find a representation of a fat individual in media whose body is not their entire plot line, or whose desire and journey to lose weight is the main part of the story. Another controlling image is the idea that everyone has a thin person inside of them, and ideology embraced by society and influencers alike. This narrative furthers the belief that a fat

person should always be striving to lose weight to preform adherence to the appearance ideal, and to be “good” morally. Because these controlling images are part of our greater Western culture, it can be assumed that providers may internalize and project these onto the individuals they are treating.

In her Ted Talk about the effects of fatphobia, author and activist Virgie Tovar discusses how this controllability myth makes fatphobia dangerous. She asserts that most people do not see fatphobia or weight stigma as forms of violence, due to the belief that everyone can control their body shape and size (Tovar, 2017). Body shame is normalized and veiled in this belief that if a person were more disciplined or dedicated, they could change their body. This belief places the responsibility on the individual to assimilate to the dominant narrative by losing weight rather than requiring others to view the individual as a part of a socially constructed system that marginalizes people in larger bodies. This morality driven view of body shape and size ignored the construct of body diversity, the idea that individuals naturally occur at different weights and body sizes even if their exercise and food intake is identical (Komaroff, 2016). Genetics, environment, medical issues, and social status all play a role in someone’s body shape and size (Bacon, 2010), even though society often asserts that body shape and size is completely controllable.

Regardless of the cause of weight gain and existing in a larger body, weight stigma harms women, and is detrimental to a variety of health measures (Hunger et al., 2015; Puhl & Heuer, 2010). Weight stigma is associated with lower rates of self-esteem, body dissatisfaction, lower quality of life and disordered eating behaviors (Durso et al., 2012). And when this type of stigma is internalized, it can lead to increased depression and more severe eating disorder symptomology (Barnes et al., 2014). On top of rising rates of prevalence, research suggests that

weight stigma is seen as a more acceptable form of discrimination due to the misguided notion that body shape and size is controllable and that fatness is a result of laziness (Puhl, Andreyeva, & Brownell, 2008). As a reaction to this type of weight stigmatization and oppression, women are turning to dieting as a means of shrinking their body to avoid this type of oppression, however intentional dieting is not without its own set of harmful consequences (Vartanian & Silverstein, 2013).

Diet Culture

Christy Harrison is a registered dietitian, author, speaker, and is well known for her podcast *Food Psych* which focuses on how individuals can let go of diet culture, and work towards body liberation and acceptance (Harrison, 2019). Harrison (2019) defines diet culture as a system of beliefs which worships thinness, rejects the idea of body diversity, promotes weight loss as a means of attaining a better life, and demonizes certain ways of eating while lifting others up to heroic status. Harrison often refers to diet culture as the life thief, a way to personify how diet culture and the thin ideal can take residence in the brain, taking with it massive amounts of time, energy, and money in pursuit of something that is not always achievable. She goes on to say that “Diet culture is Western culture, the way of thinking about food and bodies is so embedded in the fabric of our society, in so many different forms, that it can be hard to recognize” (Harrison, 2018). In Harrison’s (2019) first book *Anti Diet*, she emphasizes the idea that as long as someone is driven by diet culture, their life suffers, their connections and relationships suffer, and they may even risk long term health consequences, which is dangerous considering that dieting has become a social norm in Western culture. One of the consequences of weight stigma is the modern adaptation of diet culture, especially in Western culture. Diet culture can be seen as the reaction to fatphobia and weight stigma, as pursuing thinness is a way

for women to avoid other types of discrimination by attempting to adhere to modern cultural standards of beauty. In her book *You Have the Right to Remain Fat*, fat activist, scholar and author Virgie Tovar (2018) states “Dieting is the result of unresolved fatphobia. We become terrified of what it would mean for us to be fat because we understand fundamentally how poorly fat people are treated” (p.22), in a sense dieting is an acknowledgement that weight stigma and fatphobia exist.

Impact of Diet Culture on Women

Dieting is a common practice of women, and often occurs as a result of societal beauty and health ideals (Abramovitz & Birch, 2000). Research shows that from the age of five or six, women begin believing that their bodies are something to be fixed or changed, and this early adaptation of unworthiness leads to a lifelong battle with dieting, weight loss, and worthiness (Lowes & Tiggemann, 2003). Diet culture is impacting women at younger ages, recent research shows that up to 59% of teenage girls are dieting or restricting their food intake in some way (Dove, 2017). As stated by Engeln (2017) in her book *Beauty Sick*, beginning at age nine, 40 percent of girls say they wish they were thinner. Almost one-third of the third-grade girls report they ‘always’ afraid of becoming fat. These numbers show the power that diet culture and weight stigma has on girls and women in America, which is alarming knowing the negative impact that dieting has on a variety of life domains.

Even more than a societal norm, dieting in Western culture is seen as a moral and ethical obligation and an expectation (Lelwica, Hoglund & Mcnallie, 2009). The history of dieting is long, complex, and more dated than most people realize, and can be traced back to ideals of purity and morality during the puritanical era and the invention of the Graham Cracker (Wills, 2014). Developed by Rev. Graham, the graham cracker was invented to allow people to taste

sometime sweet without giving into what he believed was gluttony. Graham and his followers adhered to the idea of food morality, meaning that some foods are morally better than others depending on their health value. This belief continued in American society, leading people to believe that low-fat, low calories foods are a means of attaining a pure heart and avoiding a morally impure life (Contois, 2015).

The morality narrative surrounding food and dieting still exists today and send the message that food is not meant to be pleasurable, and that eating for any other reason except to fuel the body is morally devalued (Rozin, 1999). Ideas of pureness and morality are common in Western society, and often accompany protestant values which emphasize wholeness, self-discipline, and restraint. When morality is placed on food and bodies, it creates a system of control which serves to keep women societally suppressed and does little to increase visible health markers (Bacon, 2010). Alan Levinowitz is a researcher and scholar in religion and has written about how diet culture can be seen as a form of purity or religious achievement. Levinowitz (2015) echoes that asserting that certain foods are “good” and bad”, allows individuals to escape the fear of uncertainty that they may experience in other areas of their lives. Trends such as clean and organic eating, emphasize this idea of morality and purity when it comes to food and our bodies and can lead to patterns of disordered eating (NEDA, 2022).

According to the National Eating Disorders Association (2022):

Clean eating has exploded in popularity, from a fixation on leafy greens to the normalization of juice-based diets. Nutrition should be respected, but labeling food as “clean” or “dirty” is just dieting by another name, and dieting is the most important predictor of a developing eating disorder.

There is a connection between morality-based dieting and fatphobia, as this desire for purity and cleanliness can be seen as a reaction to the fear of becoming fat (Tovar, 2018).

Because society often views fat individuals as undisciplined, dirty, and lazy dieting and

intentional weight loss provide a “solution” by allowing individuals to feel morally pure for choosing “good” foods, and striving to become thinner and smaller (Vartanian, Herman, & Polivy, 2007). Although most individuals do not medically need to have such stringent restrictions on their food intake, Western society markets dieting as something that is necessary and required; especially for women and research shows that women are scrutinized more harshly for eating foods that are perceived as “bad”, when compared to their male identifying counterparts (Vartanian et al., 2007). As a result, women are spending their time, energy, and money to gain social mobility based on weight and they are doing all this only to be judged more harshly by their male counterparts. In addition to being judged by others for their food choices and body size, research shows that women also internalize fatphobia at higher rates, judging themselves more harshly when they have trouble maintaining food restraint and restriction, which is known leads to a host of negative mental health effects such as depression, low self-esteem, and increased social anxiety (Sheikh, Botindari & White, 2013).

Impact on self-image

Diet culture is 60-billion-dollar industry (Harrison, 2019), and it operates by making women feel less than and then selling them the fix to these feelings of unworthiness. Looking at the beauty industry, women spend \$1.1 billion on beauty products annually (Global Wellness Institute, 2018) and there has been a 200% increase in fat removal and body sculpting surgery procedures in the last two decades (American Society of Plastic Surgery, 2018). These measures are problematic, considering that along with rising rates of body modification and dieting, women are reporting higher rates of low self-esteem and poor self- image (Jones et al., 2004;). Diet culture directly benefits from low self-esteem, and poor body image as it continues to sell weight loss as a “fix” for low self-esteem. Women who are unable to maintain food restriction

and restraint begin to see themselves as failing in some way. As women internalize the inability to maintain restriction, this often leads to personal narratives of shame, unworthiness, and personal failure- taking the blame from society and putting it onto individual women. (Hartley, 2011).

In her book *Body of Truth* (Brown, 2015) which explores how history, science and culture impact our obsession with weight Harriet Brown (2015), discusses her own experience of the ways in which diet culture changed her self-image:

Over the years, I've seen my body as the enemy to be conquered, deprived, and beaten into submission- that is, into the smallest possible shape and size. Occasionally I felt proud of its strength and curviness. But more often I saw it as a symbol of my personal weakness and shame, and outward manifestation of inadequacies and failures. (p.xxiii).

Brown emphasizes the idea that women internalize their inability to meet beauty ideals as a personal failing something that garners shame and prevents connection and relationship with others. This disconnect from others is another devastating consequence of diet culture and weight stigma and serves to isolate women from support and friendship.

Impact on Interpersonal Relationships

The indoctrination of diet culture may affect a woman's ability to form deep and meaningful connections, especially with other women. This is since dieting is a culture filled with comparison and judgement, attributes that do not foster supportive interpersonal relationships with others (White et. al, 2006). In pursuit of a more societally acceptable body, women are trapped in an endless cycle of not feeling good enough, and this shame response is not conducive to vulnerability and connection (Lelwica, et al., 2009). This type of environment can quickly become hostile and toxic. Intentional dieting can also be very isolating, as individuals may not be willing to engage in meals with other people or may not be willing to miss a workout to spend intentional time with someone else. This could lead to the conclusion

that dieting and diet culture harms women by encouraging disconnection and fueling comparison and isolation.

Impact on Educational and Occupational Pursuits

Diet Culture also serves to keep women from pursuing educational and occupational pursuits. Recent research shows that women will pursue dieting and thinness at the cost of educational and occupational growth, making dieting a powerful economic sedative for women and a powerful way to keep women from progressing in the workplace. In a research study by Dove (2017), women surveyed indicated that they would rather lose ten to fifteen pounds than be promoted at work, and additionally the participants expressed that they have or would miss important life events due to feeling uncomfortable or fat in their bodies (Wolf, 2002). This provides further proof that diet culture is costing women their worth, power, and even their health in modern society. For diet culture to be eradicated, it is imperative that women begin to see the resistance of diet culture as a form of political advocacy and a gateway to increasing the rights of Western women. Author, activist, and educator Sonya Renee Taylor introduced the idea of the body as an act of political resistance in her book *The Body Is Not an Apology* (Taylor, 2018). In her Ted Talk (Taylor, 2017) on the same subject she stated:

There are ways to use our bodies as everyday acts of resistance, I call this work radical self-love, this moves us beyond the flimsy notions of individualist, radical self-love is interdependent, as we learn to make peace with our bodies and make peace with other bodies, we create an opening for creating a more just and equitable world.

Taylor emphasizes that body oppression is a system that profits off body hate, and that interrupting the system requires making peace with our own bodies, and the bodies of others. Embracing body diversity allows additional space, energy, and time for women to pursue educational and occupation pursuits rather than focusing on their body shape and size. In her book *The Right to Remain Fat*, Virgie Tovar (2018) highlights the utility of diet culture as a

controlling mechanism for women, stating “What we must realize is that it is not thinness that is being eroticized. What is being eroticized is the submission thinness represents in our culture. The true commodity is the willingness of women to acquiesce to culture control” (p.45). If understood in the context of a social control tactic, dieting becomes something that women can fight against through empowerment, body liberation and acceptance.

Impact on Health

Although the media sells dieting as a cure for various illnesses and a promise of health, the practice of calorie restriction and removal of entire food groups is shown to be detrimental to physical health in multiple randomized controlled trials (Bacon et al., 2002; 2005; Bacon 2010; Garner and Wooley 1991; Mann et al., 2007; Mensinger et al., 2016). These studies separated groups of women into a group of participants that focused on health behaviors, and a group of participants that measured changes in weight. What the studies found is that the women who engaged in more health promoting behaviors saw improved health markers (e.g blood pressure, hemoglobin A1C, cortisol levels) although their weight may not have changed. The other group of participants saw a brief reduction in weight, but no change in actual health markers. This research indicates that weight alone does not provide a complete picture of health, and that intentional weight loss does not automatically improve one’s health (Bacon, 2010). While dieting promises health, what it promotes is weight cycling, feelings of shame, guilt, and self-blame which have negative effects on our health (Tylka et al., 2014). The relationship between weight and health is more complex than what is often noted in single research studies and does not consider the idea of health promoting behaviors, which may be the most important factor in improving actual health markers (Chrisler & Barney, 2017). Research shows that if individuals can engage in health promoting behaviors and focus on paying attention to their own internal

cues of hunger and fullness this is a better way to improve actual health measures such as blood pressure and cortisol levels (Bacon, 2010). In addition, we know that experiencing stigmatization and discrimination is a known risk factor for stress and illness, so it is possible that dieters in larger bodies are more negatively affected by the stigma itself than their actual body size and health risk factors which may be attributed to be “overweight” (Amy et al., 2006; Chrisler & Barney, 2017).

Impact on Relationship with Food

Another potential health consequence of dieting is the risk of developing disordered eating or a diagnosable eating disorder. Shockingly, 35% of “normal” dieters will progress to disordered eating within three years, and 20-25% of those individuals will eventually meet criteria for a diagnosable eating disorder (Shisslak et al., 1995). While broadly defined, *disordered eating* includes a variety of symptoms that do not meet the threshold to be diagnosed as an eating disorder, although even that notion can be a fine line of clinical judgement. In addition to loosely defined diagnostic guidelines, disordered eating often goes unnoticed or under addressed in treatment due to the prevalence of diet culture within Western society (Puhl et al., 2015).

One type of disordered eating symptomology that is not yet a diagnosable condition is a pattern of eating known as *orthorexia*. Orthorexia is a pattern of eating where a person chooses to eat completely “clean” food, or food that is seen as morally right or good. This disordered eating trend is increasing in prevalence, although it remains a colloquially term and not a diagnosable eating disorder. This trend towards “clean” or “righteous” eating is often a slippery slope for an at-risk individual to eventually develop a diagnosable eating disorder. The prevalence of orthorexia is shocking; however, it also provides an opportunity for intervention

before this eating pattern becomes a diagnosable eating disorder if mental health professionals can detect it early on. For individuals in larger bodies, orthorexia is often praised, glorified, accepted and even suggested by society along with healthcare providers. This sends a conflicting message, as thin women are diagnosed with eating disorders for the same behaviors (Burgard, 2004; 2009).

Weight Stigma in Healthcare

Weight stigma and bias is observed in doctors, nurses, dietitians, and other health professionals; even those specializing in “obesity” (Poon and Tarrant, 2009; Setchell et al., 2014; Stone and Werner, 2012). In a review of 2284 physicians, all showed levels of weight bias with some even endorsing that “fat people are worthless” or “disgusting” (Crandall & Biernat, 1990). In addition, physicians endorse feeling that patients in larger bodies were lazy, weak-willed, and bad, and reported feeling less respect for those patients compared to patients in smaller bodies. This is problematic on many levels, most notably because of its potential negative effects on health outcomes. Patients in larger bodies often report feeling unwelcome or devalued in clinical settings, even reporting feeling ignored and that the doctor spent less time educating them on potential solutions to their healthcare issues (Foster et al., 2003; Hebl & Mannix, 2003; Maroney & Golub, 1991; Persky and Eccleston, 2011). In addition to spending less time educating fat patients on health promoting behaviors, medical professionals often prescribe dieting and weight loss to patients in larger bodies, despite research showing that it is not effective at changing long term health outcomes (McGee, 2005). Consequently, patients in larger bodies may delay or avoid healthcare due to experiences of weight stigma from medical providers, increasing the chance for more health-related complications (Musher-Eizenman et al., 2004; Puhl 2005). Many medical professionals expect individuals to “fix” their bodies through weight loss while often

overlooking the far-reaching effects of systemic injustice and oppression on their health and wellness, factors that likely have more importance than one single health measure (Kinavey & Cool, 2019). Although laden with good intentions, this type of medical care only serves to stigmatize fat individuals further, likely decreasing their individual health outcomes.

One common measure of health in the medical community is the Body Mass Index, or BMI. The BMI is a simple height-weight ratio used by doctors and insurance companies to measure health, although the research supporting it is slim for a variety of reasons. The BMI was created by a mathematician in the 19th century as a quick formula to assess the degree of “obesity” in the general population, and help the government distribute resources. The researcher who developed the tool cautioned against its use as an individual health marker (Ortega et al., 2017). It is also questionable scientifically and requires a modification of a formula to be completed. Physiologically it does not consider the varying proportions of different ethnic groups and was normed on working class white men (Burkhauser & Cawley, 2008). The BMI is often used to exclude individuals from proper healthcare, including disproportionate numbers of women and people of color (Strings, 2019). This is concerning considering the amount of health disparities that are already present for people of color and women. Contrary to misguided beliefs about body size which assert that anyone can be thin if they will themselves to be so, medical research shows that there are many complicated factors that go into someone’s body shape and size, and that no one can will themselves into being thin (Tomiyama, et al., 2013). Because of this notion that a thin, white body is achievable for all persons and that fatness is due to laziness, this form of oppression is often seen as permissible even within the context of health care. Considering that experiences of weight stigma, along with being in a larger body are risk factors

for eating disorders and disordered eating symptomology, addressing weight stigma within healthcare setting is of increasing importance (Alberga et al., 2016; Haines et al., 2006).

Weight Inclusive Approaches to Treatment

As a reaction to traditional approaches which further harm individuals in larger bodies, weight inclusive treatment was introduced as a new way to talk about health and wellness with clients of all sizes (Bacon & Aphramor, 2016). Health at Every Size (HAES) emerged to talk about health and wellness with clients of all sizes. HAES (Bacon & Aphramor 2011, 2016) is the primary weight inclusive framework through which health professionals and the public can frame weight inclusive care, although it should be noted that the ideas of HAES are rooted in the fat acceptance movement. HAES as a framework focuses on health behaviors along with the social determinants of health rather than weight or size. Practitioners who embrace the ideals of HAES believe that an individual can pursue health at any size and that health is not solely defined by any number or metric. The model offers a viable alternative to defining health by size or body mass index, which has been shown in various studies to be an inaccurate determinant of health.

The founders of HAES aimed to address both the self-care and community care pieces of weight inclusive treatment and to be intersectional in nature. On an individual level, HAES practitioners emphasize a client's ability to choose health promoting behaviors and practices and acknowledges the social determinants of health. On a community level, HAES practitioners challenge issues of accessibility such as having fat friendly furniture and aims to challenge other societal factors that promote weight stigma and continue the harmful messages behind fat phobia. Although well researched through seven randomized controlled trials (Bacon et al., 2005) the HAES framework is still considered a radical approach and is not widely accepted in

the clinical eating disorder community. Kinavey and Cool (2019) suggest that a wider lens is needed to really address the deep-seated problem of anti-fat bias in therapy and our societal framework, stating that the field must begin by recognizing the ways that weight stigma goes against our ethical code, which is a set of standards and guidelines that counselors must adhere to. The Health at Every Size (HAES) movement has played a large role in encouraging research and investigation into topics such as fatphobia, weight stigma, and weight bias within mental health treatment. Researchers and clinicians who practice HAES have worked to develop a large research base showing that many of the effects we associate with being overweight can be attributed to weight stigma (Bacon & Aphramor, 2016). This approach provides an alternative view that is still in opposition of mainstream health views, although backed by a breadth of research.

Weight Stigma in Mental Health Treatment

Although weight stigma is most frequently researched and observed in medical settings, there is a growing body of literature examining the presence of provider weight stigma within mental health settings. Several first wave feminist scholars observed the prevalence of anti-fat bias in therapy beginning in the 1980s (Agell & Rothblum 1991; Brown, 1989; Chrisler, 1989; Young & Powell, 1985), noting that weight stigma was prevalent in the mental health field and could harm women seeking treatment for a variety of mental health concerns. This early literature demonstrates that fatphobia has been acknowledged since the 1980s and still remains widely unaddressed in the field of counseling. This is alarming, considering research suggests that weight-based oppression imposed by mental health professions causes both harm and trauma to clients in larger bodies.

Mental health professionals have a history of replicating harmful societal systems (e.g., conversion or reparative therapy) within counseling, and weight-based stigma is no exception. As with other societal ideals that have been perpetuated in therapy (i.e., racism, sexism, homophobia, transphobia, ableism, and others) weight stigma represents a colonizing narrative that inflicts harm on clients and counselors alike (Moller, 2014). As stated by Kinavey and Cool (2019), “Counseling is meant to be a safe environment that is accepting of clients in all their diversity, but therapeutic relationships can be a site of injury for clients in larger bodies.” Newer research has examined the presence of body-based microaggressions in the counseling space (Schafer, 2014). These studies re-iterate that weight stigma from a mental professional causes harm, and even trauma, within the therapeutic relationship (Berman, 2017; Moller, 2014; Reader, 2014).

Weight Stigma and the Therapeutic Alliance

The therapeutic alliance is defined as the ways in which client and counselor connect and engage with one another throughout the process of therapy and is a concept that is discussed extensively in counseling research. A review of historical research reveals that a positive therapeutic alliance accounts for much of the change and growth that occurs in therapy (e.g., Ardito & Rabellino 2011; Flückiger et al., 2018; Wampold & Imel, 2015). The therapeutic relationship also serves as a corrective emotional experience, providing a blueprint for clients which may help them maintain healthy interpersonal relationships outside of therapy (Soto, 2017). While a positive and safe therapeutic relationship can be a powerful catalyst for healing, a counselor’s unintentional biases may create barriers to building and maintaining a strong alliance with clients. For clients belonging to marginalized groups such as Black, Indigenous, people of color, women, members of the LGBTQIA+ community, clients with disabilities, or clients of

size, a counselor's unexamined biases can make counseling unsafe. It can be especially harmful when counselors do not address issues of power, privilege, and societal oppression within the therapeutic alliance. Additionally, weight stigma is a socially acceptable form of stigma and counselors may have their own internalized weight bias as a result of being conditioned through the dominant social narratives. With increased knowledge of the prevalence of weight stigma, it is also important to understand the consequences of this type of stigma, and the ways it may affect client's treatment and wellbeing.

Consequences of Mental Health Provider Stigma

The therapeutic alliance is the connection between counselor and client and is shown to be responsible for much of the growth and positive change that can occur in counseling for individuals (Horvath et al., 2011; Lambert & Barley, 2002; Norcross & Wampold 2011). Unfortunately, a counselor's unexamined biases can disrupt the therapeutic alliance and cause clients to feel unsafe with their provider. These types of ruptures, which often occur as microaggressions or countertransference, are not only psychologically damaging but may discourage help seeking behaviors in the future (Sue, 2010). The following section reviews literature which explores each of these alliance ruptures to give the reader an understanding of how different types of interpersonal interactions may impede the therapeutic alliance.

Countertransference. While counselors strive to be open, empathetic, and non-judgmental with all clients, counselors are human and experience personal reactions and feelings with a variety of clients. Countertransference occurs when a counselor unknowingly projects their feelings, beliefs, or biases onto a client (Freud, 1959). For example, a counselor may take on a more parental tone with clients who remind them of a younger sibling or could respond more harshly to a client who resembles an abusive family member in appearance, actions, or

otherwise. Countertransference can also be observed in terms of the counselor's involvement with the client. Counselors may become over-involved with a situation or client to compensate for the harmful actions of others.

Similarly, to the therapeutic alliance, countertransference has been widely studied since the beginning of psychology (Bandura et al., 1960; Hayes & Gelso, 1991; Rosenberger & Hayes, 1997). Research shows that when countertransference goes unaddressed it can impair the therapeutic alliance and potentially harm clients (Rosenberger & Hayes, 2002). Research acknowledges that mental health professionals may experience countertransference towards clients in larger bodies, but how and when it occurs remains unknown (Davis-Coehlo et al., 2000; Downes, 2001; Schwartz et al, 2003). Studies that focus on other socially oppressed groups give some insight into how countertransference can harm clients in larger bodies (Gelso & Mohr, 2001).

In her work on clinician's countertransference with fat female clients, Aza (2009) found that fatphobia has a profound effect a woman's ability to connect interpersonally within the context of a therapeutic relationship. When recalling past experiences with clients in larger bodies, most of the clinician's report experiencing countertransference with a client of size. Some acknowledged using microaggressions and microinsults towards clients of size, while others discussed internal feelings of shame and disgust (Aza, 2009). Many clinicians in Aza's (2009) study reported fear of fat or becoming fat themselves, repeating stereotypes about fat bodies that are societally enforced. This research shows that the fear of fat, is experienced by mental health professionals and is a phobia that likely disconnects counselors from clients in larger bodies.

Because counselors are often educated in the dominant narrative where weight stigma is considered an acceptable form of discrimination, counselors experience countertransference related to clients who do not fit into societal standards of attractiveness and/or beauty. The fact that body size is considered a facet of personal responsibility further complicates instances of countertransference, as professionals may believe that a client in a larger body can overcome oppression and stigma through weight loss. While countertransference does not always impede the therapeutic alliance, unrecognized biases resulting from personal feelings or reactions can lead to more harmful behaviors such as microaggressions.

Microaggressions. Microaggressions are defined by Sue (2010) as “everyday verbal, nonverbal and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons solely based upon their marginalized group membership” (p.3). Microaggressions are most often referred to in the context of racial identity, however the concept has been expanded to include other marginalized identities including the LGBTQ+ community, women, transgender individuals, individuals with disabilities, and varying social classes (Nadal et al., 2016). Microaggressions have detrimental consequences which are compounded by the fact that those who commit microaggressions are often unaware of their problematic statements and behaviors. In addition, microaggressions are frequently dismissed by the transgressor, leaving the victim feeling confused and questioning the validity of their perception (Sue, 2010). A modest but growing amount of research is revealing that microaggressions are harmful to the therapeutic alliance and may affect treatment outcomes and future help seeking behaviors (Constantine, 2007).

Aza (2009) has identified several categories of weight based microaggressions. Examples include counselors giving unsolicited warnings about weight and health, counselors suggesting

weight loss and personal responsibility as a solution to weight-based discrimination, and a form of “colorblindness”. This colorblindness sends the message that counselors do not see size, and that all clients are treated the same; however, this fails to recognize and address the real and perceived challenge of living in a larger body and may leave clients feeling unseen or unheard.

Similarly, Schafer (2014) found that some clients reported a general sense that their therapist disapproved of their weight, or inappropriately attributed their presenting problems to weight or body size. For example, a client in a larger body may present to therapy to work on anxiety, but the counselor assumes that someone in a larger body wants weight loss to be a goal of therapy. While there is not enough research defining body based microaggressions, it is clear from the existing research on other marginalized groups that microaggressions are harmful to the therapeutic alliance (Spatrisano, 2019; Sue, 2010).

Weight Stigma in Eating Disorder Treatment

Research suggests a high prevalence rate of provider weight stigma within disordered eating and eating disorder treatment settings (Puhl et al., 2014). In her hallmark study of provider weight stigma within eating disorder treatment, Puhl et al., (2014) found that eating disorder professionals endorse and encourage weight related stigmatization and oppression at higher rates than mental health providers in other specialty areas. Providers in this study also expressed less confidence in client’s ability to recover if they were in a larger body. Weight stigma has a variety of consequences and for those who are struggling with disordered eating or an eating disorder, Durso et al., (2012) found that instances of weight stigma increased rates of depression, and lowered self-esteem. In addition to the negative effects on mental health, weight stigma increases body dissatisfaction (Vartanian & Novak, 2011) and leads to poor health outcomes including reduced exercise and increased disordered eating (Andreyeva et al., 2008).

While the culture narrative asserts that fatness is a merit-based pursuit, only requiring self-discipline, research suggests that the more a person is stigmatized the more they are likely to engage in disordered eating behaviors and the less they are likely to exercise, leading to further stigmatization (Bacon, 2010). Recent research has revealed that weight stigma leads to increased disordered eating in both restrictive and bingeing behaviors, creating a need for more research to address the experiences of weight stigma for clients in larger bodies (Douglas & Varnado-Sullivan, 2016). In fact, research asserts that health risks typically associated with “obesity,” may be better attributed to the harm of weight stigma itself. It has even been suggested that weight stigma may be linked to mortality (Sutin et al., 2015) and increased rates of suicide for individuals struggling with disordered eating (Douglas et al., 2019). Weight stigma prevents medical and mental health professionals from identifying eating disorders within fat people. Eating disorders are complex disorders and cannot be identified through body shape and size (Whitelocks, 2013), however many individuals in larger bodies are not being diagnosed due to the prevalence of weight stigma within the eating disorder treatment field (Tait, 2015).

Clinical Diagnosis and Treatment

Weight stigma may result in the delayed diagnosis of individuals in higher weight bodies who may meet criteria for anorexia nervosa, but do not meet the requirement of being underweight. According to Harrop (2019) a pioneer in atypical anorexia research, patients who are restrictive in their eating behaviors but who are also fat face a unique set of challenges. These individuals may face many hurdles including delay of diagnosis, longer duration of symptoms, greater levels of weight loss, and increased distress related to eating and body image (Sawyer et al., 2016). As noted by Harrop, these individuals may also experience greater delays in care than patients with anorexia who are considered underweight, due to avoidance of seeking healthcare

services (Drury, Aramburu, & Louis, 2002), healthcare providers' lack of knowledge about assessment of typical eating disorders (Hudson et al., 2013), healthcare providers' weight bias (Lebow et al., 2015) misdiagnosis, and structural barriers due to stigma.

Dr. Maria Paredes is a counselor educator and *certified eating disorder specialist* (CEDS) whose work focuses on body liberation and the elimination of weight stigma. She has written numerous blogs, one of which focusing on the idea that providers should ask themselves if they would recommend the same protocol for clients in a smaller body. For instance, providers often assume that dieting is automatically healthy if someone exists in a larger body, while not taking notice when someone in a smaller body describes the same eating and movement patterns (Paredes, 2018). This is yet another manifestation of weight stigma and its effects on the perception, diagnosis, and treatment of clients in larger bodies.

There is a common belief that eating disorders occur on a spectrum from anorexia nervosa to binge eating disorder, however this is inaccurate and suggests that someone should be diagnosed in light of their body size rather than their behaviors (Baskaran et al., 2016). This approach ignores that people of higher weights can be engaged in anorexic symptomology and thin individuals can be engaged in binge eating. These examples highlight the poignant danger of weight stigma and fat phobia when experienced by clients of size.

Access to Care

The prevalence of provider weight stigma within eating disorder treatment also perpetuates barriers to care for individuals in larger bodies. Especially as perceived within restrictive symptomology, individuals who meet full criteria for anorexia nervosa but are not considered “underweight” are often diagnosed with *Other Specified Feeding or Eating Disorder*, or OSFED (Harrop, 2019). Unfortunately, insurance companies often do not cover inpatient or

intensive outpatient treatment for individuals with this diagnosis, leaving many people without proper care and treatment.

Benefits of Exploring Client Perspectives

Watkins and Hugmever (2012) emphasize the point that if fat bodies were acceptable and treated with dignity and respect in our society, individuals may not engage with dieting and other potentially harmful weight reduction strategies, and most of those individuals would not develop a diagnosable eating disorder. This research demonstrates the need to investigate how weight stigma is perpetuated by mental health professionals in hopes of reducing the number of individuals who are diagnosed with an eating disorder each year which is the motivation for this study.

More research is needed to understand provider weight stigma from the perspective of the client (Ciepcielinski 2016). Collecting and disseminating client perceptions can increase mental health professional's awareness of certain stigmas, and aid in creating more effective treatment measures (Macran et al., 1999). Rigorous qualitative research can provide rich insight into the experience of oppressed individuals and may help treatment providers find ways to avoid perpetuating stigma within treatment settings (Schulze & Angermeyer, 2003). By exploring the experiences of the women involved in this study, mental health providers can gain an increased understanding of the harmful effects of weight stigma which may encourage mental health providers to avoid perpetuating this type of stigma within their treatment approaches.

Conclusion

Weight stigma within mental health treatment is a pervasive type of stigmatization and oppression that requires additional research to be fully explored (Puhl & Brownell, 2001, 2003).

It is abundantly clear through a breadth of research that weight stigma is perpetuated by a multitude of health professionals, including mental health professionals working within the field of eating disorder treatment, and treating individuals in higher weight bodies who display disordered eating symptoms. The limited research that is available in this area only highlights the need for future studies, especially studies that focus on the clients' experience of provider weight stigma, especially considering that mental health professionals are socialized in a world that actively oppresses those in larger bodies (West, 2016). The following chapter will describe the research methodology of this study, and how the researcher aims to address some of these gaps within the literature to better address eating disorder treatment for clients in larger bodies.

Chapter III Research Methods

The following chapter will describe and outline the methodology used in this study. The purpose of this study is to further understand phenomena of provider weight stigma as reported by higher weight women in mental health treatment who have engaged in restrictive eating behaviors. As explored in previous chapters of this study, weight stigma is inextricably tied to oppressive societal systems and can be harmful to individuals in larger bodies navigating mental health treatment. A primary goal of qualitative research is to discover and disseminate findings that can lead to social change, making it an appropriate methodology for the research questions being investigated in this study (Hays & Singh, 2012).

Previous quantitative literature shows that restrictive eating behaviors often go undiagnosed in higher weight women, a phenomenon which may be due to the social and cultural influences of weight stigma (Brownell et al., 2005). Women in higher weight bodies are silenced in mainstream culture and even more so in the context of eating disorder treatment communities. The current study aims to understand the experiences of provider weight stigma endured by these women, in alignment with the purpose of qualitative research (Creswell, 2013).

Qualitative Methodology

This chapter contains the theoretical foundations of this study, along with the research questions, data collection and data analysis procedures. Quantitative researchers seek to find a singular truth and assert the correctness of such “truth”, while the work of qualitative researchers is exploratory in nature, as they seek to understand. Instead of trying to fit human experience into pre-made assumptions, this type of research aims to explore and understand unique experiences, which help the researchers identify themes through the data analysis process. The results represent the voices of the participants, the stance and experiences of the researcher, an

interpretation of the issue, and implications for social change. Qualitative inquiry preserves the meaning that participants place on the experience or phenomenon, instead of placing the researcher's meaning onto those individuals, making it an ideal methodology to explore a phenomenon from the client's perspective.

Qualitative Methods in Eating Disorder Research

Qualitative methods are often used in psychotherapy and social change related research. While weight stigma has been studied quantitatively there is a lack of qualitative research that seeks to expand on the experiences of higher weight women seeking treatment for restrictive eating disorder symptomology. There is a need for mental health providers to hear the voices of clients in order to better inform their treatment approaches and avoid perpetrating weight stigma within the counseling space. The goal of this study is to minimize the perpetration of weight stigma from mental health professionals which can lead to a myriad of positive health benefits including decreased depressive symptoms, improved body image, decreased disordered eating and greater quality of life for individuals in larger bodies (Andreyeva et al., 2008; Vartanian & Novak, 2011). It is my hope that the results of this study will help to reduce provider weight stigma and shed light on the importance of providers becoming familiar with utilizing weight inclusive approaches.

Phenomenology

Transcendental phenomenology, as described by Moustakas (1994), is a process by which researchers seek to describe the essence of a particular phenomenon. This type of qualitative design begins without a hypothesis and aims to fully acknowledge and describe the experience of participants from their unique viewpoint (Moustakas, 1994). As described by Moustakas (1994), transcendental phenomenology is "knowledge that emerges from a

transcendental or pure ego, a person who is open to see what is, just as it is, and to explicate what is in its own terms” (p.14). Researcher’s who utilize transcendental phenomenology describe the experiences of the participants, putting emphasis on uncovering an essence of those experiences rather than interpreting or analyzing participants responses (Creswell & Poth, 2018). The research questions of this study fit well with transcendental phenomenology, as they are open in nature leaving space to allow themes to emerge through the data analysis process. This methodology was chosen in hopes that the experiences of the participants can help propel social change and challenge mental health professionals to embrace the social justice ideals of weight-inclusive care as best practices in our field, rather than a specialty.

Theoretical Frameworks

As emphasized by Creswell (2013), qualitative researchers should base their studies in a theoretical foundation to guide data analysis and practical application of the research findings. Theoretical lenses act as a guide in the formulation of research questions, interview guides, and data analysis. The use of a theoretical lens also improves the credibility of the study and increases the likelihood that results may be duplicated in the future. The theoretical lenses guiding this study are relational-cultural theory and social constructivism. Both theories have influenced my professional work and serve as a foundation for this study. Outlined in the next two sections are descriptions of each theory along with their relevance to this study.

Relational-Cultural Theory

Relational-Cultural Theory (RCT) is a postmodern theoretical orientation within the field of mental health counseling. Clinicians who utilize this theory believe that people grow through and within authentic connection to others (Jordan, 2018). As stated by Jordan, the most impactful relationships are growth-fostering and involve authenticity, mutuality, and self-awareness. These

types of relationships lead to empowerment of both individuals and allow them to form more growth-fostering relationships with others in the future. RCT theorists also assert that people unconsciously engage with strategies of disconnection, which are ways that individuals attempt to separate themselves as a form of self-protection.

Weight stigma, through the lens of RCT, can be seen as a strategy of disconnection. In Ciepielinski's (2016) dissertation exploring weight stigma through an RCT lens, she asserted that, "When an individual stigmatizes another person due to weight, this individual could be engaging in an attempt of self-preservation. The individual may be inwardly fearful of personal weight gain; therefore, the individual does not want to associate with another person who represents this fear" (p. 40). She argued that the person experiencing weight stigma may be engaging in strategies of disconnection due to the way that they are viewed and unaccepted within Western society. Disconnection separates people from one another and is the opposite of what RCT theorists refer to as "the five good things" which include zest, an increased sense of worth, clarity, productivity or creativity and a desire for more connection (Miller, 1986).

RCT theorists also acknowledge the importance of power and privilege within relationship. Defining power as the capacity to produce change, to move and be moved by another. RCT scholars believe that having open conversations about power and privilege within a therapeutic relationship helps to achieve authentic connection. In contrast, when power and privilege go unacknowledged in the therapeutic alliance it can create division, anger, disempowerment, depression, shame, and disconnection (Walker, 2008). Within the context of weight stigma, it is appropriate for counselors to discuss cultural differences that may occur between mental health professional and client, such as differing body sizes. There is healing in mitigating power and privilege dynamics, however the mental health field does not often view

thinness as a privilege. RCT theorists would aim to remove barriers to authentic connection by having open conversations with clients about the varying identities they possess, including body shape and size and how that provides them privilege or oppresses them.

In order to achieve authentic connection with clients, counselors need to acknowledge the stigma and bias that comes with existing in a larger body, in the same way that RCT counselors likely address other stigmas. As providers gain self-awareness of their role in perpetuating weight stigma, they can explore and challenge their own body beliefs and the societal messages that marginalize fat bodies. From an RCT perspective, this self-awareness and acknowledgement of power differences is essential to therapeutic change. In order to gain appropriate knowledge and training in these areas, providers should embrace social justice frameworks such as Health at Every Size (HAES), which aim to reduce weight stigma and allow people of all sizes to have access to competent care.

Health at Every Size and Relational Cultural Theory

As discussed in chapter two, health at every size (HAES) is the most widely acknowledged weight inclusive model of care. Practitioners who ascribed to this philosophy believe that health cannot be determined by weight alone, and that anyone can pursue health through health behaviors regardless of their size. These practitioners also believe that everyone deserves access to stigma free treatment, regardless of their body shape and size, or health status.

HAES overlays seamlessly with a Relational-Cultural lens as they both emphasize the holistic nature of health and the sociocultural factors present in eating disorder treatment. Brady, Gingras, and Aphramore (2013) merged the two frameworks together, describing RCT through a HAES lens as a way for dietitians to help clients pursue health in a way that maintains connection and relational strength, while recognizing power and privilege dynamics between

client and provider. It is important to consider how the philosophical backings of these two frameworks connect with one another and what implications that may have on the results of this study and the implications for mental health providers. While it is not considered a theoretical framework, the philosophy of HAES and more broadly weight inclusive care influenced the development of the research questions and interview guide of the study.

Social Constructivism

An overlapping theoretical basis for this study is the idea of social constructivism. Transcendental phenomenology is part of the constructivist paradigm, specifically social constructivism. Social constructivists assert the belief that people make meaning and sense of their surrounding by developing meanings that are part of their larger world context (Creswell, 2013). These experiences are described and remembered differently for each individual and may change over time once with increased lived experience of the phenomenon.

Ideals of health, wellness, and beauty are age old and typically define beauty as thin, white, able-bodied, and cisgender, all concepts that are socially constructed. Fatphobia is rooted in these cultural ideals, which cause individuals to fear fat and perpetuate stigma and oppression onto fat people (Klaczynski, Daniel, & Keller, 2009). Health ideals are also markedly positivist, meaning that there is a “right” weight, body size, calorie intake, and other standards making it easy for mental health providers to unconsciously convey these societal standards to clients, expecting them to want to align with cultural health and beauty standards. Unfortunately, this is often done without regard to someone’s overall health which cannot be measured solely by a number on a scale.

Research Questions

Research questions guide the qualitative process by helping researchers to discover the essence of a lived experience (Creswell & Poth, 2018). The first research question guides this study, with subsequent questions designed to deepen exploration into the individual experiences of research participants.

RQ1: What are the lived experiences of higher weight women seeking mental health treatment?

RQ2: How do higher weight women perceive and report experiences of weight stigma imposed by mental health professionals?

RQ3: How do these experiences of weight stigma influence the therapeutic alliance from the perspective of the client?

Participants

Participants were recruited using purposive non-random sampling through the use of online Health at Every Size (HAES) groups, various eating disorder recovery groups on social media platforms and through the Association for Size Diversity and Health (ASDAH) list-serv. A recruitment email (Appendix A) was sent to the above organizations and posted in their member groups. In addition, a recruitment graphic (Appendix B) was shared on the social media pages by individuals who are part of these organizations. The number of participants needed in a phenomenological study differs. Polkinghorne (1989) recommended between five to 25 participants, while Creswell and Poth (2018) advise obtaining a sample of three to 25 participants. While many scholars suggest a different number of participants, the number varies for each unique study and phenomena being considered. I conducted interviews until I reached data saturation; a point where I was able to gather an in-depth description of the phenomena

being studied, laying the groundwork for future research to assess the same phenomena. The study had nine total participants, however one of those participants had an incomplete demographics data form and was unable to be contacted to complete the form before the data analysis process started. In total, around seventy individuals completed the interest survey, many of those did not meet criteria, a select few met the criteria and were contacted but never responded to schedule an interview time.

Inclusion Criteria

Participant inclusion criteria was as follows: self-identified as a woman, be at least 18 years old, wear a pant/dress size 14 (US) or above, indicate having struggled with emotional or behavioral restrictive eating behaviors based on information provided in Qualtrics screening (Appendix B) and have sought mental health treatment in the past five years. Because past research indicates that weight stigma reduces the likelihood of proper diagnosis of restrictive symptomology in higher weight individuals (Harrop, 2019), participants were not required to have a formal eating disorder diagnosis. Participants were excluded if they had been formally diagnosed with binge eating disorder (BED). This exclusion criteria is intentional knowing that binge eating disorder is stereotypically associated with individuals in higher weight bodies, and there is a plethora of qualitative and quantitative research investigating instances of weight stigma for that specific population. The purpose of this study is to look at a subset of higher weight women who report restrictive symptomology, as the literature demonstrates a gap in research for this specific population.

I intentionally avoided using the Body Mass Index (BMI) as an inclusion criterion, or to identify whether someone is larger bodied. As discussed in chapter two, the BMI has both a racist and classist history and was never intended to measure the health of individuals (Burgard,

2009). It is also known to be harmful and stigmatizing to those in larger bodies, restricting their access to care which goes against the goal of this study (Sawyer, 2016; Tomiyama et al., 2016;). There are some limitations in allowing participants to self-identify their body size, including the inaccurate self-perception of participants who may suffer from a distorted view of their own body as part of their disordered eating symptomology. It is my belief that the benefits of avoiding stigmatization mitigate the possible risks of using an outdated and oppressive measure such as the BMI. In order to obtain a sample of participants that I was hoping to target, I included US pant/dress size 14 or larger as one of the inclusion criteria. The idea was that this type of inclusion criteria would minimize the risk of utilizing outdated and potentially stigmatizing terms such as “obese” or “overweight” and avoid utilizing the BMI for the reasons stated above. This pant size was chosen as it is typically considered to be “plus size” according to the fashion industry and common plus size clothing brands.

Data Collection

The study was approved by the Institutional review board (IRB) at The University of Arkansas (Appendix C) Potential participants first completed an interest survey (Appendix D) which also disqualified individuals who did not meet the inclusion criteria. This screening included a restrictive eating checklist (Appendix E) which asked participants to check any restrictive eating behaviors that they have engaged in. If potential participants met all the inclusion criteria, the survey then guided them to an electronic informed consent (Appendix F) where they could indicate that whether or not they consented to the study. Participants who consented to the study electronically were contacted and scheduled for an interview.

Participant Interviews

Due to the physical distancing guidelines related to COVID-19, all interviews were held virtually via Zoom (2013). I conducted interviews in a private office and allowed participants to choose a private setting of their choice. Participants were advised to consider this a confidential meeting and encouraged to find a comfortable private space and utilize headphones during the interview. Before the interview, participants were provided a link to the demographic questionnaire (Appendix G). At the beginning of each interview participants were taken through a verbal informed consent, which included asking participants for permission to audio and video record their interview (Appendix H). Participants were informed of the research purpose and informed that there will be one 60 to 90-minute semi structured interview (Appendix I) and a member check through email several weeks or months later depending on when data collection is complete. Participant data was protected behind multiple locked sources, including a password protected laptop and encrypted file folders on that computer. In addition to these security measures, all participants were assigned a pseudonym by the researcher to protect their identity. All paper files have only a pseudonym and randomly assigned number and do not reveal any identifying participant information.

Potential Risks and Benefits

Due to the potential of emotional distress and trauma that can be incurred by remembering experiences of fat phobia, participants will be informed that there may be a risk of emotional distress by participating in the study. Because of this inherent risk, I gathered information to provide referrals to eating disorder specialists approved by the National Eating Disorder Association who indicated having awareness of and training in the Health at Every Size approach so that participants can access safe services as needed. Three participants asked for

these resources, and I provided a link to the Association for Size Diversity and Health provider listing.

Data Analysis Procedures

The collected data was analyzed using Moustakas' (1994) approach to analyzing transcendental phenomenology. This approach to qualitative research involves several stages including bracketing, horizontalizing, developing clustered meanings, and developing textural and structural descriptions of the phenomenon being studied.

Bracketing

Bracketing or epoche as described by Moustakas (1994) is the process by which the researcher attempts to set aside their own bias and experiences to see the phenomena as if it were the first time it is being seen and is the first step in transcendental phenomenology. This is a process that begins prior to the first interview and will continue throughout the data analysis process. During the bracketing process, I used journaling and self-reflection to assess my own position within the research along with the ways in which my own experiences and biases could impact my analysis of the data. This is a method of bracketing that has been shown in qualitative research to increase the researcher's ability to set aside their own biases and examine the phenomena with a fresh perspective, although it is impossible for any study to be free of bias (Creswell, 2013). I journaled on each individual interview question, as well as keeping a journal that I wrote in after each individual interview. I also took time to reflect on my own experiences of provider weight stigma, contemplating how these experiences may have shaped me as a provider, working to allow my own preconceptions and prejudgments come into and leave my mind. I recognize that these experiences impact my practice as a researcher and clinician and allowing myself to recognize and let those go before each interview and during the writing

process gave me a sense a closure. This process of reflection allowed me to compartmentalize my experiences as recognize them as my own and not belonging to the research participants. I felt that my mind way clear before each interview and I was able to fully listen and hear the participants without allowing my perceptions to cloud what I was hearing.

Horizontalization

Following the bracketing process I transcribed and read each interview, finding statements of significance related to the research questions and removing any repetitive statements within the transcripts. As I read through the transcripts and pulled out statements of significance. From the statements of significance, I developed clusters of meanings or themes which are further described in the results section of this study.

Textural and Structural Descriptions

The next step in the data analysis process involves constructing the textural and structural descriptions that detail what the participants experienced (Moustakas, 1994). During this step, I began to organize the statements of significance into what eventually became the themes of the study. A description of what each participant is provided (textural description) is provided in chapter four and allows the reader to gain more understanding into each individual experience of provider weight stigma. Next, I wrote a structural description, also called imaginative variation which provides context to each participant's experience of weight stigma, and a description of their own experiences that have impacted their understanding of PWS.

Clusters of Meaning

As I organized the textural and structural descriptions into themes or clusters of meaning, I identified main themes within the data and further organized them in subthemes. I completed this refining process several times, continuing to refine the significant statements into relevant

themes and revisiting each while reading through the transcript again. I also named and organized the themes more than once, as I continued to gain feedback from external auditors and peer debriefing, along with spending more time in the data. Transcribing by hand helped me during the horizontalization process as I became very familiar with all my data over time. I also utilized peer debriefing with a colleague who is familiar with qualitative research, notable research in the areas of weight stigma and fatphobia. She received the preliminary data and themes, and I incorporated her feedback in the final synthesis of themes.

Synthesis

The final step in phenomenological reduction is the process of synthesizing these textural and structural descriptions to describe the overall essence of the lived experiences being explored in this study (Moustakas, 1994). The invariant essence provides a core description of the phenomenon studied and its context. I compiled the significant statements supporting each theme and organized them with participant data, creating a structural description of provider weight stigma. This structural description includes the common themes experienced by the group. The initial thematic labels that came from the analysis process allow the research to expand upon what participants experienced as individuals and how they experienced weight stigma collectively (Creswell & Poth, 2018). Finally, I took the textural and structural descriptions and synthesized these into one composite description of the phenomenon of weight stigma. This process is referred to by Moustakas (1994, p. 100) as “intuitive integration” and through this process a meaning is ascribed to the experience of provider weight stigma.

Chapter IV Results

The purpose of this phenomenological study is to explore the phenomena of weight stigma as experienced by higher weight women in mental health treatment who also engage in restrictive eating behaviors. This group of women face a unique set of challenges, including barriers related to the disordered eating symptoms and barriers due to the weight stigma exhibited by mental health providers (Harrop, 2019). By exploring this phenomenon from the client's perspective, the results of this study can help bring awareness to mental health professionals and those who train them to avoid this type of stigmatization with their clients.

This chapter describes the findings of this study, summarizing the analysis of eight individual semi structured interviews. Nine participants completed the semi-structured interview; however, one participant had an incomplete demographics questionnaire and after multiple attempts to contact this participant without success her interview was redacted from the study. Each interview was video, and audio recorded over Zoom (2013) and transcribed by the author by hand. The first section of this chapter provides demographic data and informational snapshots for each study participant, providing a summary of the unique themes that were discovered in their interviews. Following the individual snapshots, a textural and structural description of the group themes are explored. Finally, I present field notes, along with self-reflection regarding the process of coding and analyzing the data.

Participant Demographics

Eight participants were interviewed for this study. Participants were from various regions of the United States including Minnesota, Arkansas, New York, Missouri, and California. Participants self-identified as heterosexual/straight ($n=4$), bisexual ($n=2$), asexual ($n=1$) and Queer ($n=1$). Participants were largely Caucasian ($n=6$), with one participant identifying as

White and Jewish and one participant identifying as Latina. Their level of education ranged from an associate degree ($n=1$) to doctoral degree ($n=2$), with other participants having a bachelor's degree ($n=3$), and a master's degree ($n=2$). All participants identified as female ranging in age from 23 to 54 years old. The following table provides more information on each participant and her relevant demographic data (see Table 1). Some demographic data was left out of Table 1, such as religious affiliation and relationship status, as those descriptors were not deemed relevant to the study or findings.

Table 1
Participant Pseudonyms and Demographic Data

Pseudonym	Age	Sexual Orientation	Race	Education	Self-Identified Size	Level of Care
Crystal	34	Bisexual	White	PhD, Ed.D, MD, JD	Super Fat	Outpatient
Whitney	40	Asexual	White	PhD, Ed.D, MD, JD	Mid Fat	Outpatient
Sidney	47	Heterosexual	White	Masters	Mid to Large Fat	Outpatient
Millie	23	Queer	White	Bachelors	Super Fat	Outpatient; Intensive Outpatient
Charlotte	54	Heterosexual	White	Associates	Plus Size	Outpatient
Alexis	40	Heterosexual	White/Jewish	Masters	Mid to Super Fat	Outpatient
Jasmine	40	Heterosexual	White	Bachelors	Small Fat/Plus Size	Outpatient
Mia	29	Bisexual	Latina	Bachelors	Mid Fat	Outpatient

Participant Descriptions

All eight participants indicated that they had restrictive eating behaviors according to the checklist that was provided in the original participation survey (Appendix E). Participants saw a variety of mental health professionals, some did not remember the professional discipline of their provider, however the others indicated social worker, professional counselor, and psychologist as the discipline of their chosen provider. Participants indicated past or present experiences of provider weight stigma imposed by these mental health professionals, and all experiences discussed in the interview happened in an outpatient setting. Participants were asked to self-identify body size with the survey providing the following suggestion: plus size, curvy, larger bodied, higher weight, small fat, mid fat, super fat, etc. One participant identified as super fat ($n=1$), with others identifying as small fat, mid fat, and plus size. Brief demographic descriptions of each participant are provided below and followed by table 3 that further outlines the demographics of each study participant.

Crystal

Crystal is a 34-year-old white, bisexual married woman with a doctorate level degree who identifies as a super fat. Crystal sought mental health treatment due to trauma from past abuse and wanting to work through grief associated with her mother's death. At the time she sought services she was completing her doctorate and job searching, which she describes as extremely stressful and said that she was having suicidal thoughts related to finishing her degree and finding a job in academia. Crystal's restrictive eating started as a child, with the most intensive periods of restriction in high school, college, and graduate school. She sought an outpatient therapist through her university counseling sessions and attended weekly sessions for approximately one year.

Whitney

Whitney is a 40-year-old white, asexual single woman with a doctoral degree, who identifies as mid-fat. Whitney described struggling with depression and anxiety as the initial reason that she sought mental health treatment beginning in her teens and continuing through present day. Whitney said that her restrictive eating behaviors began around age nine, and continued from there, Whitney sought outpatient mental health treatment and medication management consistently for five years and has been in outpatient counseling off and on since 2010.

Sidney

Sidney is a 47-year-old white, straight, married woman with a master's degree who identifies as mid to large fat. She first sought mental health treatment for an eating disorder, and her restrictive eating behaviors began around age eleven. Sidney mentioned in the interview she feels that much of her body size can be attributed to weight stigma and how medical professionals responded to her being in a larger body as a child. Sidney sought outpatient eating disorder treatment for five years in the past, and most recently from 2010-2018.

Millie

Millie is a 23-year-old white, queer, dating, female who identifies as super fat, and has a bachelor's degree. She first began mental health treatment to address symptoms of obsessive-compulsive disorder at age twelve. Millie said that her restrictive eating behaviors began around age seven when she started labeling certain foods as "good," and others as "bad." Millie began mental health treatment at the outpatient level, eventually was referred to intensive outpatient treatment, and then returned to outpatient in 2020 where she has continued seeing a mental health professional in private practice.

Charlotte

Charlotte is a 54-year-old white, straight single female who describes her body as plus sized. Charlotte holds an associate degree, and first sought mental health treatment for relationship issues after going through a second divorce and wanting to process through childhood traumas. Charlotte said that her restrictive eating behaviors began around age 13, and she has sought outpatient mental health services on and off for the last 25 years with various providers.

Alexis

Alexis is a 40-year-old straight white married female. She identifies as mid to super fat and holds a master's degree in social work. Alexis first sought mental health treatment through outpatient services due to a difficult friendship and wanting to explore some of her own trauma as a mental health professional in training. She was seen off and on in outpatient private practice for several years. Alexis noticed restrictive eating behaviors beginning around age ten and noticed that these behaviors continued to worsen from there into adulthood.

Jasmine

Jasmine is a 40-year-old white, heterosexual, married female with a bachelor's degree, and identifies as both small fat and plus size. Jasmine's restrictive eating behaviors began around age fourteen. She first sought mental health treatment due to postpartum depression and grief related to a lost pregnancy and has been in outpatient mental health counseling on and off since 2012.

Mia

Mia is a 29-year-old bisexual Latinx single female with two bachelor's degrees. This participant uses the term mid fat to describe her body. She first sought mental health treatment to

obtain an assessment for weight loss surgery. Mia does not remember exactly when her restrictive eating behaviors began but remembers that she was put on her first structured diet at age eleven and has struggled with restrictive and disordered eating symptoms since this. This participant was seen in an outpatient level of care.

Individual Synthesis

The section below outlines the individual synthesis for each interview participant. Unique themes were identified for individual participants that were not experienced collectively but still provide important information relevant to this study. In the section below, I outline individual themes for each participant that were not necessarily experienced by all the participants.

Participant One: Crystal

Crystal is a college professor who first sought mental health services during graduate school after the death of her mother and the stress of finding a job post-graduation. Crystal was attending school on a small campus where she was one of only a few fat women on the campus. Crystal spoke often about how she was grateful for her counselor on one hand, but on the other hand recognized the harm and trauma that came from this provider's own weight stigma and unaddressed fat phobia. One example of this ambivalence is:

She was great in a lot of ways but that persistent disagreement about the weight stigma made it hard for me to deal with those issues with her, because it always came back to attempts to lose weight and how I should attempt to lose weight.

Crystal had the unique experience of being seen by a mental health provider who identified as a “former fat person” and had lost an “extreme” amount of weight. Crystal noted that this came up nearly every session stating, “She spent a lot of time talking about her own experiences losing weight, almost every session she talked about her own experience of weight loss; it came up quite frequently.” This lends itself to other ethical concerns for this mental health professional

and adds an interesting element of how providers may perpetuate weight stigma in different ways based on their experiences with their own bodies.

In summarizing her experience in mental health treatment, she said that she had to “justify” her body constantly adding:

You would hope it [weight stigma] wouldn't have to be in your healthcare, but it is in your healthcare. All of it. And I think that's why I haven't processed the trauma of it, its just well throw that on the heap of healthcare trauma it is just what you live with when you live in a body like this.

After her experience of provider weight stigma, Crystal ended treatment and still struggles to find a provider. In her interview she talked about the need for a credential that could identify a provider as “fat positive” and not just “body positive.” Crystal's interview brings light to the unfortunate reality that women in larger bodies must endure this type of stigmatization in every healthcare setting and that you become so use to it, you do not even feel or recognize it anymore; perhaps because recognizing every microaggression would be too painful. Crystal would like MHP's to be more critical in the way they view fatness, the same ways that they are expected to be critical of other historically marginalized populations and for them to recognize the harm that they are causes by attributing body size to trauma.

Participant Two: Whitney

Whitney began her interview by voicing some of the effects of provider stigma, which included delays in diagnosis, and lack of access to appropriate care as she described here:

It was everything to not being diagnosed with anorexia when I had lost my period and had lost a significant amount of weight but was not emaciated or 85% of ideal body weight situation to more treatment very focused on weight loss.

Whitney talked about her experience with this eating disorder therapist who was very focused on diet culture and body size. Reflecting on the experiences afterwards, Whitney realized that she processed all these experiences and mental health interventions through the lens of her own

internalized fatphobia, “Oh god I’m really not worth it, I’m just a total fuck up,” and “I was very much processing all of that through a fat-phobic lens, through my body, my will power, I’m the problem lens.” Whitney talked about how confusing it was that she was doing all these things under medical supervision, and how much of a mind game it was to lose weight temporarily under the supervision of a mental health provider and nutritionist, just to gain it back and then be blamed for being the problem. Whitney said, “I was looking for a therapist to read the riot act on my behalf.... And when they did not, when they instead encouraged the continued pursuit of weight loss, I started to become angry”. Whitney remarked that this anger caused her to start questioning why her weight was something that providers considered a failure.

Once Whitney became empowered through self-education, she was put into the educator role with this mental health provider even after their therapeutic relationship was terminated, eventually asking her to remove the information about gastric band hypnosis, and the mental health provider agreed to although Whitney feels that she only did it as an attempt to save her reputation and business. This push pull and continual pressure to educate her own mental health provider created a disconnect between herself and her own body. She spoke of the frustration that came with her mental health provider not acknowledging systems of power and privilege when it comes to body shape and size:

Just getting them to understand the entire way we think about health and weight and the entire way we think about people in fat bodies is oppression; to me most people have a hard time getting there. And that therefore not only is what they’re doing a form of oppression, but they need to back out of that and back into helping people understand that much of what they’re feeling is about being in a marginalized body as opposed to themselves being somehow wrong.

When discussing resilience, Whitney talked about leaning on several forms of resilience including relationships, online community, advocacy, and involvement in professional organizations that fight against weight stigma. She emphasized her involvement in these

organizations and their leadership structures and a huge tool in her eating disorder recovery. She shared that advocacy and involvement in these organizations gave her a place to put her anger and put that anger to use to make changes for others, and to “help someone else get out of internalized fatphobia” and realize that their body is not a result of their failure. It has also been a powerful form of resilience for her to reclaim the word fat and use it as a descriptor just as she describes herself as being tall and having brown hair.

When asked what would have been different if Whitney’s mental health provider was educated on weight inclusive care she said, “Decades of suffering wouldn’t have happened.” She also talked about how she believes she would weigh less without the influence of these harmful practices, and as such would face less weight stigma and barriers related to body shape and size now around “airplanes, chairs, and medical care.” She expressed frustration that HAES aligned providers are still the minority and still difficult to find. Whitney desires for treatment to be different for anyone that goes through it now, and she wants mental health providers to take a critical look at themselves and their own biases and address that “being in a larger body isn’t always a lack of willpower, or compliance... and that their treatment is the thing that is not working in this situation.”

Participant Three: Sidney

Sidney is a university professor who has the unique experience of seeking mental health care both in a thin body and in a larger body. She said that when she sought treatment in a larger body, she saw how differently she was treated by mental health providers although her presenting issues remained the same. Sidney started a medication that caused weight gain and at that point mental health providers began to suggest weight loss as a treatment for her symptoms. When she first began to experience weight stigma, she did not have the language to name what

was happening and she internalized the providers weight stigma and began to feel that something must be wrong with her because she lived in a larger body. When speaking about the ways in which she internalized these messages she shared:

You internalize those messages of lose weight, lose weight, lose weight. Losing weight is the only way to be healthy and when you fail to do that you internalize that failure and you are yourself as the failure, and yourself as the problem which just then leads to more mental health problems, it just kind of perpetuates and becomes the cycle.

This internalized weight stigma led Sidney to begin empowering herself through education surrounding the failure rate of dieting and weight loss. As she continued to study the Health at Every Size philosophy, she began to advocate for herself with different providers and she found healing in being able to disagree with them. This disagreement and push into the educator role created relational distance between her and her providers, “Instead of wanting to go talk about things with them, instead of wanting to go and dig into other things it became ‘oh no I’m going to have to go and talk about my weight today’.” This “emotional burden” made her hesitant to seek further mental health care, and healthcare in general because she was always worried about the “losing weight discussion.” She explained that this loss of trust made it difficult to think about even finding a new provider when she needed the support, knowing that she would likely have to advocate and educate her provider. She spoke about the frustration of finding a provider who is grounded in a HAES approach and how rare that truly is.

At the time that she was seeking treatment, Sidney was experiencing symptoms of moderate to severe depression, and she spoke of how hard it was to even have energy to engage in mental health services stating, “When you’re depressed already, it’s hard enough to find the energy to go and seek help and to have extra issues of dealing with weight stigma it just makes it that much more difficult to seek care.” Sidney shared the ways in which provider weight stigma affected her physical health and engagement in health promoting behaviors. She reported that her

food restriction continued, worrying about how many calories she was eating and continuing to internalize those thoughts of failure.

Sidney noted several ways that she leaned into resilience even amidst experiencing provider weight stigma. Exposure and connection with other fat people helped her to find a community of people that looked like her and challenged the status quo, and the social norms that are so present in our society. She talked about self-education as a form of empowerment, stating that she started by reading any book about HAES that she could get her hands on, and also started following blogs, and building intentional community of other people who believed in these principles. Specifically, she talked about the power of connecting through online support groups on social media platforms and how helpful that felt when she could not find an in person community of other fat people. One specific benefit from being in these groups for her was learning the HAES language, and ways to advocate for herself both with healthcare professionals and friends and family in her life who are still bought into diet culture.

When asked about her advice to mental health providers, she stated:

Their “help” is hurting people, and if they want to help their patients educating themselves about weight stigma and inclusive practices is huge, its so important because how many people actually fit a BMI that is in a normal range? She continued on to say that the “help” that many mental health providers think they are giving is actually harmful.

Participant Four: Millie

Millie is a speech-language professional and professional opera singer, who has experienced weight stigma from a variety of mental health professionals since age 12. She was first brought to mental health treatment by her parents when she started to experience symptoms of obsessive-compulsive disorder. At the time, she was seeing a psychologist who was suggesting weight loss even though she was beginning to show signs of a restrictive eating

disorder; she believes that her larger body pushed the psychologist to “prescribe” weight loss and disregard the restrictive eating behaviors; or even see them as “good” since they had the potential to cause weight loss. She talked extensively about how the providers she was seeing would complement her weight loss, even though the methods she was using to lose weight were harmful to her mental health. When asked about the effects of provider weight stigma on she talked about her mistrust in the mental health care system after enduring so much PWS:

I’ve been prescribed gastric bypass surgery again for mental health treatment, and I’m so tired of having to fight with my providers that I’m actually going through the rigemoral even though I don’t intend to go through with the surgery.

This is a statement to the emotional exhaustion that results from having to continually advocate for oneself with providers and educate them on weight inclusive practices. She spoke of how exhausting it is to “justify” her fatness and make herself “worthy” of proper treatment. She shared that the whole thing has been so exhausting to the point where she does not want to seek out care at all, and often avoids it resulting in bigger health issues.

Sidney grew up with sisters who all have similar mental health diagnoses and concerns but live in smaller bodies. She talked about how “triggering” it was to see the options that they were given by providers when she was presented with weight loss surgery as the solution to her mental health concerns. She stated, “I shouldn’t have to fight for something I want, I’m allowed to want proper treatment.” This provider weight stigma had led Sidney to feeling disconnected from her own body, at times describing that she felt like a “head attached to a body,” she talked about not having a lot of body awareness after years of being told that her body was not something that could be trusted, leading her to not want to connect with at all. A unique experience of this participant is her learning to become more embodied and connected to herself through her career as an opera singer. About this experience she explained the following:

I took opera training, and having to force myself to be aware of my body, to think about how does my stomach feel when I do this? Or how am I placing my arms, are my arms getting in the way of how deep I can take this breath, what if I'm laying on my back because the staging is weird or whatever. It took that for me to finally connect the two, because like Is aid it turned from me feeling like a floating head going room to room to me actually being a full physical person.

To her, this practice of becoming aware of her physical body in the opera space helped her to reconnect with her body and become more embodied. She was observed to dissociate during the interview and commented that she felt she was speaking from such a detached place. She clarified that she does not feel detached from the experience but detaching from sharing her experience is a way to keep herself safe. When asked what she wants providers to know about her experience of provider weight stigma she said:

Do something, fucking do something. Even something as small as making sure the chairs in your waiting room are comfortable for fat people to sit in, like there's no arms or if they do have arms they are like spaced out further or something. Making it an accessible practice, like it's not on me for them to exercise their agency in solving the problem. Just make the environment more welcoming to fat people.

In addition to asking providers to be pro-active about the physical accessibility of their spaces, she wants providers to know that prescribing food restriction is harmful, especially at a young age it gave her the message that she "didn't deserve a basic thing that is required to live." Like other participants, she reiterated the need for official training and credentialing. She has utilized fat positive online communities to locate reviews and information about various providers, but she still finds it hard to trust that someone is truly rooted in fat acceptance due to all of the negative experiences she has had.

Participant Five: Charlotte

Charlotte is still at the beginning of her self-education journey and started reading and learning about weight inclusivity because of not seeing representation of older women in body positive spaces. She had one experience with an outpatient therapist where she experienced

weight stigma in an overt way. Although she had not yet started her own journey of deconstructing weight stigma, she knew that it was wrong for the mental health provider to suggest that “anorexia wouldn’t kill her” and she began to tell her story to anyone who would listen. She shared that when she saw the advertisement for the study, she wanted to share her story again in hopes that it would prevent someone else from experiencing this with a mental health professional. This experience led to a general mistrust of mental health professionals, and she did not seek treatment again for a period of years after this experience.

At the time, she internalized the experience and described her inner monologue as “low brain chatter” stating, “the low brain chatter then would have told me that maybe a touch of anorexia would have done me good. My chatter would have said that she [the social worker] is scary and don’t go back to her.” She distinctly remembers coming to the realization that the scale had always been traumatic for her, recalling a memory where her dad made her get on a scale in front of a boy that she liked. She said that she had shared these memories with the mental health provider so to have shared those and then still be asked to get on a scale in front of her was extremely damaging. Because of a lapse in insurance, she had to end care with this provider and even the ending of care was something that she experienced as traumatic. She remembers the provider saying that she “wouldn’t be able to do this alone,” and that the client needed her to get better. After that phone call, she never returned to therapy and ended her relationship with this provider. At the time when she ended care, Charlotte said that she was still engaged in weight watchers, and any kind of diet that she could share; for her to recognize that what this provider said was not okay was a huge deal. Years later she began to process how this affected her and spoke of a general mistrust in the mental health field moving forward, preventing her from seeking care for several years.

Charlotte's story is unique in that she spoke at length about the lack of representation for women her age on social media, even in weight inclusive spaces. Charlotte said that this lack of representation pushed her to create her own social media presence where she shares herself doing a variety of workouts to show women in their 50's and older that they can do these things too. Even after leaning into HAES principles, Charlotte still struggles with internalized fat phobia although she believes deeply in the idea that health and weight are not connected:

There is still a part of me that wants to lose weight, of course I want to lose weight; but I want to be strong and healthy. I want to have wellness more than that number on the scale, I'm not chasing the scale anymore, I'm not doing it.

Charlotte's relationship with this provider affected her health behaviors positively over time, she almost had the attitude of wanting to prove this provider wrong by assuring that her health markers were above and beyond what they needed to be even if her weight remained higher. Although she does not make the correlation directly, she did allude to the fact that the opinions of others only push her further to work on her own health behaviors and markers.

Charlotte had always had a fraught relationship with her own body, starting at a very young age when her stepfather would make negative comments about her body in public, and force her to weight herself. She does not know if her relationship with this provider changed the trajectory of her personal relationship with her body, she feels that it may have set her back at the time, but she is happy to be where she is now in her relationship with her body and has spent the last year or so learning about the embodying body positivity. She spoke more of the importance of finding people her age on social media who are talking about body acceptance, and how that has been incredible hard for her to find. She spoke of the importance of following bodies that even she feels uncomfortable seeing and how seeing those bodies in sports bras and crop tops helps her challenge her own internalized fat phobia:

It's scary, like oh my gosh I could never do that, how dare she? And then I'm like wait and I have to talk myself out of it, and I make myself look. I make myself keep scrolling through and looking because I'm going to get desensitized to it and if I'm okay with the way they look, why can't I be okay with the way I look?

Participant Six: Alexis

Alexis is a mental health professional herself and talked about how she did not recognize what she experienced as weight stigma until she was learning about it herself through her process of self-education. The therapeutic relationship where she experienced weight stigma was one of several years and as she noted it the “weight piece” held her back significantly from healing trauma. She first spoke about how her therapist attributed the fat on her body to the trauma that she had endured stating:

My therapist was very much of the belief that trauma and weight are connected to the point where when you heal your trauma you will lose weight so that was my barometer for whether I was doing better or not.... I had not been dieting for a long time but I actually went on some eating plan and lost weight because I felt like I needed to in order to finish therapy.

In this case, the mental health professional's own weight stigma caused the client to resume potentially harmful restrictive eating behaviors to feel that she had made progress in mental health treatment. This association between trauma and weight significantly affected this participant's relationship with her own body, and she began to feel like she couldn't listen to herself or trust her own body. At the conclusion of this therapeutic relationship, Alexis began to seek out ways that others had learned to accept their bodies and was introduced to the Health at Every Size movement and its principles. When speaking about how the philosophy of HAES has impacted her own life, she stated, “I'm an Orthodox Jew; I have a pretty solid belief system that my life goes by and this is like I've never felt so strongly about anything before like I do with HAES.” She spoke about how different her experience may have been if her provider was rooted in weight inclusive care principles. She shared:

I think I would have suffered a lot less; I think like I said before I would have been more open. More open in terms of feeling that sense of “Ok this is place where I can relax, this is place where I can be me.” I don’t think I ever fully had that experience with her.

This participant talked about how she feels that her experience in mental health treatment would have been entirely different if her therapist had examined her own weight bias and ideas about bodies and trauma. She would want mental health professionals to know that “being in the mindset where they need their body to be smaller is literally destructive. Its not a neutral thing at all, especially in a trauma situation.”

A unique aspect of Alexis’ story is that she herself is now a mental health professional and has sought out trainings such as becoming a certified Intuitive Eating counselor so that she can help her clients now and, in the future, receive weight inclusive care. Her experience is so important because it shows how insidious this type of stigma can be, but that the way it is delivered does not change how it is experienced by the client in a therapeutic relationship.

Participant Seven: Jasmine

Jasmine is a woman whose story centers around experiences with weight stigma in mental health care as she was seeking support for postpartum depression. As a mom she made it clear it is important to her that her experience of weight stigma is shared so that her children may have a lesser chance of experience this type of harm themselves. At several points she mentioned how her children were the motivation for her involvement in the study. When she first sought mental health care, it was at the suggestion of a primary care doctor as she was struggling with severe postpartum depression. She went to the mental health provider that her primary care provided referred her to and explained what she was experiencing, and the MHP began telling her that she needed to buy more fresh fruits and vegetables and begin a structured exercise routine, and even suggested that weight loss would heal her post-partum depression. This was

after the participant had already expressed to the MHP that their family was currently living on food stamps and was food insecure, not always knowing where the next meal would come from. Even after sharing this, the MHP's solution to her depression was fresh foods and exercise.

This experience led her to feel “exhausted” at the prospect of finding a weight inclusive provider and caused her to mistrust the mental health field in general for many years. When asked how the provider’s own weight stigma affected her view of mental health professionals, Jasmine stated, “I only went twice, if that tells you anything.” The suggestions from this provider caused the participant to lose trust in her own body, a feeling she had already felt as a result of several miscarriages, “She offered solutions that weren’t ever feasible given our situation and really kicked off a period of unhealthy behaviors with exercise and these sorts of things.” Because she did not lose weight, Jasmine internalized these experiences and began to blame herself. She talked about how hard it already was to navigate grief and loss. She felt that she was doing something wrong, and that was a feeling that was only echoed from her previous experiences with miscarriage. She spoke about how powerful it would have been if the mental health professional had said that the miscarriages and weight gain weren’t her fault and that it wasn’t her body’s fault. She distinctly remembers experiences where she was forcing herself and her kids to do certain types of exercise and how badly she felt about doing that rather than allowing movement to be something enjoyable for their family. She found one Instagram account in particular of a weight inclusive therapist and that was the first time she realized that mental health professionals like this existed. She is grateful for finding the page, but it also made her think about the fact that she happened upon it by accident, and that everyone should have access to these principles in their mental health treatment experiences, it should not be left up to whether or not they find social media accounts with weight inclusive providers.

When I asked her what she would want mental health providers to know about her experience of PWS and how it affected her, she stated:

I would want her to know that telling someone that you can fix mental health issues with exercise and diet is not the answer more often than not. I would want her to know that allowing your opinion of someone's body size to dictate how you care for them causes so much harm, and as a mental health professional your job is to do no harm at the bare minimum. The weight stigma caused a lot of harm, a lot more mental health issues that have to be untangled now and that not examining that within yourself, not admitting it, not acknowledging that it is real just makes everything worse. It is not good practice, and it is not compassionate practice.

Jasmine eventually began seeing a weight inclusive mental health provider although she and her husband had to save money for months because this was someone in another country, and someone who cannot take their insurance. She expressed gratitude for this provider, but also frustration at the enormous barriers present for her to seek care from this provider. She hopes that her children and grandchildren will grow up in a world where all mental health providers are trained in weight inclusivity and that someone else does not have to go through what she did to seek and receive compassionate care.

Participant Eight: Mia

Mia's story centers around the work that she did internally to justify her mental health professional's weight stigma. Mia and her mental health professional are both from an immigrant background and are also both people of color, so they shared some similar identities; however, Mia experienced both covert and overt weight stigma with her MHP within the therapeutic alliance. She first sought mental health counseling at the suggestion of medical professionals, after it was recommended that she seek weight loss surgery as a solution to her current medical concerns. At the time she sought services she recognized that she was engaging in some restrictive disordered eating and was worried that going to a mental health professional would confirm this. However, you must be certified by a mental health professional in order to be

approved for weight loss surgery. When she began treatment, the MHP she was seeing started to recommend books with different types of dieting in them. Mia began suggesting other books that focused on fat liberation and the systemic oppression of fat people, but her mental health provider would not read them. At the center of her experience was the mental health professional continually bringing her struggles back to personal fault and not acknowledging the systems of oppression at play, such as suggesting she “lose weight” or “purchase another seat” when she spoke about feeling uncomfortable in airline seating.

This is just one example of instances where Mia’s mental health professional suggested that weight loss was a viable solution to the systemic oppression of fat individuals and barriers that result from this type of oppression. She described that at the beginning of her anti-diet journey she started to think that this idea of weight inclusivity could be “cult-like” and that her counselor’s skepticism and weight stigma only confirmed this for her, rather than encouraging her to continue to look into these principles and how they could be helpful to her. Mia felt that she was constantly being challenged rather than supported in her fat liberation journey which made it more difficult for her to lean into and made it easier to think about going back to restrictive eating behaviors. Mia noticed that her counselor seemed to have a threshold to her body acceptance or body positivity. She noted:

There was a disconnect for me because she was the one who led me on this path and challenged my own eating behaviors and [told me] to give myself permission to listen to my body and do all these things; but she had a limit to that. That was the weird part of it all, so there was a limit, and I somehow passed the limit.

When asked about ways that she remains resilient, she mentioned being part of several online communities and social media spaces with other fat people and those who are interested in Intuitive Eating and the Health at Every Size approach. One unique experience that she explained is the lack of weight inclusive resources in Spanish:

I have other fat relatives in Mexico, and I will never be able to share my resources with them because they are all in English and there are no resources on diet culture, dismantling diet culture, or intuitive eating. They tried to translate Intuitive Eating, but Spain did it, and Spain Spanish is very different than Latin American Spanish. There is no resource for non-English speakers really about diet culture, there is very niche and that is frustrating. The only people I can talk to about these conversations have to be English speakers.

She went on to explain that the conversations being had in Mexico right now are the same ones that we were having in the United States in the 1970s and 1980s, and that it is difficult for her to not be able to connect to these concepts and resources in her native language.

Along with being part of several online communities and social media spaces, Mia is also an advocate for others and sees that as a vital part of her resiliency although at times she finds it hard to advocate for herself:

She was getting fatphobia from her therapist and when she reached out to me and asked if that was normal; that's when I started questioning and pushing back more on my own experiences and also for her. Told her to please advocate and all of the sudden I was like no it's not okay for other people, I'm okay because I can handle myself but for other people to go through this, I don't want them to go through this.

Mia works on Diversity, Equity, and Inclusion initiative at a large university, and she spoke so bravely about the way that weight stigma infiltrates even the most "woke" spaces. This is part of her experience that was repeated and echoed within the therapeutic alliance where her mental health profession perpetuated some of the same ideas and thought philosophies:

And even within my team and within other DEI spaces; even within the most "woke" spaces, the spaces working through anti-oppression work; even in those spaces that I have to engage with every single day, I still get invalidated based on size. I still hear the "oh my god, I feel so fat because I ate a bag of chips," and then they say, "Ok back to anti-racist work."

When asked what she would want mental health providers to know about the way that PWS affected her and her treatment, she talked about the need for mental health professionals to be open to the values and ideals that are important to their clients, and open to the resources that

clients bring into sessions and how those may be important to them and their journey. She also talked about the importance of knowing up front the intersectional identities of her mental health professional; and knowing whether or not they have experience working with people in larger bodies. She talked about the fact that the experience taught her that someone can be an “eating disorder professional” but not have any experience with clients in larger bodies or any knowledge about fat liberation.

Group Synthesis

In with the phenomenological approach used in this study, I identified four thematic clusters through which participants invariant constituents were organized and are displayed in the table below. It is common in qualitative research (Creswell & Poth, 2018) for the researcher to also identify sub-themes, which are also presented in this part of the results section. The subthemes included help to provide clarity and further refine the larger themes which are broad in nature. My data analysis was guided by the theoretical foundations proposed in chapter three of this dissertation, including relational cultural theory, social constructivism, and Health at Every Size (Health at Every Size, n.d.). Table 3, below, shows the primary and sub-themes that were derived from the data. Each individual synthesis is followed up by a thematic abstraction which provides the relevant participant quotes for each theme and subtheme.

Table 2
Thematic Labels

Theme	Subthemes
Psychological harm	A. Microaggressions B. Pathologizing fatness C. Suggesting personal responsibility for body size
Damage to client’s relationship with self	A. Doubt and confusion B. Internalized fatphobia C. Disconnection and detachment D. Increased disordered eating and movement patterns
Damage to therapeutic alliance	A. Forced educator role B. Mistrust in the mental health field C. Difficulty finding a fat positive provider
Forms of resiliency	A. Advocacy for self and others B. Connection with others C. Self-Education

Psychological Harm

The first major theme identified within the data is the presence of psychological harm or trauma inflicted by mental health providers. Study participants identified this theme in a variety of scenarios including microaggressions, pathologizing fat, and suggesting personal responsibility for body size rather than addressing systemic oppression. Many participants used the terms “trauma” and “harm” when describing the psychological effects of provider weight stigma that they experienced in mental health treatment. This theme was present in every interview, although there were unique variations based on the individual’s context and own interpretation of this interpersonal harm.

Microaggressions

Interview participants described body based microaggressions and spoke about the harm that was inflicted on them as a result of these subtle comments and suggestions. Crystal talked at length about her provider's suggestion for her to lose weight even though she was exhibiting disordered eating patterns and restricting food intake already. She felt conflicted because this mental health professional helped her in a variety of ways but caused harm when it came to the way that she viewed larger bodies. She stated the following in her interview:

She helped me a lot with past trauma, and she helped me even with some of the trauma about my body, but in other ways there was always a point where it came back to the fact that she thought I should be trying to lose weight, she gave me suggestions.

Many of the study participants shared a similar experience of feeling “confused” and “disappointed” that their mental health providers supported them in some areas but not when it came to accepting their body. While some microaggressions appeared more veiled in nature, other participants spoke of very direct interpersonal harm such as Whitney when she discussed some of the interventions she was offered during her treatment:

They offered something called virtual gastric band hypnosis. So it was like hypnotherapy as if you got your stomach amputated, as if you had gastric band surgery. They had you buy an outfit that didn't fit you and hang it prominently in your room, so you woke up to seeing it every day. They had you carry around a golf ball to remind you of what the size of your stomach was and how much you should be eating. In the hypnosis when they are walking through this thing, you're in the operating room, picture your children coming to see you, and how happy they are basically that you are not going to die now that you're going to lose weight.

She followed this up by stating, “Any eating disorder, whether it's an emaciated person with anorexia, the fat person with anorexia, or binge eating like with any person you have completely missed the do no harm principle.” In another example of direct harm, Charlotte discussed ways in which her mental health provider harmed her during treatment with the use of the scale, and how her mental health provider weight her in every week, close to tears during the

interview she stated, “She [the MHP] actually said the words, ‘a touch of anorexia wouldn’t kill you’.” While these two examples are more overt, other study participants discussed more subtle forms of microaggressions such as their providers coming up with goals for them or suggesting weight loss but never mentioning this to the client.

During the interviews, many participants shared things that they wish their mental health provider knew about how they were harmed by weight stigma. When asked what she would want future professionals to know, Millie said the following regarding relational harm:

I want them to know that they traumatized me, it was measurable, quantifiable trauma. I’m not blaming them for how society treats fat people, I’m blaming them treating me horribly the way that they did. They did harm.... I want them to know they’ve done harm.

The group emphasized the often-insidious nature of weight stigma and how it can sneak into therapeutic spaces without much notice at all. When asked what she would like to share about her story, Alexis said the following:

It’s interesting that I even responded because nothing about it [provider weight stigma] was ever overt, but I do feel like my main therapeutic relationship which is one of several years it was something that held me back significantly, the weight piece....My own therapeutic experience was harmed by weight stigma.

Similarly, Mia also talked about the subtle ways that weight stigma was brought into the room during her experiences with mental health professionals. She described a time where she was feeling grief and sadness related to getting on an airplane and being told that she needed to buy another seat. Mia said that instead of addressing the feelings, or talking about how the system of fatphobia is wrong here her mental health professional asked, “Is this something that can be addressed on your end? Is there something you can do?” This assumption that the client should change themselves to adapt to the system rather than challenging the system is a subtle way that mental health professionals may be invalidating clients in larger bodies.

Pathologizing Fat

Another identified type of psychological harm is the pathologizing of fatness by mental health professionals. The group talked about how their provider would blame their body for their mental health concerns, making it known that being in a larger body was something to be fixed. Study participants spoke about the ways their mental health professional blamed their bodies for the trauma they had endured, suggesting that they may not be in a larger body had they not experienced trauma. When talking about how her mental health professional viewed fat, Charlotte shared, “the number on the scale isn’t my worth, it isn’t my worth so stop weighing people... I would absolutely tell her that she probably has an eating disorder if she hasn’t figured it out already.” Several participants talked about their MHP’s pursuit of thinness and how that appeared in the space, including Alexis who shared how her MHP’s diet was often a topic of conversation, conveying the message that she as the client should be dieting as well:

My own therapist who I really loved and appreciated in a lot of ways, was very into different types of eating regiments and eliminating things and all that she used for her own mental health and that seeped into therapy. It never felt like a safe place where I could fully heal because that was always there.

Sidney also talked about how her own MHP’s pathologizing or fear of fat was in the room and created a lack of trust explaining:

There was a lack of trust there because I automatically felt defensive about it, so I think the quality as a patient in the defensive state is not conducive to a good therapy session, so I think it definitely impacted the quality of those sessions.

This type of pathologizing is not new to the mental health field and has happened with a variety of other marginalized populations over time. Millie likened the pathologizing of fat to the inhumane treatment of women in mental health institutions in the 1900’s, stating:

It reminded me of high school, learning about mental institutions in the 20th century, women being sent to mental institutions because they were cranky on their period, that is kind of what it felt like to me....a really arbitrary pathologizing of something that occurs

naturally. If it weren't natural it wouldn't happen, so to be treated unnaturally, it just made me fear for how other people are treated in mental health spaces.

This type of pathologizing led some participants to believe that their body was a problem to be fixed, whether this was stated overtly or not they felt that their bodies were unacceptable. This type of marginalization can push individuals to find like-minded communities where they can feel accepted, but as Crystal shared, this advocacy was something that her MHP considered a problem:

It wasn't just that my weight was a problem, it was that pro-fatness was the problem. Pro-fat acceptance was a problem, activism around fat bodies and fat acceptance was the problem. I would talk about how unfairly people treat fat women, and she would be sympathetic, but she was also trying to push the weight loss thing.... That was a big hurdle for me.

All the participants received messages from their mental health professional about their body being wrong, making it clear through these participant quotes that this pathologizing of fat bodies proved a hinderance to their treatment. In addition to impacting their treatment outcomes, this pathologizing of fat may have also created further mistrust between them and their mental health treatment provider, impacting their desire to seek mental health treatment in the future.

Suggesting Personal Responsibility for Body Size

In addition to pathologizing fat, many of the participants spoke about their mental health provider suggesting weight loss as a way to avoid societal marginalization and suggesting that being in a larger body was entirely the fault of the client and something to be controlled. This belief does not take into account the various reasons why someone may exist in a larger body, and does not recognize the principle of size diversity, or the idea that there is a natural spectrum of different body sizes. Whitney spoke about the frustration she felt as her mental health provider continued to suggest weight loss as a solution to her mental health concerns, when asked what she would like the MHP's to know about her experience she said the following:

Not all of my life's problems are going to be changed by a number and it's so dismissive of me as a human being. There are problems that would be solved, like oppressive problems that could be solved but that is not even what you are thinking about. Just getting them [MHPS] to understand that the entire way we think about health and weight, the entire way we think about fat bodies is oppressive. Getting them to understand that there are structural issues versus individual issues and to stop blaming the individual and start for themselves and their patients to point out the structural.

While providers continue to suggest weight loss as a solution to societal harm, participants brought light to the truth that pressuring people to adhere to societal standards does not address wider systems of oppression. Millie stated the following in her interview:

Body positivity makes it feel like the pressure of loving yourself is on you alone, and if you don't love yourself there is something wrong with you. [It doesn't recognize that] there are people telling me that I am worthless and don't deserve biological right to food. Body positivity isn't going to stop that, fat acceptance is.

This idea that we are responsible for loving and accepting our bodies can take pressure off mental health professionals to explore and own up to their own biases and creates a destructive mindset for people in larger bodies who feel they need to shrink in order to get proper care.

Alexis talked about how this mindset to shrink was detrimental to her overall mental health, although it was pushed and supported by her mental health provider:

For some people being in the mindset where they need their body to be smaller is literally destructive. It's not a neutral thing at all, especially in a trauma situation. She encouraged me to do so many wonderful things and got me connected to my body and for that I am so grateful but having that piece there just almost un-did it all.... That's how significant I feel it is.

Throughout the interviews, participants often reflected on how their experience may have been different if their provider was versed in things like weight inclusivity and fat acceptance.

Jasmine reflected on her experience stating:

She [the therapist] could have helped me realize the situation we were in wasn't my fault, it wasn't my husband's fault, it wasn't the poor choices on our part and I think it could have completely changed the trajectory of my relationship with movement and relationship with my body. I think it would have not left me in such a tangled mess for so many years.

Several group members said that they wished their MHP would have talked to them about the body-based oppression and how those systems are flawed, rather than blaming them for not meeting societal standards of beauty. In her interview, Mia spoke about the impact of suggesting personal responsibility as she discussed some of the societal barriers that she faces daily in her body:

I can get in trouble for wearing a crop top to the office, even if you're telling me just do it. There are still things that other people can get away with for being straight sized, that I can't get away with because society is going to have those parameters for me. So, even if I am liberated internally and I feel like I can wear whatever I want, that didn't stop the societal piece, which I think was a disconnect for her too.... You can tell me how empowered I am all day, but I'm telling you that the moment I walk out that door that doesn't stop people from staring and giving me ugly looks.

These statements bring awareness to the importance of the mental health professional recognizing weight-based oppression to ensure that they are not repeating that system within their office.

Damage to Client's Relationship with Self

The group collectively experienced damage to their self-image or relationship with themselves as a result of provider weight stigma. Participants shared that provider weight stigma changed the way in which they saw themselves and over time led to self-doubt and further internalization of fat phobia. Participants also reported that PWS effected the way they relate their body and their motivation to take care of themselves. The group described feeling a sense of disconnection from their own body as a result of being told that their larger body was wrong by both society and mental health providers. These subthemes are explained and expanded upon in the sections below with supporting quotes from study participants. This theme correlates to the concept of authenticity with relational-cultural theory. Authenticity is important tenant of Relational-Cultural Theory and requires that both mental health professional and client show up

to the space as their full and honest selves. This type of genuineness requires something called anticipatory empathy which indicates that the client is sure that the provider will meet them with compassion and empathy (Jordan, 2018). In the instance of weight stigma, this type of authenticity is not achieved, leading the client to disconnect from the provider along with disconnection from one-self. Each subtheme in this category is discussed below with examples from each participant.

Doubt and Confusion

Participants described questioning and doubting themselves as a result of experiencing provider weight stigma. Participants spoke about how difficult it was to continue trying to accept their bodies when providers were telling them that their body was somehow unacceptable, a message that they already receive culturally. Participants talked about how their experience may have been different if the provider was able to challenge this self-doubt and confusion rather than amplifying already harmful cultural messages about body shape and size. When asked about how PWS affected her relationship with herself Mia stated:

It definitely caused a lot of questioning of what I was learning, which made It twice as hard to do this personally because I thought well if I can't talk to you [my therapist] about it and I don't have any other fat people in my life I don't know where to turn to. For her being my first therapist, I had no standard to camper it to and so for me it was well this is what it is. They're not going to know everything about everything and that was my understanding. I kept thinking, well I know she has a lot of clients and maybe I'm the one with the least problems, I as trying to give her a pass all the time.

Alexis noticed that her provider's view of her body as something to be fixed, caused her to question whether or not that was true and left her feeling stuck in her healing process, she commented on this experience saying:

It definitely kept me in the headspace that my body is the problem, my body is the primary problem, and all my problems are connected to my body and my weight. Her weight stigma kept the connection between happiness and weight linked.

This connection between happiness and weight can be dangerous, knowing that the client's body may not change, and they may see that as a failure. Crystal talked about how she had started learning about fat acceptance and fat activism as a way to continue to heal from the trauma of living in a larger body, but that her provider's weight stigma caused her to gaslight herself expressing:

It made me really question my own beliefs about fat acceptance and think maybe there is something wrong with me, and that is just something in my life I had worked so hard to move forward from on my own.

Similarly, Whitney talked about how the things that her mental health provider suggested about her fat body caused her to question herself, saying, "I was very much processing all of it through a fat-phobic lens, through a 'my body, my willpower, I'm the problem' lens."

Internalized Fatphobia

In addition to self-gaslighting, study participants reported increased levels of internalized fatphobia because of provider weight stigma. Like with any internalized stigma, internalized fatphobia impacts the way that someone sees themselves and their value in the world. Alexis noticed the impact of internalized fatphobia as she reflected on her therapeutic relationship with this provider, sharing in the interview:

Once I extracted myself from the therapeutic relationship, all of the sudden I heard this voice saying this is what I need, and you know how to do this because you've been thinking about it for a long time. The thing is while I was there I was feeling like the bar she set was that my body was going to change, when you heal you're going to look a certain way, you're going to feel a certain way, you're going to present a certain way. So I thought I'm never going to get there.

Several other participants said that a shrinking body was seen as a marker of success in treatment, and they felt as if they would never heal if they existed in a larger body. Jasmine emphasized this when she stated, "I blamed myself, I thought I was doing something wrong, I thought I wasn't working out good enough or hard enough or whatever and I spent a lot of years

fighting with myself.” This type of internalization of stigma is something that people often do not recognize or acknowledge until after the event has passed, which is something that Sidney emphasized in her interview as she talked about what it was like to reflect on her time in mental health treatment:

During the times that I experienced stigma, I didn't know I was experiencing it because until the later days I really internalized it. You internalize these messages of “lose weight, lose weight” losing weight is the only way to be healthy, and when you fail to do that you internalize that failure and see yourself as the failure, and yourself as the problem which then just leads to more mental health problems.

This internalized fatphobia affected each participant in differing ways, Millie described it as “emotionally exhausting” to seek therapy and then feel that you are also absorbing fatphobic messages from your provider. Crystal talked about how the internalization of fatphobia affected her in and how she viewed her success in her career:

I am really successful as a scholar and as an educator, but you know sometimes I feel like a failure because of my fatness, and I write about how fucked up that is but I still feel it ya know? Even though I am someone who strongly affiliates with fat acceptance even in my professional work; there is a lot of residual shame since I've gained weight.

In differing ways, this internalized fatphobia affected participants and how they saw themselves and their value based on their weight. Towards the end of her interview and with an exasperated sign, Whitney stated, “All of this was processed through internalized fatphobia...” and while not all the participants labeled it so directly, many articulated the ways in which provider weight stigma caused them to internalize negative messages about their body.

Within relational-cultural theory controlling images refers to society's pre-made assumptions about certain groups of people, images and messages that serve as forms of chronic disconnection and isolation for those with marginalized identities. These types of images “hold” people in the place that they are, immobilizing them from seeking freedom from these stereotypes and assumptions (Jordan, 2018). These strategies of disconnection give rise to

internalized oppression which was seen in this study as participants reported internalized fatphobia because of experiencing PWS.

Disconnection and Detachment

Participants in the study discussed how provider weight stigma caused them to disconnect them from their body and intuition. Participants talked about how confusing it felt to be told that they needed to trust their body to heal trauma, while being told that their body needed to be smaller. Relational images are described as the inner constructs and expectations that we each create out of our experience in relationships (Miller & Stiver, 1997). While these images can represent personal relationships, they are also found in our society at large. Those with historically marginalized identities are chronically disconnected which affects one's sense of worth and value in the world. The participants in this study indicated that they felt a sense of disconnection and even harm because of PWS. This disconnection mimics the type of oppression and disconnection that these individuals experience in greater society. While mental health treatment is meant to be a space of healing, if harmful relational images are repeated within the therapeutic space, it can become yet another site of interpersonal injury, causing participants to detach from their own body to avoid feeling the pain of this type of interpersonal injury. Alexis spoke boldly about this in her interview stating the following:

It [PWS] made me feel like I couldn't really listen to myself, I couldn't really trust myself. There is a lot of body stuff going on there, learning to trust yourself, trust your body. But when your weight is higher its almost like you have these two messages... [one being] you have to get close to your body, become embodied, feel yourself and trust yourself. But, on the other hand its oh well don't trust your body, your body is the enemy you have to fix it; that definitely impacted me.

Similarly, Whitney spoke about the ways in which provider weight stigma created a battle between her and her body and intuition:

Those experiences put me at constant battle with my body. Everything was still, “Ok when I lose weight this will be better. I just haven’t figured out the magic thing, I’m just not good enough for this” so those experiences only ever put me at war with my body.

For the client in a therapeutic relationship this battle between wanting to learn to trust your body and being told that your body is wrong can lead to years of disconnection and distress, leading to further trauma. Several participants shared how this disconnection resulting from provider weight stigma followed them for years after leaving treatment, Millie said, “For many years I felt like a head attached to a body. I didn’t have a lot of body awareness, mostly because I did not want to interact with it at all.” A poor relationship with one’s own body was something that all the participants shared, when asked how she felt PWS affected her relationship with her body Charlotte expressed:

My relationship with my body has not been good for a long time.... I’ve always struggled with that relationship, always felt not good enough, not important. I had bariatric surgery, 8 or 9 years ago and even getting as low as I did, I wasn’t good enough, it [my weight] wasn’t low enough.

This avoidance of feeling connection to one’s body was something that several participants discussed, with each person dealing with this emotional pain in a different way. Crystal said the following about the effects of PWS on her relationship with her body:

I’m really not happy with my body right now. I think it’s okay with me because I can reconcile those feelings with the structural places they come from and the places in my autobiography that they come from and continue doing the work.

She considers her experience of PWS to be part of her journey and something that drove her to continue doing the work of fat activism and fat acceptance both personally and professionally.

Other participants such as Jasmine provided words of wisdom to future mental health professionals about avoiding weight stigma saying, “I could have ended up someone with an eating disorder, I could have ended up committing suicide, there are so many ways that this could have ended up worse than it did. I’m lucky that I am even here to tell a story.”

Increased Disordered Eating and Movement Patterns

Participants in the study reported various ways that provider weight stigma impacted their health behaviors including impacts on their relationship with food and exercise, and their motivation to engage with other positive health behaviors. Several participants spoke about how ironic it felt for their mental health provider to ask them to take care of themselves, but also suggest restrictive dieting in the same session. Sidney spoke to how disempowering it felt for her to constantly hear that her body needed to be changed:

Rather than going home and feeling empowered to take care of my health and take care of myself I feel belittled and like a failure and when you feel like a failure and you are told you are a failure over and over again you are not going to even make the changes that you know would be helpful for you, it's just not going to work.

Mental health professionals may have good intentions, but when they suggest intentional weight loss it leads to clients feeling disempowered to engage in behaviors that may actually improve their health, separate from the scale. Jasmine talked about the long-term effects of PWS in relation to her relationship with exercise and movement, describing how PWS made it hard to engage in joyful movement:

I spent the last several years since I've learned about intuitive eating and health at every size and the concept of joyful movement. I've been trying to work on my relationship with exercise and it's been really difficult, and I still have a hard time with exercise that has been scheduled, I have a really hard time with that and I have a really hard time forcing myself to do it.

Further emphasizing the potential harms of provider weight stigma, many of the participants including Whitney discussed how weight stigma itself has played in a part in continued body changes, in turn causes more stigmatization:

I'm quite convinced that I am really only the size that I am because of much of the treatment that I've had and because of the reaction to me when I wasn't a gawky little kid. I do really feel like if this would have just been left alone, I probably couldn't have developed an eating disorder, I probably wouldn't have gotten all this treatment that reinforced my eating disorder, I wouldn't have restricted as much, and I wouldn't have

binged as much, and I wouldn't have fucked up my metabolism and I probably would be at a very different set point for my weight.

In sum, this group expressed that provider weight stigma discouraged them from engaging in health promoting behaviors, creating a vicious cycle where they continued to experience negative impacts of stigma and decreased motivation to take care of themselves.

Damage to The Therapeutic Alliance

One of the purposes of this study is to examine how provider weight stigma impacts the therapeutic alliance. The results of this study showed that weight stigma can negatively affect the therapeutic alliance in a variety of ways, creating further harm and separation between client and provider. Experiencing this type of damage within a therapeutic alliance also caused the participants to avoid seeking help in the future due to a deep distrust in mental health providers, and difficulty finding a fat positive provider. Relational-cultural theorists believe that the ability to build relational resilience is seen as a marker of growth in psychotherapy (Jordan, 2018). Relational resilience means that even after disconnection or ruptures, clients can repair relationships and feel safe to enter new vulnerable relationships with others. This is another RCT idea that was represented in the data of this study. Participants reported fear and avoidance of help seeking behaviors after experiencing PWS and were less willing to seek help again after experiencing PWS.

Relational cultural theorists believe that humans grow within and from connection with one another (Jordan, 2018). RCT theorists seek to decrease the suffering caused by disconnection and help individuals build relational resilience (Jordan, 2018). As discussed in previous chapters, through this lens provider weight stigma could be seen as a form of disconnection, serving as a limitation to the therapeutic alliance. This is further supported by the data presented as each participant expressed that PWS negatively affected their relationship with the mental health

professional and at times prevented them from seeking services in the future. Many of the participants talked about the fear of seeking services again, and dreading having to “justify” their body, or having to fight and advocate for proper care. Client’s suffering was obviously increased by the present of provider weight stigma, again furthering the disconnection between client and provider. Below is a summary of the major concepts of relational cultural theory, and how those concepts are represented in the study data. This theme of damage to the therapeutic alliance is separated into several subthemes described below which further delineate and describe ways in which PWS can rupture the therapeutic alliance, and influence help seeking behaviors in the future.

Forced Educator Role

Several participants described being put in the educator role with their mental health provider, having to educate the provider on weight stigma and how it affects them. This is a phenomenon that occurs for people with other historically marginalized identities and places an emotional burden on that individual in order to educate someone else about their identity. Crystal described in her interview how she often found herself in this role with her provider:

I had to go into professor mode, into educator mode, I mean there is a certain level of self-protection and armoring that goes into that. Not that teaching can’t be vulnerable but I think that if I could have been more vulnerable then maybe I would have been able to find better ways of dealing with my own struggles with my body and finding ways to live in my big fat body as it is, rather than continuing to struggle with this on-going worry about my health and my size and just coping with the world that doesn’t fit someone my size as a super fat.

Other participants discussed how they attempted to educate their provider but felt that it was not received. Mia talked about how she would often bring her counselor resources on weight inclusive care including books and articles, but felt that the professional did not take the time to investigate the resources she was sharing:

Every time I went into the office, I would bring a book and share it with her. I took her a body book and she's like this is all good stuff, but I felt like I couldn't talk about it if she had not read it and can't understand it. So, her not being able to know what I was actually reading and understand the concepts was very frustrating.... Now that I process it later, I feel like that was a lot of work I was doing for the fact that I was in therapy. I don't think you are supposed to be doing that much work in there.

Participant Sidney also felt frustrated that she was the one often having to educate her mental health providers about weight stigma and weight inclusive care. In her interview she shared a message for providers in the future, "I shouldn't have to tell my doctor; she should be reading students and should have some kind of education on how to approach healthcare as a way to feel better but not necessarily to look like society thinks you should." In sum, participants expressed not only being forced into an educator role but feeling frustrated that when they did take the time to educate their MHP's, the providers were unwilling to truly educate themselves on the topics at hand.

Mistrust in the Mental Health Field

The concept of general mistrust in the mental health field emerged in every interview during the data collection process. Participants expressed how weight stigma made the therapeutic alliance feel unsafe, and even prevented them from seeking help in the future for fear that they might have to "justify" their fatness to a new professional. Crystal talked about how this mistrust mimics how she feels as someone who identifies "super fat" in a world that is not made for those in larger bodies:

If you are a fat woman there are two places where you find yourself in constantly. You are either fighting with your body all the time to make it smaller or you are fighting with society to live in your body. And it doesn't feel great to be in therapeutic spaces where you feel like you have to fight, either with your body on therapeutic advice or with your therapist as a part of society's idea that being fat is a problem.

Participants shared a common fear that the therapeutic space would mirror the rest of the world and become an unsafe place for someone in a larger body. Sidney said that experiencing

provider weight stigma made her “leery” of finding care in the future, “Not only do you have your mental health problems, but you have to deal with the stigma that you expect to face from providers.” Several participants talked about the “emotional burden” associated with seeking care after experiencing provider weight stigma and the fear that instilled in them. Millie expressed in her interview, “The prospect of having to justify my fatness, having to justify it all as a step of making myself worth of proper treatment is just too much.” This type of mistrust infiltrates the therapeutic alliance and harms the present therapeutic relationship as well as making participants leery of seeking care in the future due to anticipating weight stigma. When asked how PWS affected her view of mental health professionals, Jasmine summarized it in this way:

It really made me distrustful of the profession in general, it made me feel like why bother? Why bother talking to them, they are all the same. It made me feel like well I’m just going to have to do whatever work I need to for myself, by myself because they only do that for skinny people... they only do good therapy for certain types of people.

This idea that “good therapy” is something that is only done for certain types of people came up in several participant interviews, such as Whitney who likened the mental health industry to diet culture, “Its giving poor treatment and then blaming you for the poor outcome and that’s how I view mental health providers in the eating disorder spaces.” In summary, provider weight stigma creates mistrust between provider and client and may even prevent clients from seeking future treatment for fear of how they may be perceived.

Difficulty Finding a safe provider

Another sub theme collectively expressed by participants is difficulty finding a fat positive mental health provider after relational rupture with their original mental health provider. In her interview, Crystal said:

The worst thing about it was that it made it harder for me to think about finding another therapist. I don't want to go back to another therapist who is going to think that the fact that I have experienced trauma is the reason I am fat.

Likewise, Sidney talked about how her experience of provider weight stigma made her “hesitant” to seek any kind of healthcare and to have an “open relationship” with providers in the future. She said that she will always worry about mental health professionals suggesting weight loss as a way to heal. Whitney emphasized this hesitation, stating, “The fact is Health At Every Size aligned providers, fat positive providers are still the minority.” While the scarcity of these types of providers was talked about in every interview, some participants stated the need for an official credential that would indicate fat positivity. Millie said in her interview:

The thing is I don't know if they have been HAES educated, if they would have implemented those practices. Having the education doesn't necessarily mean that they utilize the education... I think there needs to be some sort of measurable competency whether that be an actual database of “fat people have said you are ok”, academics don't necessarily mean anything.

Comparably, Mia spoke about the need for transparency from mental health providers:

I would appreciate the differentiation between eating disorder and body positivity and self-image conversations and things like that; they've named it. And I want you to be very clear when you work with EDO's; have you ever worked with fat bodies?

Along with difficulty finding a fat positive provider, participants voiced the need for insurance companies to panel and cover these types of professionals. In her interview, participant Jasmine said:

Every time I go and talk to someone, I was doing all the things they told me to do, trying to lose weight and I was still struggling with depression. I started seeing a therapist outside of what is covered by our health insurance because that is where I could find somebody who was HAES aligned and that sort of thing. I should be able to go get healthcare that is inclusive now, not have to save up money for years and years.

In conclusion, participants discussed how difficult it can be to find a fat positive provider and the need for some type of universal credential that would indicate that a professional is fat positive

and not just “body positive” but that they are a safe person who has education and experience working with fat bodies.

Forms of Resiliency

Women in larger bodies display a great amount of resilience against the oppression and stigmatization that they face every day. This resilience has consequences, and there is some risk in celebrating it, however; the question was intentionally put into the interview to give participants a chance to reflect on their own strength as the last thing that they discussed with the researcher. It was the researchers’ goal that this would help empower participants to reflect on the ways in which they have positively coped with this type of stigmatization. Participants named a variety of resilience strategies, including resilience through advocacy for self and others, connection with others (including online communities) and self-education as a form of empowerment. Each of these subthemes are described and expanded upon below. These forms of resiliency speak to the power of connecting and the idea that humans grow through and within connection, which is one of the core tenants of the theoretical lens guiding this study (Jordan, 2018). Participants shared about how connection in various forms provided a safe haven for them to continue to learn to accept themselves, and to advocate for others to do the same and expect the same treatment from their providers.

Advocacy for Self and Others

The group expressed advocacy as their main form of resilience against weight-based oppression. This included macro examples such as advocating on-line, and micro examples like calling out weight stigma in the workplace or within the family; and advocating for oneself at the doctor’s office. Some talked about the way in which this type of advocacy helped solidify their own beliefs about weight inclusivity and improved their own confidence in those principles and

how they could apply them in their life. One participant had the unique perspective of becoming a mental health professional herself, and she talked about “believing in HAES as a therapist” and helping her clients learn about and adopt these principles as a form of advocacy. Whitney has severed in a variety of roles within the larger eating disorder treatment advocacy community and when asked about how she stays resilient she shared the following:

I actually think advocacy is a big tool in recovery, that doesn't have to be on some grand scale, but little by little educating anyone who is willing to listen about diet culture or the failure rate of intentional weight loss, or the harms of weight cycling, or pulling apart the health equals weight thing. You realize that there is something at play and you're not totally at blame and you have a place to put your anger.

Another participant who took her advocacy to a larger scale is Crystal who is a scholar whose research centers around fat studies. When talking about forms of resilience she mentioned her role as a professor, “I was teaching about fatness, so when I taught about fatness students would usually really hear it, and that really helped. I felt vulnerable when I talked about that stuff with my students, but usually it landed for them.”

On a personal level, participants like Jasmine talked about how they engage in advocacy as a way to prevent their children from experiencing what they experienced in mental health treatment. She expanded on this idea of protecting younger generations from weight stigma by sharing:

I know I can't change what is happening in the world, but I can change the narrative we have at home and make them strong enough to withstand it. That is a part of the reason I wanted to participate in this study.

Charlotte remains resilient by sharing and advocating on her social media platforms where she focuses on how older women can embrace the concepts of weight inclusivity and fat positivity:

Women my age aren't hearing this message because we aren't represented, and I can't tell you how many women I follow on Instagram that are young, thin, white females that are touting eating disorders. You find one person of color and it's like Yes! It's something different, she has a different perspective. But there's no one my age, there and

I keep searching and searching and searching. I'm asking friends to help me find someone, someone over 50, someone whose been battling this for years, someone who understands, someone that I can follow and look to. Finally, I just said I'm going to be the person, no one can find anyone who is so that person so I am just going to have to be that person for myself and anyone else who will listen.

It is clear through the participant statements that advocacy plays a big role in resiliency, and that all the participants found ways to engage in advocacy as a part of their own healing process along the way helping to heal others in their vicinity. In addition to engaging in advocacy, participants found resiliency through a variety of avenues described below, including connection and relationship with others both in person and in virtual spaces.

Connection With Others

Participants expressed utilizing personal relationships along with online fat positive communities to build resilience and gain the language needed for self-advocacy. Regarding online communities, several participants talked about groups that focus on fat positivity, fat activism, weight inclusivity, intuitive eating, and eating disorder recovery for those in larger bodies. Sidney said that being part of these online communities gives her the “language needed” to advocate for herself in spaces like the doctor’s office. Participant Mia stated:

I'm on at least three different pages that relate to food conversations. My problem has been that I have a lot of identities that intersect, and it is really hard to find people who have those intersections.... I have two other pages that are specifically on intuitive eating, that have either like intuitive eating and PCOS or intuitive eating and insulin resistance, so I follow pages like that. I'm grateful to have found people within my own sorority that are doing fat liberation work that I have been able to stay in touch with who have connected me to other professions. That has been really interesting to get to see that, so I intentionally build an online community.

Jasmine also mentioned some specific fat positive Instagram and other social media platform accounts that have helped her gain exposure to other people in larger bodies living their lives freely. Another form of connection often mentioned was the support of friends and family members who have embraced the idea of weight inclusivity along with their loved ones. Jasmine

spoke about how impactful it felt for her husband to embrace and learn about the Health At Every Size movement and support her in teaching these principles to their children:

One thing that helped was the support of my husband, he has always been so supportive. Once I started learning about Health at Every Size and all that, he believed me whole heartedly.... Having that really helped, just having one person who supports you, who believes you makes such a big difference.

Another participant (Millie), discussed the importance of “curating” a friend group of individuals who are on board with fat acceptance and understand the concepts enough to be supportive:

I mindfully curate my friends, like if they do any sort of diet talk I don't... I don't cut them off completely I just let that relationship dry up. The resilience comes from mindful cultivation of who I surround myself with and who I interact with. I've been able to build my own bubble, it's nice.

Whether virtual or face to face, the importance of supportive connections remains a strong theme throughout the interviews with each participant expressing the ways in which connection has helped them heal and grow in their pursuit of healing and understanding of weight stigma.

Self-Education

An important part of resilience is the ability to feel empowered in one's body. Participants said that learning about the concepts such as body liberation and Health at Every Size keeps them grounded in the face of weight stigma and encouraged further healing. It is notable that much of the education on the concepts discussed above was reported as self-education and was not introduced by mental health providers. Several participants talked about how different their experience would have been if these principles were introduced to them by their mental health provider, as Whitney said:

My relationship with my body looks very different now but that did not come from paying for mental health services, that came from my own learning and some of the amazing work that people have done in the fat positive, and HAES aligned spaces. But yeah, that didn't come from mental health providers.

Similarly, participant Mia talked about how she gave her mental health professional “too much credit” knowing that she herself did much of the research and education about weight stigma and weight inclusive approaches on her own. This type of self-education seems to ground many of the participants and allow them to be resilient in the face of stigma. Crystal spoke about how her professional work as a scholar in fat studies often empowers her:

I’m reading and writing, I’m still doing the work as an educator and doing the work as a scholar. Even when I find myself doubting myself, I start working on on-going projects and I start reading pieces by other fat acceptance people and I think you know what... it’s not me. That scholarship really empowered me at a time when I needed it and so it continues to empower me.

In summer, participants in this study described several ways in which provider weight stigma impacted their relationship with self, body, and their view and trust in the mental health field. Notably, study participants voiced frustration and confusion due to the fact that MHP’s told them they could not trust their body, while also asking them to become more attuned to their body in order to heal trauma patterns and responses. Participants described how experience this type of stigma impacted other areas of their lives, impacting their intuition, ability to trust themselves, and desire to care for themselves and engage in health promoting behaviors. Several participants mentioned that PWS impacted their healing process and noted that it was confusing to hear their therapist suggest that they become “embodied” to heal trauma, while in the same breath saying that they could not trust their internal cues because those had led them to becoming fat.

Essence of the Experience

Overall, the themes of the research reflect a need for providers to recognize the harm caused by provider weight stigma. Participants reported psychological harm that was categorized into microaggressions, pathologizing of fatness, and providers suggesting personal responsibility

for body size rather than recognizing structural systems of oppression for those in larger bodies. All participants discussed damage to their relationship with self as a result of PWS including doubt and confusion, internalized fatphobia, disconnection and detachment from themselves and increased disordered eating and movement patterns. Participants unanimously, viewed themselves and their bodies more negatively after experiencing PWS. Another purpose of this research was to investigate the ways in which provider weight stigma harms the therapeutic alliance. Participants reported that the therapeutic alliance was harmed in a variety of ways including the participant being forced into an educator role with their mental health professional, overall mistrust in the mental health field, and difficulty finding a fat positive provider.

Undoubtedly, participants experience of provider weight stigma negatively impacted their willingness and ability to seek mental health treatment in the future. The participants displayed a remarkable sense of resiliency and talked about several ways in which they leaned into that resiliency including by advocacy for themselves and others, connecting with others both online and in-person, and continuing to educate themselves in the areas of fat liberation, intuitive eating, and weight inclusive approaches. All of the participants agreed that their treatment would have been enhanced if the provider was educated in weight inclusive paradigms and wanted mental health providers to know how harmful PWS was to them during treatment.

Trustworthiness and Verification Methods

It is imperative in qualitative research that investigators employ multiple measures to ensure that the data is upheld to the strongest standards of trustworthiness and rigor. Multiple measures were taken to assure that each of these constructs were met in this study. Examples of the ways in which each assumption was met are detailed below.

Credibility

Credibility is the ability to assure that the interview questions measure what the researchers are aiming to measure. In qualitative research, credibility indicates the ability of the findings to represent reality. By adopting research methods that are well established in qualitative research, the researcher maximizes trustworthiness and ensures that the results are likely to provide information and insight that answer initial research questions. By choosing transcendental phenomenology, which is well established in both qualitative studies and within science in general, credibility is increased. Another way to increase credibility is to assure triangulation of the data. Triangulation, as defined by Shenton (2004), consists of “The use of different methods, especially observation, focus groups, and individual interviews” (p. 65). In this study, triangulation was achieved using researcher bracketing and journals/memos, individual interviews and member checks.

Member checks were completed by email, giving participants a chance to review their transcripts and make any desired changes to their statements as well as provide any other feedback. As suggested by Shenton (2004), another way to increase credibility is to welcome peer debriefing and peer scrutiny of every research study. I utilized two external auditors, both of which have training and knowledge of qualitative research methods as well as expertise in weight stigma and fat phobia on a clinical level. Each external auditor received a preliminary table of themes along with original research data, and their feedback was utilized in the writing of chapters four and five. In addition to external auditing, I also debriefed with colleagues in the field of weight stigma as I was working through the project, welcoming feedback and comments that they offered for the study.

Transferability

In addition to improving measures of credibility, trustworthiness is also increased by maximizing measures of transferability. The concept of transferability is the amount to which the findings of this study may be applicable to other populations. In this study transferability was achieved through the utilization of purposive sampling and by providing a thick description of the phenomenon being studied through interview data. There are several different types of purposeful sampling used in qualitative studies. The goal of such sampling strategies is to attain a more accurate picture of the phenomenon being examined. The sample for this study is homogenous, because participants will be selected based on a group of common characteristics including gender, and self-identification of gender, body size, and experiences of restrictive eating disorder symptomology. Homogenous purposeful sampling increases transferability because the phenomenon can be more closely examined when the participants have similar characteristics and experiences. In addition to purposeful sampling, the descriptions that came from the original data allow readers to make reasonable conclusions from the data which are discussed in the results section of this paper.

Dependability

Trustworthiness may also be increased by ensuring dependability, a concept that measures the ability of the study to be replicated and indicate similar findings. Shenton (2004) proposes that by engaging in reflective appraisal of the project, and evaluating the effectiveness of the inquiry undertaken, the researcher can increase dependability of the study. In addition to bracketing my own experiences through journaling and memos, I also utilized journaling and reflecting during the data analysis process, frequently asking for feedback and input from

colleagues in my doctoral program. This allowed me to explore my own thoughts and feelings related to the themes that were discovered through the process of data analysis.

Confirmability

Finally, trustworthiness can be ensured by increasing the confirmability, or objectiveness of the study. Although researcher bias is inevitable, steps must be taken to ensure that the themes which come from the data are true to the data and not filtered through the lens of the researchers. Confirmability was achieved in this study using thoughtful reflexivity and disclosure of my position as the researcher. My positionality is discussed at length in the first chapter of the study. This type of transparency is considered essential in good qualitative research, and helps the reader position the researcher within their various experiences and beliefs.

Findings Summary

Chapter four reviews the data analysis and synthesis for each participant experience with provider weight stigma. The individual conceptualization and the group synthesis are reported first in a narrative and the represented using tables to display the data. Four major themes were taken from the data analysis which included individual interviews, researcher memos, and member checks. Those four major themes were then broken down into thirteen sub-themes helping to organize the data and capture the nuances of each related major themes, all themes and subthemes can be seen below in Table 3. All participants indicated that they experienced relational harm because of provider weight stigma, and the essence of that experience showed that this harm kept them disconnected from the provider, themselves, and their bodies.

Table 3
Group Experience Organized by Themes and Subthemes

	Crystal	Whitney	Sidney	Millie	Charlotte	Alexis	Jasmine	Mia
<i>Psychological Harm</i>								
Microaggressions	X	X	X	X	X	X	X	X
Pathologizing fat	X	X	X	X	X	X	X	X
Suggesting personal responsibility	X	X	X	X	X	X	X	X
<i>Damage to relationship with self</i>								
Doubt and confusion	X	X	X	X		X	X	X
Internalized fatphobia	X	X	X	X	X	X	X	X
Disconnection and detachment	X	X	X	X	X	X	X	X
Increased disordered eating and movement patterns	X	X	X	X	X		X	X
<i>Damage to therapeutic alliance</i>								
Forced educator role	X	X	X	X				X
Mistrust in the mental health field	X	X	X	X	X	X	X	X
Difficulty finding a safe provider	X	X	X	X	X	X	X	X
<i>Forms of Resiliency</i>								
Advocacy for self and others	X	X	X	X	X	X	X	X
Connection with others		X	X	X	X		X	X
Self-education as a form of empowerment	X	X	X		X	X	X	X

Conclusion

It is clear through the participant data presented in this chapter that provider weight stigma had a profound impact on participants in a variety of ways. While some participants reported more overt types of stigmatizations such as being weighed or being told that weight loss was a solution to their mental health concerns, provider weight stigma seemed to happen in a variety of subtle ways that may have been outside of the provider's awareness. Provider weight stigma impacted the participants relationship with themselves, relationship with their body, and the therapeutic alliance with the mental health provider; causing the participants to mistrust the mental health profession in general because of their experiences. In a variety of ways, study participants described being harmed by this stigmatization and not wishing for anyone else to go through this kind of experience. Amidst such harmful experiences, participants were also able to identify ways in which they cultivated resiliency despite these experiences. Forms of resiliency were similar for all the participants and centered around connection and relationship with others as well as self-education and the utilization of advocacy as a form of empowerment. Study participants were very clear in wanting providers to know that PWS caused harm, and that this type of harm is easily preventable with education and dedication to the ideas of weight inclusive care and fat positivity. The next chapter explores the possible limitations of the study, along with providing implications for mental health professionals and educators and both practice and educational recommendations.

Chapter V Limitations, Implications and Recommendations

The purpose of this study was to explore client experiences of mental health provider weight stigma. My goal was to help uncover the harm that can be perpetuated when a mental health professional may have unexamined biases and assumptions related to weight and perpetrates weight stigma within the mental health space. I wanted to know the essence of this experience for clients, specifically focusing on how it impacted the therapeutic alliance for these women in larger bodies.

Limitations

As with any study, there were limitations throughout the process of this study, which are explored in the following section. The cohort of eight participants were largely made up of white women, meaning the participant experiences were experienced through a similar cultural lens. Although diversity of participants existed in age, education level, and physical location not having a varied group of ethnic or racial diversity may impact the ability of this study to provide suggestions applicable to different groups of people.

Another possible limitation to be considered is the difference in mental health disciplines represented by the providers discussed in the study. Most participants reported experiencing provider weight stigma from professional counselors, social workers, and psychologists; however, two participants included additional experiences of provider weight stigma with a psychiatrist. Psychiatrists are unique in that they are medical doctors who also provide mental health care, but their training is based on a medical model (Farre & Rapley, 2017; Laing, 1971). The possibility of participants wanting to share experiences with psychiatrists was not something that I considered at the beginning of my study and was unsure how to categorize that data, or whether it should be included. While most experiences were with primary mental health

providers, there were some experiences that were excluded from the data due to those experiences being with psychiatrists. Medical weight stigma is well established in the research (Drury, 2002; Schwartz et al., 2003), although the purpose of this study was to focus primarily on mental health providers and while psychiatrist do provide mental health care, they are also trained as medical doctors which may influence their views on body shape and size as well as their propensity to impose weight stigma upon their patients. Ultimately, I chose to retain the data in order to attempt to summarize and understand the entirety of the experience of PWS for each participant.

Implications

Participants in this study indicated that mental health provider weight stigma had a lasting effect on their mental health and well-being, several identified the experience as being traumatic or emotionally damaging. Participants were asked how their experience would be different if the mental health provider was trained in weight inclusive care and what they would share with that provider if they had the opportunity to speak with them again. In the following sections, I utilize some of their responses as implications for mental health professionals and training programs. It is my hope that their vulnerabilities in sharing advice for mental health professionals can be utilized to help mental health professionals examine their own weight stigma and anti-fat attitudes and shift the way that we care for women in larger bodies.

Mental health professionals in a variety of disciplines operate under ethical codes which serve as a framework for competent, professional, caring, and ethically sound practice (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2017). While every discipline has a different specific code of ethics, they share core values and at the bare minimum they ask that professionals are avoiding doing harm

to their clients. The data gathered in this study shows that some mental health providers are causing harm and potentially misaligning with ethical standards when they perpetuate weight stigma. This shows the importance of mental health professionals recognizing body shape and size as a dimension of diversity and addressing their own biases surrounding weight and size in the same way that these professionals address other kinds of biases that they may have. It is imperative for mental health professionals to spend time addressing their own weight bias in order to avoid doing harm to clients in larger bodies because of their own biases or lack of knowledge.

Recommendations for Mental Health Professionals

As discussed previously, Health at Every Size is a social justice movement and philosophical framework that has been adopted in many different professions. Mental health professionals who utilize this framework in their work with clients, emphasize health as a multi-dimensional construct that does not focus on the scale. Mental health professionals can use the HAES principles as a guide in their work with clients, helping clients to reframe weight loss goals considering the evidence base which shows us that weight loss is not sustainable and is harmful (Bacon, 2010). Below are recommendations for ways that mental health professionals may begin to utilize a weight inclusive framework with their clients to avoid perpetuating weight stigma.

Engage in Self-Exploration

It is vital that mental health professionals explore their own relationship with their body, their own relationship with food and how those things affect them and may affect their clients. MHP's should examine and explore personal beliefs, values, and biases in an effort to prevent those from impacting client care. Professionals may explore this in a variety of ways including

journaling, supervision, personal counseling and reading weight inclusive books such as *The Body Is Not an Apology* (Taylor, 2018), *Health at Every Size* (Bacon, 2010), *Body Respect* (Bacon & Apramore, 2016), *Anti-Diet* (Harrison, 2019), and *Fearing the Black Body* (Strings, 2019). In addition to spending time exploring their own relationship with body, mental health professionals may also benefit from being curious about their own levels of weight bias, similarly to the way in which MHP's are expected to gain awareness around other types of biases such as racism, sexism, ableism, and others. While the tools to explore this type of bias are not as vast, counselor can utilize instruments such as the Harvard implicit bias test (Greenwald et al., 2009) Weight Bias Internalization Scale (Durso & Latner, 2008), Fat Phobia Scale Short form (Bacon et al., 2001). These various instruments can help mental health professionals gain a base level understanding of what judgements may be present for them when they interact with individuals in larger bodies. The Implicit Bias test (Greenwald et al., 2009) is a tool that is widely used to measure implicit bias for a variety of identities and can be utilized to help assess a person's attitudes on weight by showing images of "fat people" versus "thin people" and asks the individual to indicate the level of "good" and "bad" associated with those pictures. In addition to the Harvard IA, both the weight bias internalization scale (Durso & Latner, 2008) and Fat Phobia Scale Short form (Bacon et al., 2001) provide an opportunity for students and professionals to measure their own levels of weight stigma and fatphobia through self-assessment. Future research is needed to determine further methods to help mental health professionals explore their own biases around weight, however educators may choose to utilize and adapt activities and experiential techniques that they utilize to help students explore biases in other areas.

Avoid Overt Harm

Mental health professionals should first avoid causing harm to clients in larger bodies by ensuring that clients are not weighed, encouraged to pursue intentional weight loss, or told that their body is something to be fixed. Participants reported being weighed and being asked to engage in “virtual gastric bypass” as well as being told by their mental health provider to pursue intentional weight loss or weight loss surgery. Avoiding this type of outward harm and stigmatization is essential in ensuring that clients in larger bodies feel safe in accessing mental health care, however the results of this study suggest that provider weight stigma is also happening in more subtle ways which require an adjustment to the way that mental health providers practice with clients in larger bodies. The section below provides practical suggestions for mental health providers in clinical practice. These suggestions serve as a guide to help MHP’s implement policies and procedures that embody weight inclusivity for all clients.

Provide Accessible Spaces

When participants were asked what advice they would give to professionals regarding PWS, several of them stated that accessible seating and welcoming spaces are impactful and leave a lasting impression. Mental health professionals should ensure that their spaces are welcoming and accessible for people in larger bodies, some suggestions on how to do that are outlined below. Suggestions for creating an accessible space include making sure that there are waiting room chairs or couches without arms, and chairs with higher weight capacities. This also includes ensuring that any clinical spaces (such as group or individual counseling rooms) have comfortable and adequate seating for those in larger bodies. If working in a school or community agency, mental health professionals can advocate for appropriate and adequate seating to be present in waiting rooms and other treatment spaces. As stated by Kinavey and Cool (2019):

Anti-fat bias...is even a factor in how we set up the physical spaces in which we work. If we cannot see the limitations of our own office furniture, how will we learn to see the limitations of our own belief systems?

Mental health professionals should be mindful of the media available in waiting rooms and common spaces as well as make a concentrated effort to display diverse body shapes and sizes in artwork displays. Furniture provided should be accommodating of diverse sizes and abilities as well as arranged to welcome all who enter. Providing accessible and comfortable office spaces and classrooms is an important step in acknowledging body shape and size as a dimension of diversity.

Utilize Size-Inclusive Language

In addition to creating accessible and comfortable physical spaces, feelings of safety can be increased with the utilization of size inclusive language in client paperwork and clinician documentation. This process may include removing descriptors such as “overweight,” “average weight,” or “obese” in clinical paperwork. Terms such as these are stigmatizing for people in larger bodies. As articulated by Wann (2009), the word “overweight” is inherently anti-fat:

Instead of a bell curve distribution of human weights, it calls for a lone, towering, unlikely bar graph with everyone occupying the same (thin) weights. If a word like “overweight” is acceptable and preferred, the weight prejudice becomes accepted and preferred. (p.IX-XXVI)

By replacing words like “obese” and “overweight” and replacing them with language such as “smaller bodied” or “larger bodied,” mental health professionals can show an acceptance for clients in varied body sizes. In addition, MHP’s should avoid utilizing these types of harmful descriptors in their own personal paperwork and move towards more weight inclusive terms to avoid perpetuating weight stigma. These small shift in language go a long way in ensuring that clients of all body sizes feel welcomed in treatment spaces.

Recognize Weight Inclusivity as Anti-Oppression Work

It is important for all mental health professionals to acknowledge body size as a dimension of human diversity. Weight centered approaches that support intentional weight loss can be considered racist in nature as they emphasize the colonization of black bodies (Harrison, 2021; Strings, 2019). In her revolutionary work on the racist roots of fat-phobia, Strings (2019) brings attention to the white supremacist origins of fat phobia that led to the current American appearance ideal which centers thin white bodies. The narrative that “good” bodies are thin is an assertion of white supremacy and should be addressed as such (Patton, 2006). In addition, many of the tactics to promote thin bodies as the “ideal” are ways to promote covert racism (Saguy, 2013) and maintain ideals of whiteness. Mental health professionals should address the problematic roots of weight management as part of a critical look at white supremacy. There is need for MHP’s to acknowledge that weight-based oppression is inextricably tied to other forms of societal oppression and include size and weight as an identity in discussions about intersectionality. Clinicians should read and immerse themselves in first-hand accounts of weight stigma for various groups with historically marginalized identities in order to understand how weight stigma works in conjunction with other systems of oppression and how we can begin to dismantle those systems. Clinicians may consider readings books such as *Fat and Queer: An Anthology of Queer and Trans Bodies and Lives* (Morales, 2021), *Hunger* (Gay, 2017), *Unashamed: Musings of a fat, Black Muslim* (Vernon, 2019) among others. These firsthand accounts, although clinicians who may have multiple privileged identities to begin understanding the roots of weight stigma and how we continue to promote it through the ideals of white supremacy.

Become Familiar with Weight Stigma Research

Mental health professionals can fight against weight stigma by ensuring that they are up to date on current research and practice recommendations for clients in larger bodies. This is especially important for clinicians who work from a HAES framework, or who work with clients who present with disordered eating or eating disorder symptoms. Understanding the research base behind weight inclusivity allows professionals the knowledge and confidence to work with clients in larger bodies without perpetuating weight stigma. Understanding of this research base also allows clinicians to advocate for their clients by reframing goals and utilizing psychoeducation when needed to inform clients of the potential failure and harm of intentional weight loss.

Recommendations for Training Programs

As with any other form of intersectional identity, mental health training programs have an ethical responsibility to train their students in weight inclusive care and specifically Health at Every Size as a social justice framework and philosophy for care. To do this, programs need to include body shape and size as a form of diversity and explore it as we do other intersections such as race, gender, sexual orientation, age etc. As more research is disseminated, educators in these training programs will have more concrete recommendations to give students regarding best and ethical practices in these areas. Further research is needed to determine the best ways for programs to help students examine their own weight biases and work through these, but there are also things that education and training programs can implement now. Suggestions for education and training programs are outlined below with recommendations for further curriculum development based on this study and potential future research. While these recommendations can be utilized within graduate training programs, these are also topics of

training that would be beneficial for all providers who may not have previous education about the harmful effects of weight stigma. In their text *Weight Bias in Health Education*, Brown and Ellis-Ordway (2021) discuss ways in which health education programs can begin introducing students to weight inclusive practices. While many of these practices are specific to medical professionals, the mental health field can adapt similar ideas as we discover how to make these principles especially applicable for graduate students in mental health training programs. The rest of this section outlines some possibilities for ways that educators can begin bringing these topics into relevant courses.

Training Within Diversity Focused Courses

Training on weight inclusive care helps future mental health professionals avoid perpetuating weight stigma and allows providers to give compassionate care in accordance with ethical guidelines. Graduate level training programs should consider including this type of curriculum and training in their assessment and diagnosis courses when discussing eating disorders. Participants in this study described delayed diagnosis because of weight stigma, which is also supported by Harrop's (2019) research on the presence of delayed diagnosis, misdiagnosis, and improper treatment for women in larger bodies who display restrictive eating patterns. Training future mental health professionals to understand weight stigma would allow them to be able to identify disordered eating accurately for clients of all sizes. Educators can use tools such as the Harvard Implicit Bias to help students explore levels of their own weight bias that may be happening outside of their awareness. These topics can either be integrated into a variety of courses or taught as their own segment of a diversity focused course that explored a multitude of historically marginalized identities.

Training Within Assessment and Diagnostic Courses

This type of curriculum is also appropriate for diversity focused courses and discussions surrounding multicultural competence and cultural humility to emphasize body size as a dimension of diversity. Like the way in which mental health professionals are expected to address other types of biases, MHP's should be expected to examine and explore their own biases surrounding body shape and size. Educators can make this change by being mindful to include body size as a category of diversity when asking students to reflect on their experiences and how their own experiences may create unconscious biases. When students are learning about different systems of oppression present within our society (for example sexism, cisgenderism, ableism, racism etc.) educators can include information about the role of these systems in continuing weight stigma and the origins of weight stigma within colonization and white supremacy. This type of training may help mental health professionals avoid some of the harmful outcomes of weight stigma including delayed diagnosis and misdiagnosis of eating concerns for individuals in larger bodies. MHP's should be well educated in the myths of eating disorders, so that they are aware that all types of eating disorders occur for individuals of every body type, race, gender, and socioeconomic status.

Introduction to Weight Inclusive Frameworks

Once trainees have an awareness of their own level of bias, the consequences of weight stigma, and the societal systems that perpetuate weight stigma they are ready to be introduced to a weight inclusive framework such as Health at Every Size. Educators can introduce students to this concept utilizing the available curriculum (retrieved from haescurriculum.com), as well as presenting the principles of health at every size and helping trainees understand how these principles relate to the helping profession. Educators should utilize the vast evidence base

supporting Health at Every Size to present trainees with a solid base of understanding of the philosophy and how it was developed. Students in these types of trainings could gain experience by working through case examples and learning how to apply these principles to the case and the way that they would work with that potential client. Students should also be introduced to the principles of weight inclusivity within other texts such as *Decolonizing Wellness, A QTBIPOC Centered Guide to Escape the diet trap, heal your self-image and achieve body liberation* (Kinsey, 2022).

An introduction to weight inclusivity is not complete without an introduction to the accompanying systems that contribute to weight stigma. Programs should focus on introducing students to systems of oppression such as racism, capitalism, sexism, cisgenderism, ableism and others and how those systems contribute to the formation and continued presence of weight stigma in our world. A good start would be to assign students readings from books such as *Fearing the Black Body* (Strings, 2019) and *Belly of the Beast* (Harrison, 2021) which focus on the politics of anti-blackness and anti-fatness, bringing awareness to the ways in which white supremacy and weight stigma are inextricably related.

Creating Further Change

While it may be considered a first line of defense that graduate level training programs begin to incorporate weight inclusivity into their curriculum, it is also important for these topics to be explored within clinical supervision and taught to current clinicians in agency and private practice setting who may not already have this training. Clinicians may consider the idea of holding a consultation group within their practice for other professionals who wish to work from this perspective, in addition to seeking out additional training and supervision from qualified professionals in this area.

Recommendations for Future Research

In addition to practice and training recommendations, the results of this study point towards ideas for future areas of research that would add to the growing body of literature focused on weight stigma within mental health treatment. These recommendations are separated into categories, outlining the importance of each type of study and how it may continue to advance clinical research in this area.

Impact of Provider and Client Identity

Future research should focus on the experience of provider weight stigma for those with specific intersectional identities, such as race, age, sexual orientation, and other historically marginalized groups. It would be beneficial to examine levels of provider weight stigma based on counselor racial identity; to see if weight stigma is being perpetuated more by mental health providers belonging to certain racial groups. I chose not to ask participants this for a variety of reasons, one being it seemed unreliable to ask clients to recall the racial identity of their provider; and they may not know and may be making assumptions or generalizations. However, based on anecdotal data it seems possible that white female providers are perpetuating weight stigma at higher rates. Future research should explore the impact of Eurocentric beauty ideals and white supremacy on the perpetuation of weight stigma, and the levels of weight bias in mental health providers. It is also possible that clients belonging to different racial groups may experience and/or interpret weight stigma differently based on cultural norms. This is not something that I was able to explore due to my sample size being largely Caucasian women but is another area of future research that could be beneficial to the field.

Best Practices in Mental Health Training Programs

There is also a need for research that explores the best way to train MHP's and future MHP's to explore and investigate their own weight bias in the same way that we train MHP's to explore biases connected with other historically marginalized identities. Body shape and size is more often being seen as an intersectional identity, and something that should be explored in mental health professional training programs. As recommend in her study on PWS in eating disorder treatment (Ciepcielski, 2016) we still urgently need research that will help develop training programs that can serve to reduce weight stigma for general mental health providers, in addition to eating disorder specialists. Future research could include the implementation of other pedagogical techniques that are used to educate on other type of marginalized identities and how to increase trainee and provider levels of awareness surrounding their own biases and possible areas of growth.

Exploration of PWS Within Historically Marginalized Populations

Future research could explore both qualitatively and quantitatively how provider weight stigma is experienced for those belonging to other historically marginalized groups. Specifically, research that examines how provider weight stigma is experienced by members of the LGBTQIA+ community, men, people of different races, indigenous populations, those with disabilities and others. This study is just an introduction; however, the general body of weight stigma research needs be expanded to study these populations specifically, uncovering similarities and differences between how provider weight stigma effects individuals belonging to these groups and how it can be prevented.

Impact of PWS on Disordered Eating Behaviors

One theme that arose in this study was the effect of provider weight stigma on health behaviors, specifically how it may affect disordered eating symptoms for clients who experience this type of stigma from their mental health treatment team. A future area of research would be to explore how weight stigma may impact or encourage disordered eating symptoms as a result of stigmatization. The existing literature on this topic is sparse and focusing on medical stigma and its effects on binge eating. It would be advantageous to the eating disorder treatment field to discover how this type of stigmatization from providers affects the occurrence or frequency of disordered eating behaviors. For instance, exploring the incidence of increased disordered eating patterns or increased food intake restriction because of provider weight stigma and how those impact eating disorder treatment outcomes.

Conclusion

This research was conducted to explore the experience of mental health provider weight stigma for women in larger bodies who also engaged in restrictive eating behaviors. The purpose of the research was to provide helpful information to mental health professionals and graduate level educators who train future mental health professionals. This phenomenological study resulted in the description of eight women's experiences with provider weight stigma and how it impacted them. Using semi-structured interviews these eight women bravely provided details about their story and wisdom for mental health providers. In conclusion, these women's experiences bring awareness to how harmful provider weight stigma can be for clients and shed light on practice recommendations for mental health clinicians and graduate level educators.

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APPENDICES

Appendix A: Recruitment Email

My name is Meredith Moore, and I am a doctoral student in the Counselor Education and Supervision program at the University of Arkansas. I am conducting a dissertation study exploring higher weight women's experiences of provider weight stigma in mental health treatment.

I would like to invite you share your story by participating in this study, if you:

- (1) Identify as a woman who is at least 18 years old
- (2) Wear a pant/dress size of 14 (US) or above
- (3) Have sought mental health treatment within the last five years
- (4) Have engaged in restrictive eating behaviors including, but not limited to restricting or counting calories or macros, eliminating food groups, fasting, avoiding foods with high carbohydrate content (bread, pasta), and/or engaging in dieting.
- (5) Feel as though the mental health professionals on your treatment team displayed signs of weight stigma (also referred to as fatphobia, weight bias, or fat shaming).

Definition of Weight Stigma: “Negative weight-related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are overweight or obese” (Puhl, Moss-Racusin, Schwartz, & Brownell, 2007, p. 347).

Participation: Participation in this study involves an individual interviews and participation in a focus group. The interview(s) will be conducted using video conferencing technology and will be recorded so that the interviews can be properly transcribed. Interviews may vary in length but will typically last 60-90 minutes.

****Weight stigma can have potentially damaging consequences and may affect treatment outcomes. Individuals in larger bodies deserve to access care that is free of these types of biases.***

If you are interested in participating in this study or know someone who may be, please click this link:

https://uark.qualtrics.com/jfe/form/SV_1Oia4n4WV0tC14G

Or email me at mwblackw@uark.edu

Thank you for your time and consideration.

Sincerely,

Meredith Moore, MS, LAC

This research is being overseen by an Institutional Review Board (“IRB”). If you have questions about your rights as a research subject, please contact the University of Arkansas IRB Coordinator at 479-575-2208.

Appendix B: Recruitment Social Media Graphic



**HAVE YOU EXPERIENCED
WEIGHT STIGMA OR
FATPHOBIA FROM A MENTAL
HEALTH PROVIDER?**

**Volunteers needed for
research study**

We would love to hear your story if you

- identify as a woman
- Are at least 18 years old
- Wear a pant size 14 (US) or larger
- Have sought mental health treatment, and felt that the provider perpetuated weight stigma/fatphobia
- Have engaged in restrictive eating behaviors

Scan this QR code to complete the screener or contact mwblackw@uark.edu



This research is being overseen by an Institutional Review Board ("IRB"). If you have questions about your rights as a research subject, please contact the University of Arkansas IRB Coordinator at 479-575-2208.

Appendix C: IRB Approval Letter



To: From:

Date: Action: Action Date: Protocol #: Study Title:

Expiration Date: Last Approval Date:

Meredith W Moore BELL 4188

Douglas J Adams, Chair IRB Expedited Review

03/17/2021

Expedited Approval

03/12/2021 2102319096

Higher Weight Women's Experience of Provider Weight Stigma in Mental Health Treatment

03/11/2022

The above-referenced protocol has been approved following expedited review by the IRB Committee that oversees research with human subjects.

If the research involves collaboration with another institution then the research cannot commence until the Committee receives written notification of approval from the collaborating institution's IRB.

It is the Principal Investigator's responsibility to obtain review and continued approval before the expiration date.

Protocols are approved for a maximum period of one year. You may not continue any research activity beyond the expiration date without Committee approval. Please submit continuation requests early enough to allow sufficient time for review. Failure to receive approval for continuation before the expiration date will result in the automatic suspension of the approval of this protocol. Information collected following suspension is unapproved research and cannot be reported or published as research data. If you do not wish continued approval, please notify the Committee of the study closure.

Adverse Events: Any serious or unexpected adverse event must be reported to the IRB Committee within 48 hours. All other adverse events should be reported within 10 working days.

Amendments: If you wish to change any aspect of this study, such as the procedures, the consent forms, study personnel, or number of participants, please submit an amendment to the IRB. All changes must be approved by the IRB Committee before they can be initiated.

You must maintain a research file for at least 3 years after completion of the study. This file should include all correspondence with the IRB Committee, original signed consent forms, and study data.

cc: Erin K Popejoy, Investigator

Appendix D: Qualtrics Interest Survey

Q1 Thank you for your interest in participating in this research study.

The purpose of this study is to explore the phenomena of weight stigma as experienced by higher weight women seeking mental health treatment. The goal of this study is to illuminate these women's experiences, with the hope that the findings may contribute to the education of future mental health professionals.

This questionnaire will be used for screening purposes ONLY to determine your eligibility for the study. If you do not qualify for the study, your responses will be destroyed.

Do you identify as a woman?

- Yes (1)
- No (2)

End of Block: Gender

Start of Block: Age

Q14 Are you 18 years of age or older?

- Yes (1)
- No (2)

End of Block: Age

Start of Block: Pant/Dress Size

Q15 Do you wear a pant/dress size 14 (US) or above?

- Yes (1)
- No (2)

End of Block: Pant/Dress Size

Start of Block: MH Treatment

Q16 Have you sought mental health treatment in the past five years?

- Yes (1)
- No (2)

End of Block: MH Treatment

Start of Block: Restrictive bx

Q17 Below are examples of restrictive eating behaviors, please indicate which of these you engaged in during your time in mental health treatment.

- Limiting the amount of food you eat to influence body shape/size/weight (1)
- Engaging in dieting or diet plans in hopes of losing weight (3)
- Fasting for long periods of time (4)
- Excluding food groups (5)
- Following food rules (calorie limits, not eating past a certain time, etc) (6)
- Using a calorie counting app or counting calories in your mind (7)
- Avoiding foods with high carbohydrate content (bread, rice, potatoes, etc) (8)
- Eliminating sugar (9)
- Feeling pre-occupied with a desire to be smaller (10)
- Having a list of "forbidden" foods (11)
- Not engaging in social interactions or connection with others due to food rules or diet restrictions (13)
- Fasting or "saving" calories for alcohol or a large meal later in the day (12)

End of Block: Restrictive bx

Start of Block: Weight Stigma

Q18 Do you feel as though you experienced weight stigma from the mental health professionals on your treatment team? These behaviors could also be referred to as fatphobia, weight bias, or fat shaming. Definition of weight stigma: "Negative weight related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are overweight or obese" (Puhl, Moss-Racusin, Schwartz & Brownell, 2007, p.347).

Yes (1)

No (2)

End of Block: Weight Stigma

Start of Block: Consent

Q19 Consent to Participate in a Research Study

Principal Researcher: Meredith Moore, MS, LAC

Faculty Supervisor: Dr. Erin Kern Popejoy, LPC-S

INVITATION TO PARTICIPATE

You are invited to participate in a research study aimed at exploring the experiences of provider weight stigma.

WHAT YOU SHOULD KNOW ABOUT THE RESEARCH STUDY

What is the purpose of this research study?

The purpose of this study is to explore the phenomena of weight stigma as experienced by higher weight women seeking mental health treatment. The goal of this study is to illuminate these women's experiences, with the hope that the findings may contribute to the education of current and future counselors.

What am I being asked to do?

Your participation will require the following:

If you choose to participate, you will be asked to complete a demographic questionnaire, an online individual interview (60-90 minutes), a check-in through email, and a focus group with all participants (60-90 minutes). These interviews will be conducted and recorded using Zoom for Telehealth, an encrypted and HIPAA compliant platform.

What are the possible risks or discomforts?

The risk of participating in the interview is that it may cause you some emotional discomfort. There is also a risk of loss of confidentiality in any group-based study. All focus group participants will be asked to keep information and discussions private; no other risks are likely.

What are the possible benefits of this study?

Although there are no anticipated direct benefits to the participants, the responses they provide may help provide education to mental health providers and improve treatment for other women in the future.

Will I receive compensation for my time and inconvenience if I choose to participate in this study?

There is no compensation for study participants.

What are the options if I do not want to be in the study?

If you do not want to be in this study, you may refuse to participate. Also, you may refuse to participate at any time during the study with no consequence.

How will my confidentiality be protected?

All information collected will be kept confidential to the extent allowed by law and University policy. Transcripts will only include pseudonyms, and that recordings will be destroyed at the end of the study and no identifying information will be used in any reports or publications resulting from this study.

What do I do if I have questions about the research study?

You have the right to contact the faculty advisor, and/or principal researcher as listed below for any concerns that you may have.

Dr. Erin K Popejoy LPC-S
Faculty Advisor
University of Arkansas
479-575-2213
erinkern@uark.edu

Meredith Moore, LAC
Principal Researcher
University of Arkansas
479-575-5276
mwblack@uark.edu

You may contact the University of Arkansas Research Compliance office listed below if you have questions about your rights as a participant, or to discuss any concerns or problems with the research.

Ro Windwalker, CIP
Institutional Review Board Coordinator
University of Arkansas

479-575-2208
irb@uark.edu

- I have read the above statement, I understand the risks and benefits posed and I consent to participating in this study. Clicking "yes" serves as my electronic signature and consent to participate. (1)
- I do not consent to participate in this study. (2)

End of Block: Consent

Start of Block: Contact Info

Q20 Your Name (First & Last)

Q21 Your Email Contact (For scheduling purposes)

Q22 Your Phone Contact (For scheduling purposes)

End of Block: Contact Info

Start of Block: Thank you!

Q23 Thank you! The researchers will contact you to schedule your individual interview.

End of Block: Thank you!

Appendix E: Restrictive Eating Questionnaire



Below are examples of restrictive eating behaviors, please indicate which of these you engaged in during your time in mental health treatment.

- Limiting the amount of food you eat to influence body shape/size/weight
- Engaging in dieting or diet plans in hopes of losing weight
- Fasting for long periods of time
- Excluding food groups
- Following food rules (calorie limits, not eating past a certain time, etc)
- Using a calorie counting app or counting calories in your mind
- Avoiding foods with high carbohydrate content (bread, rice, potatoes, etc)
- Eliminating sugar
- Feeling pre-occupied with a desire to be smaller
- Having a list of "forbidden" foods
- Not engaging in social interactions or connection with others due to food rules or diet restrictions
- Fasting or "saving" calories for alcohol or a large meal later in the day



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Appendix F: Informed Consent

Consent to Participate in a Research Study

Principal Researcher: Meredith Moore, MS, LAC Faculty Supervisor: Dr. Erin Kern Popejoy, LPC-S

INVITATION TO PARTICIPATE

You are invited to participate in a research study aimed at exploring the experiences of provider weight stigma.

WHAT YOU SHOULD KNOW ABOUT THE RESEARCH STUDY

What is the purpose of this research study?

The purpose of this study is to explore the phenomena of weight stigma as experienced by higher weight women seeking mental health treatment. The goal of this study is to illuminate these women's experiences, with the hope that the findings may contribute to the education of current and future counselors.

What am I being asked to do?

Your participation will require the following:

If you choose to participate, you will be asked to complete a demographic questionnaire, an online individual interview (60-90 minutes), a check-in through email, and a focus group with all participants (60-90 minutes). These interviews will be conducted and recorded using Zoom for Telehealth, an encrypted and HIPAA compliant platform.

What are the possible risks or discomforts?

The risk of participating in the interview is that it may cause you some emotional discomfort. There is also a risk of loss of confidentiality in any group-based study. All focus group participants will be asked to keep information and discussions private; no other risks are likely.

What are the possible benefits of this study?

Although there are no anticipated direct benefits to the participants, the responses they provide may help provide education to mental health providers and improve treatment for other women in the future.

Will I receive compensation for my time and inconvenience if I choose to participate in this study?

There is no compensation for study participants.

What are the options if I do not want to be in the study?

If you do not want to be in this study, you may refuse to participate. Also, you may refuse to participate at any time during the study with no consequence.

How will my confidentiality be protected?

All information collected will be kept confidential to the extent allowed by law and University policy. Transcripts will only include pseudonyms, and that recordings will be destroyed at the end of the study and no identifying information will be used in any reports or publications resulting from this study.

What do I do if I have questions about the research study?

You have the right to contact the faculty advisor, and/or principal researcher as listed below for any concerns that you may have.

Dr. Erin K Popejoy LPC-S Faculty Advisor University of Arkansas 479-575-2213 erinkern@uark.edu

Meredith Moore, LAC Principal Researcher

IRB#: 2102319096 APPROVED: 12-Mar-2021 EXP: 11-Mar-2022

University of Arkansas 479-575-5276 mwblack@uark.edu

You may contact the University of Arkansas Research Compliance office listed below if you have questions about your rights as a participant, or to discuss any concerns or problems with the research.

Ro Windwalker, CIP
Institutional Review Board Coordinator University of Arkansas
479-575-2208
irb@uark.edu

I have read the above statement and have been able to ask questions and express concerns, which have been satisfactorily responded to by the investigator. I understand the purpose of the study as well as the potential benefits and risks that are involved. I understand that participation is voluntary. I understand that significant new findings developed during this research will be shared with the participant. I understand that no rights have been waived by signing the consent form. I have been given a copy of the consent form.

____ I agree to participate in this research study

Name: _____

Signature: _____ Date: ____/____/____

IRB#: 2102319096 APPROVED: 12-Mar-2021 EXP: 11-Mar-2022

Appendix G: Demographic Questionnaire



First and Last Name

Age

Gender

Sexual Orientation

Race/Ethnicity

Religious Affiliation

Current relationship status

- Single
- Divorced
- Married
- Life Partner
- Dating
- Widowed
- Other

How do you identify your body shape or size? Some common terms used are plus size, curvy, larger bodied, higher weight, small fat, mid fat, super fat etc.

Highest degree earned

- None
- Technical/Vocational
- GED
- High School Diploma
- Associate's
- Bachelor's
- Master's
- Ph.D, Ed.D, M.D., J.D, etc

What was the reason that you first sought mental health counseling/treatment?

At what age did your restrictive eating behaviors/thoughts/patterns begin?

Please list your past levels of mental health treatment and approximate dates (outpatient, intensive outpatient, partial hospitalization, inpatient/hospitalization).



Appendix H: Verbal Informed Consent Script

I am conducting research about higher weight women's experiences of provider weight stigma in mental health treatment and I am interested in your experiences. The purpose of the research is to understand how provider weight stigma might affect treatment. Your participation will involve one informal interview that will last between 60-90 minutes and a focus group lasting approximately 90 minutes.

The risk of participating in the interview is that it may cause you some emotional discomfort. There is also a risk of loss of confidentiality in any group-based study. All focus group participants will be asked to keep information and discussions private; no other risks are likely.

Although there are no anticipated direct benefits to the participants, the responses they provide may help provide education to mental health providers and improve treatment for other women in the future.

Please know that I will do everything I can to protect your privacy. Your identity or personal information will not be disclosed in any publication that may result from the study. Notes that are taken during the interview will be stored in a secure location. All interview records and transcripts will be destroyed at the end of the study and any information obtained during the interviews will be kept confidential to the extent allowed by law and University policy.

Before we begin, I would like to go over the consent form that you completed prior to our meeting today and allow time for you to ask any questions or voice any concerns that you might have.

Would it be all right if record audio and video of this interview for transcription purposes?

Appendix I: Semi-Structured Interview Guide

1. What is your experience of weight stigma imposed by mental health providers?
2. How have these experiences of PWS affected you?
3. How did those experiences change the relationship between you and that mental health provider?
4. How did PWS affect the care you received?
5. How did PWS affect your relationship with your body/self?
6. How did PWS change your view of mental health professionals?
7. What would you want those mental health providers to know about the way that weight stigma affected you and your treatment?
8. How have you remained resilient amidst weight-based stigmatization and oppression?
9. What is your relationship with your body like now?
10. How might things have been different if your provider knew about weight inclusive approaches such as Health At Every Size (HAES)?
11. Is there anything else we did not cover regarding your experience of PWS?