A QUALITATIVE EXPLORATION OF LICENSED PROFESSIONAL COUNSELORS' THERAPEUTIC RELATIONSHIPS WORKING WITH CLIENTS WITH BODY IMAGE CONCERNS

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by

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DEDICATION

I would like to thank all my mentors, professors, friends, and family who have given me the space and time to grow both professionally and personally, encouraged me throughout this process, and have become my confidants and colleagues along the way. The unsurmountable support, patience, and love throughout this laborious journey will be forever cherished and be some of my most treasured memories. I cannot express enough gratitude to those who have provided me with the tools and space to patiently conduct my research and guided me through this experience.

ABSTRACT

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Counselors working with clients with body image issues might also struggle with body image concerns, and how they manage this struggle within the therapeutic relationship could be a key factor in treatment effectiveness. Exploring and understanding successful counselors' methods would benefit counselors, clients, and society. The purpose of this transcendental phenomenological study was to explore body image concerns of licensed professional counselors who currently work with clients concerned or diagnosed with body image, disordered eating, and eating disorder symptomology. The theoretical framework comprised feminist psychodynamic theory, which suggests that internalizing culture is part of developing individual perspectives on body image, and objectification theory, indicating how Western beautify standards have led to the objectification and sexualization of thin women. Answering the research question required exploring counselors' perspectives of how their body image influences the therapeutic relationship with clients who present with body image struggles. Moustakas's transcendental phenomenology was the approach used to explore the experiences of licensed professional counselors with their body images when working with clients with body image distortions. Data analysis occurred following the seven steps of Moustakas's modified van Kaam method. Analysis of the data collected from semistructured interviews with 11 participants elicited three significant themes: (a) working with clients who struggle with body image concerns affects counselors' body image awareness, (b) working with clients who struggle with body image increases counselors' positive body

image, and (c) education and supervision are needed to address body image when working with clients with body image concerns. The study has implications for direct therapeutic work for clinicians, counselor educators, and supervisors. Clinical improvement could occur through body image–specific training, continuing education, and supervision in working with the body image of both counselor and client.

KEY WORDS: Body image, Body dissatisfaction, Ideal body image, Self-objectification, Feminist theory, Weight bias

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CHAPTER I

Introduction

Background of the Study

Body image carries excellent distress for many individuals in the United States. It is described as a multidimensional construct that reflects attitudes and perceptions related to one's physical appearance (Cash & Pruzinsky, 2002). Body image is a reflection of how individuals view their bodies in comparison to cultural norms and ideals rather than their own physical proportions (Ayala et al., 2007). Cultural attitudes toward body images and diet culture, including eating disorders (EDs) and disordered eating (DE), influence women's and young girls' eating pathology, leading to internalizing stigmas surrounding fatness and thinness (DeLucia-Waack, 1999; Stice, 2002). Health care providers in the United States, including mental health clinicians, have likely received the same Western cultural messages as their clients about body ideals, diet culture, eating pathology, and attractiveness. Thus, they have the same opportunities to internalize these messages. The resultant body image concerns of health care providers impact the work between clinicians and clients (Daly, 2016).

Many cultures place considerable emphasis on physical appearance as an element that defines an individual's personal and social value (Thompson et al., 1999). Researchers suggest that individuals evaluate and alter their physical appearance as they adjust to new cultural contexts through acculturation (Bem, 1981). Research indicates that higher levels of acculturation to Western cultures are associated with increased body image problems. However, researchers do not indicate how this relationship translates into treatment outcomes for members of minority cultures seeking ED treatment and how

treatment is perceived compared to the majority culture (Ayala et al., 2007; Joiner & Kashubeck, 1996; Nieri et al., 2005; Pepper & Ruiz, 2007).

Current research on the importance of understanding the impact of the counselor's body and body image on the treatment of body image concerns and EDs in clients has received limited exploration and provided limited amounts of written literature (Lowell & Meader, 2005). The literature that has focused on clinician's body image has been collected and published in the form of personal reflections, in which clinicians describe the effect their body image, body size, and shape have on their treatment with clients through a psychoanalytical orientation (Burka, 1996; Jacobs & Nye, 2010; Lowell & Meader, 2005; Orbach, 2004, 2006). Other researchers have examined similar data points and focused on the issues through a feminist psychoanalytic perspective (Costin, 2009; Gutwill, 1994; Rabinor, 1995). Due to concerns about transference and countertransference, clinicians struggle with allowing their bodies and body images to be a part of the treatment and clinical work (Burka, 1996; Costin, 2009; DeLucia-Waack, 1999; Lowell & Meader, 2005; Orbach, 2004; Shisslak et al., 1989; Warren et al., 2009). Costin and Johnson (2002), Johnston et al. (2005), and Warren et al. (2013) pointed to disadvantages in the literature focusing on clinicians and countertransference and transference due to triggers, overidentifying with clients, loss of objectivity, and relapse risk for clinicians who previously received treatment for EDs and consider themselves in recovery.

Shisslak et al. (1989) investigated and collected data from various types of health care professionals working with clients diagnosed with ED. The researchers found impacts on clients' perspectives body image work; in addition, the clinicians noticed that

their own body image perspectives changed. Additionally, Warren et al. (2009) supported Shisslak et al.'s 1989 findings that health care providers observed changes in their views on food, their eating habits, and a heightened sense of awareness of other people's appearances as well as their own after working with clients with ED. According to the study, 72% of the participating health care providers reported becoming self-conscious about their appearance while working with clients diagnosed with ED. Although Warren et al.'s study provided insight into health care providers and their work with EDs, there is a need for more data and insight on how licensed professional counselors' (LPCs) work with body image clients, not just EDs, impacts the counselor's own body image. Thus, the goal of this study was to explore LPCs who identified as having body image concerns and are working with clients presenting with body image concerns and how the counselor's body image impacts the clinical work.

Statement of the Problem

Shisslak et al. (1989) noted the importance of observing how clinicians manage their body image concerns during their sessions with clients. When establishing rapport and developing a treatment plan in therapy, counselors must bring their own experiences into session. If counselors struggle with body image, how they manage this struggle within the therapeutic relationship could be a key factor in treatment effectiveness. Experiential knowledge is the information counselors have gained from firsthand experiences with mental health disorders and treatments they have received as clients (Berg, 2008). Experiential knowledge can positively influence a client's recovery, including increased empathy and knowledge about a client's disorder (Netten, 2003; Wilrycx et al., 2014). However, there are also disadvantages, including when and if it is

appropriate for the clinician to disclose their history in treatment (Costin & Johnson, 2002; Johnston et al., 2005).

As a result of limited research exploring the topic of body image in counselors who work with clients seeking treatment for body image concerns, the literature review will focus on the development of body image and how it might affect the participants of this study. Additionally, I will examine the relationship between clients and their counselors. The literature review will conclude with a discussion of the role of the counselor's body image and how it relates to the counselor's application of techniques and modalities within the therapeutic process. The theoretical and empirical literature shows that countertransference impacts the nature of the treatment relationship (Epstein & Feiner, 1988; Gabbard, 2001; Greenberg & Mitchell, 1983; Rosenberger & Hayes, 2002; Singer & Luborsky, 1977) in such that the countertransference can create "blind spots" or personal issues outside the counselor's awareness and how it affects the process and outcome of therapy (Hayes, 2004). Theoretical literature addresses the influence of counselor body image on countertransference issues with eating-disordered clients. However, the empirical literature does not explore and measure counselor countertransference variables that affect treatment, such as the counselor's body image, personal ED experience, counselor education, supervision, and work experience.

Purpose of the Study

The purpose of this phenomenological study was to explore body image concerns of LPCs who currently work with clients concerned or diagnosed with body image, DE, and ED symptomology. The aim of this study was to determine how LPCs' awareness of their own body image concerns and perspectives can affect transference and

countertransference management when working with clients presenting with body image concerns, EDs, and DE. Most counselors treating female clients with body image and EDs are female (Barbarich, 2002; Bloomgarden et al., 2003; DeLucia-Waack, 1999; Franko & Rolfe, 1996; von Ranson & Robinson, 2006). These counselors are likely impacted by similar sociocultural influences specific to being female as their female clients (Bloom et al., 1994; DeLucia-Waack, 1999). These influences could include sociocultural messages about ideal standards of the female appearance that affect a woman's view of herself (Bloom et al., 1994; Wooley, 1991).

Counselors' attitudes and feelings toward a client are top factors in facilitating therapeutic change (Metcalf, 2003; Wallerstein, 1986). Counselors' reactions in treatment, however, could be outside of their awareness. Latts and Gelso (1995) hypothesized that increased counselor knowledge and insight into countertransference management would positively affect the success and outcome of treatment for clients with body image concerns and DE.

The literature shows that supervision, professional training, and work experience often have a positive impact on the treatment relationship (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Greenberg & Mitchell, 1983; Hamburg & Herzog, 1990; Singer & Luborsky, 1977). Despite research on demographic variables such as work experience, supervision, and professional training, there has been minimal exploration in combination with clinicians' personal experiences with body image concerns, EDs, and DE and the impact of these factors on clinical work (Barbarich, 2002). Several researchers have recommended further investigation, which has not yet occurred. It is vital to examine the relationship between clients and counselors and the impact the counselors' perceptions of

their body images can have on the therapeutic alliance. Another topic meriting research is how counselors' body image affects the application of techniques and modalities within the therapeutic process. Therefore, this study was an examination of the relationship between LPCs' personal body image concerns and their clinical work with clients with body image concerns.

Significance of the Study

This study focused on the physical and emotional components of body image as they relate to the therapeutic process. Future researchers can examine how counselors' body image influences their clinical work. Findings from this study could help clinicians decrease the potential for transference and countertransference by gaining additional insight into how their personal body image perspective, DE, and EDs could impact therapeutic work. As Koenig (2008) discussed, counselors' perceived body image is a secret they cannot keep, as doing so would instantly create a dynamic between the client and counselor. Allowing counselors to have a better understanding of this dynamic could lead to improved treatment protocols for body image concerns.

The clinician's body image and how it impacts the management of countertransference within the treatment of body image concerns is a potential barrier that has not received empirical study. In a survey with a convenience sample, von Ranson and Robinson (2006) determined that clinicians generally tried to tailor ED treatment to the client's individual needs. Although many clinicians surveyed cited using empirically supported treatments, such as cognitive behavioral therapy or interpersonal psychotherapy, 50% (n = 52) used an eclectic approach to treatment, which included psychodynamic, narrative, supportive, addiction, and EMDR therapeutic approaches (von

Ranson & Robinson, 2006). The concept of countertransference allows for an examination of clinician reactions and attitudes regardless of theoretical orientation.

There has been limited empirical research on countertransference reactions in counselors treating eating-disordered clients (Franko & Rolfe, 1996). Clinicians working with clients with body image and DE reported an increased awareness of food, their physical condition, and changes in eating habits, body image, and appearance. However, the focus of these studies was not on how clinician reactions are handled within the therapeutic alliance (Shisslak et al., 1989). Additionally, a gap in the empirical literature could be filled by exploring clinicians' management of countertransference when considering the impact their body image has on the therapeutic alliance. There are areas of literature that illustrate the counselors' perspectives of their body image, which can influence treatment with clients seeking treatment for body image concerns; however, there is limited reporting on how countertransference can influence the therapeutic alliance (Burka, 1996). Research on this topic is important because it would increase awareness for clinicians working with body image concerns. This could translate into more effective treatment and increased attention to this subject throughout the supervision and professional training process for LPCs focusing on treating clients with body image issues, DE, and EDs.

Definitions of Terms

Acculturation. Integrating into a different culture includes adopting the beliefs, attitudes, and behaviors of the majority or dominant culture to minimize the differences between cultures (Berry et al., 1986).

Anorexia Nervosa. This disease is an ED characterized by abnormally low body weight, an intense fear of gaining weight, and a distorted perception of weight (American Psychiatric Association [APA], 2022).

Binge-Eating Disorder. Binge-eating disorder involves recurrent eating patterns in which an individual discreetly eats a large amount of food that most people would eat over multiple sittings (APA, 2022).

Body Dissatisfaction. When an individual has a preference for body characteristics that differ from their current physical attributes, the individual perceives their body negatively (Cash & Smolak, 2011).

Body Dysmorphic Disorder. This is a mental health disorder in which individuals are preoccupied with a perceived flaw or defect in their appearance that is not often visible to others (APA, 2013).

Body Surveillance/Body Checking. Body checking is an overevaluation of the shape and weight of one's body. Individuals pay selective attention to the parts of their body they dislike, which increases their body dissatisfaction (Fairburn et al., 2003).

Body Image. Thompson et al. (1999) defined body image as how one perceives their looks, how others view them, and how they feel about their appearance. Body image is a multidimensional construct involving cognitive, affective, and behavioral elements.

Body Image Evaluation. Individuals' satisfaction or dissatisfaction with their body and the evaluative self-formed beliefs around it.

Body Image Investment. How one places importance on cognitive, behavioral, and emotional factors that pertain to current life events influencing individual body image

experiences. These can include information processing, internal dialogues, body image emotions, and self-regulatory actions (Cash & Smolak, 2011, p. 40).

Body Mass Index (BMI). BMI is calculated by dividing weight by height to categorize the individual. It is not a diagnostic tool that determines an individual's health (APA, 2022).

Bulimia Nervosa. An ED is characterized by recurrent episodes of binge eating and recurrent inappropriate compensatory behavior to prevent weight gain. These compensatory behaviors could include self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise (APA, 2022).

Compensatory Behaviors. These behaviors are attempts to compensate for the number of calories or amount of food eaten or to relieve the negative emotions triggered by eating. They are often driven by a fear of weight gain (APA, 2013).

Countertransference. Countertransference is the conscious and/or unconscious reactions, behaviors, and emotions counselors have toward the clients they treat in a therapeutic setting (Land, 2004). Countertransference often acknowledges that the counselor's reaction to a client may be in part formed or impacted by their unresolved personal conflicts. These experiences can create a conflict that can be triggered both in and outside therapeutic sessions. Counselors may begin to reflect avoidance behaviors, become more reactive than reflective and begin to feel unsure or develop distorted perceptions of their clients (Walker & Lloyd, 2011).

Disordered eating. DE is when changes in eating habits and patterns are outside of the norm for the individual. Examples include dieting, food restriction, and the use of

diet pills or laxatives. If habits or patterns continue over some time and are not addressed, behaviors could become a symptom of an ED (APA, 2022).

Feminist Theory. Feminist theory includes consciousness-raising, social and gender role analysis, resocialization, and social activism (Israeli & Santor, 2000). This theoretical model focuses on the influences of biological, social, and cultural impacts on mental health. Feminist theorists evaluate women in a patriarchal society through sex roles, female socialization, women's status, and subjective experiences as they are influenced by culture, history, and individual characteristics (Worell & Etaugh, 1994).

Ideal Body Image. The ideal body image is often globally accepted and idealized as the beauty norm (Garner et al., 1983).

Licensed Professional Counselor. According to the Texas Administrative Code (2022), an LPC is "a person holding a Licensed Professional Counselor License as a professional counselor with authority to practice in independent practice" (para. #18). This includes professional counselors who have completed their supervised internship requirements, indicating full licensure status.

Self-Objectification. As a result of continual body monitoring, individuals view themselves from an external view, as an outside observer, and as an object responding to the environment (Calogero & Pina, 2011).

Transference. The term transference is used to define the clients' emotional reactions to counselors, such as a patient redirecting feelings for a significant person to the counselor. Transference can be reflected toward a counselor in the form of rage, hatred, mistrust, parentification, and extreme dependence (Hayes et al., 2007).

Weight Bias/Stigma. Individuals classified or viewed as obese experience frequent bias and discrimination, which can have an adverse impact on physical and psychological outcomes, including the individual's body image (Cash & Smolak, 2012). These adverse impacts can be a result of discrimination from comments and mistreatment from people in the workplace, health care providers, educators, and interpersonal settings.

Theoretical Framework

This study was grounded in feminist theory. Feminist theory is built on the understanding that countertransference encompasses the counselor's transference relationship with the culture at large (Bloom et al., 1994). Feminist psychodynamic theory presents the development of women's body image as including the internalization of culture. Bloom et al. (1994) stated, "In many psychoanalytic theories, the culture is either not seen or is reduced to one isolated factor rather than a force that is continuously shaping and interacting with the individual" (p. xii). Consumer and public culture serve as a relational matrix to which women and men attach, consciously and unconsciously, such that social symbols representing the "ideal" thin female become internalized.

Cultural countertransference is established when individuals connect to the symbolic systems of their culture (Bloom, 2002). Women will compare themselves to the cultural ideal and other women to assess how they measure up. The comparison will become more evident for individuals suffering from EDs as they are more susceptible to overvalued appearance and the physical body, thus leading to a sense of becoming aware of the treatment provider's appearance (Warren et al., 2009).

The counselor's physical attributes are likely to trigger thoughts and feelings for the client regardless of if it is a topic of discussion in the session. How a counselor

assigns meaning to their body can be an important element of therapy. Women's relationships to each other's bodies in the female therapeutic dyad, which is mediated by the cultural ideal, represent an important area of investigation (Warren et al., 2009).

The study also had a foundation of objectification theory, which suggests that women of any age have internalized ideals about their appearances and bodies that impact their psychological functioning. This internalization can manifest into shame, anxiety, depression, body image distortion, EDs, DE, sexual dysfunction, and other physical and mental health concerns. Body surveillance means assessing one's self-appearance based on someone else's perspective (Cash & Smolak, 2011).

Most objectification research focuses on body surveillance as the main criterion or variable. Self-objectification represents individuals' continuous assessment of their attributes and ensuring their body image is acceptable to others (Fredrickson & Roberts, 1997). Comparing oneself to the ideal body image and objectification of women can lead to self-objectification. Fredrickson and Roberts (1997) stated, "Objectification theory takes as a given that women exist in a culture in which their bodies are—for whatever reason—looked at, valued predominately for its use to (or consumption by) others" (p. 177).

According to Choate (2005), negative body image perceptions can be influenced by media, family and peers, cultural factors, and hypervigilance about one's body. Developing these factors can occur with a counselor's support through psychoeducation, focusing on building a support system, and increasing one's positive self-worth. Objectification can impact women differently due to the sociocultural environments to which they belong.

Bodily appearance is an individual's physical appearance, including body size, weight, and shape; comfort with one's body; and comfort in one's attire. Bodily and physical appearance are equally important and unavoidable disclosures in the clinical encounter (Daly, 2016). Burka (1996) remarked, "he therapist's body has great significance for the patient, and the therapist's actual and symbolic physicality plays a very important role in the patient's experience of aliveness and in the vitality of the therapy" (p. 274).

The client's body can become a transference object for the counselor. According to Orbach (2004), "It is a body that represents the imaginative and cross transference needs of the therapist and the patient. It is not a 'natural' or 'neutral' body. It expresses the relational complexities between the two people in the room" (p. 149). Burka (1996) recognized, however, that the client's perception of the counselor's physical self is both determined by the visual experience of looking at the counselor and heavily influenced by fantasy, internal object representations, and the current cultural meanings attributed to the appearance of the body.

Despite these important conceptualizations about the counselor's body and its impact on the life of the therapy, discussions of the role of the counselor's body in the therapeutic setting are limited in the literature (Lowell & Meader, 2005). Some psychoanalytic theorists have published personal reflections describing how aspects of their body size and shape have affected treatment with clients (Burka, 1996; Jacobs & Nye, 2010; Lowell & Meader, 2005; Orbach, 2004, 2006). Studies also indicate that clinicians are having trouble allowing their bodies to be the subject of discourse (DeLucia-Waack, 1999; Lowell & Meader, 2005; Shisslak et al., 1989; Warren et al.,

2009). The literature shows that transference and countertransference issues are particularly powerful in the treatment of EDs; however, researchers have not explored these issues specific to body image (Costin, 2009) or the counselor's actual body (Burka, 1996; Lowell & Meader, 2005; Orbach, 2004).

Research Questions

This study addressed the following qualitative research question: From the counselor's perspective, and in a therapeutic setting, to what extent does the counselor's own body image influence the relationship with clients who present with body image struggles?

Limitations

This study focused on exploring the experiences of LPCs regarding their body image and its influence on their clinical work integrating body image, ED, and DE treatment. The participants engaged in semistructured interviews with open-ended questions, self-reporting about their work with body image and their own body image perspectives. As the study focused on self-reporting the individual's perspectives, there could be bias due to participants' limited awareness of their body image preoccupation. Although the study was open to participants nationwide, the counselors' limitations to geographic locations limited participation from LPCs from other areas, training programs, state legislations, and legal codes. The generalizability of this study could be limited due to the smaller sample size. Awareness of my own potential bias based on my work experience and specialized training in the field of EDs was also a limitation of the study.

Delimitations

Participation in this study was delimited to fully licensed LPCs with at least 2 years of experience after meeting the criteria for full licensure and being endorsed by the state's licensing board. Due to the study's use of fully licensed counselors as a criterion for participation, there were no counselors-in-training or those with other types of licensure who counsel clients with body image concerns. Participants had experience working with clients with body image concerns and either experienced or were experiencing struggles with their own body image.

Assumptions

Several assumptions were made in creating this study and collecting data. The first assumption was that all participants were honest with the screening criteria, informed consent, and data collection interviews. The second assumption was that the clinicians selected for this study understood their own body image concerns and how they impact their clinical work accurately. The last assumption was that the methodology and research design were appropriate for collecting relevant and accurate data.

Organization of the Study

In Chapter II, I will review the literature on body image, body dissatisfaction, body image development, sociocultural factors affecting body image, and body image in counselors. Next, I will explain the theoretical framework and its integration into this study. There will be a discussion of the effects of the clinician's body image and body dissatisfaction perspectives and the impact on their clinical work supporting clients with body image concerns, DE, and EDs. This delineation will show how body image concerns might manifest differently in minority cultures, how representation is varied in

minorities, and how it could lead to components of acculturative stress. Chapter III presents the study's methodology, Chapter IV includes the themes that emerged from participant interviews, and Chapter V offers a discussion of the findings, suggestions for future research, and implications for practice.

CHAPTER II

Review of Literature

Counselor education and training are of utmost importance when preparing clinicians to address a variety of issues. Understanding one's beliefs and gaining an awareness of how those beliefs affect the counseling session is pivotal. A better understanding of how LPCs' body image plays a role in their proactive practice could inform counselor training and education and enhance the therapeutic dyad, potentially improving client outcomes.

Bodily and physical appearance are equally important within the rapport-building process and occur through unavoidable disclosures (Daly, 2016). Burka (1996) reported that the therapist's body could be a part of the patient experience through actual and symbolic physical significance in the aliveness and vitality of therapy. Bodily appearance is an individual's physical appearance, which includes body size, weight, shape, comfort with one's body, and comfort in one's attire.

The bodies of both client and therapist can play significant roles in therapy, so the client's body can become an object of transference for the counselor. Orbach (2004) suggests the body represents both therapist and client needs due to the relational complexities between the parties. Burka (1996) expressed that a client's perception of the counselor's body is influenced by the individual's interpretation, internal representations, and cultural attributes assigned to the appearance.

The literature shows that transference and countertransference are powerful in the treatment of EDs; however, a research limitation is the lack of exploration of these issues specific to body image (Costin, 2009) or the counselor's actual body (Burka, 1996;

Lowell & Meader, 2005; Orbach, 2004). This chapter presents a review of the literature on the following topics: (a) therapeutic alliance in counseling, (b) feminist and objectification theory, (c) development and disturbances in body image, (d) sociocultural factors, (e) media portrayal of body image, (f) increase in cosmetic surgery, (g) DE and (h) EDs and their relationship to body image concerns, and (i) counselors' personal experiences with body image.

Transference/Countertransference: Therapeutic Alliance

Countertransference is counselors' conscious or unconscious reaction, behavior, or emotion toward the clients they treat in a therapeutic setting (Land, 2004). With countertransference, counselors' reactions to a client could result from unresolved personal conflict triggered inside and outside therapeutic sessions. Counselors could present avoidance behaviors, become more reactive than reflective, and feel unsure or develop distorted perceptions of their clients (Walker & Lloyd, 2011). A countertransference reaction could cause ruptures in the therapeutic alliance, and counselors might seem less empathic to the client's needs (Hayes et al., 2007).

Transference is a client's emotional response to a counselor, perhaps redirecting feelings for someone else toward the counselor. Transference toward a counselor can take the form of rage, hatred, mistrust, parentification, or extreme dependence (Hayes et al., 2007). If the counselor cannot understand or identify the source of the intrusion, countertransference and transference could create a conflict that interferes with therapy. Counselors need to receive effective training and supervision and recognize these issues when they arise.

Body image countertransference issues can emerge through overidentification with the client, control in minimizing countertransference and transference, secret-keeping, hopelessness, and avoidance of affect reflected in the counselor's perception of body image and personal experiences (DeLucia-Waack, 1999). Shisslak et al. (1989) found that 28% of health care providers working with EDs reported being moderately to greatly affected by working with the ED population. Furthermore, the study showed that at least 25% of health care providers involved in treating patients with EDs believed they were moderately to greatly affected by their patients' characteristics and symptoms.

Even without a clinical ED, individuals can suffer from self-esteem and emotional difficulties that manifest as DE and body image concerns (Levitt, 2006). Weight- and body-related issues fall on a continuum, with the less-extreme points often overlooked. However, individuals on the low end of the spectrum require intervention to prevent worsening (Levitt, 2006).

Internal communication is an interpersonal and constructive process to explore the connotation of weight and body image concerns and their impact on an individual's physical and mental health. Engeln-Maddox et al. (2012) created the Negative Body Talk Scale to evaluate and measure how often an individual engages in internal communication about their body, or "fat talk," and suggested that scores were predictive of body image disturbances, DE, and body dissatisfaction. By monitoring their internal communication, counselors can reduce the opportunity for transference and countertransference during the therapeutic process.

Feminist Theory

Biological makeup has long been viewed as the reason for men's and women's different roles; however, feminist theory suggests this perception is inaccurate. According to traditional views, female oppression has created psychological distress. Much of the early research occurred by and with men, highlighting stereotypes and power differentials by looking at different perspectives of social conditioning, stereotypical sex roles, and value systems. Feminist theorists have raised awareness of gender bias and its impact on the results. The theory suggests the need to recognize differences between men and women based on their unique strengths and not biological differences.

Feminist theory applies to the effects of privilege, exploration of gender, language in context with gender, and gender equality. This theory helps individuals of all gender identifications explore their gender, race, ethnicity, culture, and the interrelated impact. According to feminist theory, women have internalized the media, social and cultural standards, and gender roles and standards that impact their self-esteem and social-emotional well-being (Bessenoff, 2006; Dalley et al., 2009, Posavac et al., 2001; Yamamiya et al., 2005). Feminist theorists use psychoeducation to increase self-esteem and social-emotional well-being through awareness of inequality based on unrealistic ideals; in this way, they promote positive body appreciation and recognition and celebrate cultural and individual differences (Kinser, 2004; Snyder, 2008; Tong & Botts, 2009).

Feminist psychodynamic theory suggests that women's body image development includes the internalization of culture. Bloom et al. (1994) noted, "In many psychoanalytic theories, the culture is either not seen or is reduced to one isolated factor rather than a force that is continuously shaping and interacting with the individual" (p.

xii). Consumer and public culture provide a relational matrix to which women and men consciously and unconsciously attach, internalizing social symbols representing the "ideal" thin female. Clinicians working within this model emphasize three major influences on women's body image: (a) contradictory communications from the consumer culture, (b) the individual's deep psychic structure that is primed to receive cultural messages, and (c) the gendered division of labor that asks women to do what is not possible: represent all objects of desire while nurturing others (Bloom et al., 1994; Gutwill, 1994).

Feminist writers have addressed the role of society and culture in the etiology of body image disturbance and eating pathology (Becker, 2003; Dorian & Garfinkel, 1999; Gilbert & Thompson, 1996; Smolak & Murnen, 2004). Feminist theorists have identified Western society's overt and covert messages presenting thinness as the key to happiness and success. Members of the media denigrate and stigmatize fatness, linking it to ugliness and failure (Striegel-Moore & Smolak, 2001). Society promotes economic implications of thinness and beauty as well (Gilbert & Thompson, 1996). Being thin is associated with a higher socioeconomic class, indicating a relationship between thinness, wealth, and beauty (Dorian & Garfinkel, 1999). Additionally, marketers and advertisers in Western culture understand that promoting the idealization of thinness and exploiting women's longing to look beautiful and younger sells products and increases revenue (Groesz et al., 2002). For example, the dieting culture has a more prominent place in women's lives than men's (Dorian & Garfinkel, 1999; Gilbert & Thompson, 1996).

Along with pervasive gender discrimination, violence, and abuse in some vocational and societal settings, changing gender role expectations for women create

power imbalances that affect women's functioning. Thus, women who feel vulnerable due to gender-related power struggles and conflicting societal demands could perceive thinness as a socially and interpersonally desirable way to manage or deflect such challenges (Dorian & Garfinkel, 1999).

Despite encouragement to achieve professionally and vocationally in recent decades, women retain their traditional roles as nurturers and caretakers (Gilbert & Thompson, 1996; Smolak & Murnen, 2004). The resulting Superwoman Syndrome, which demands success in both workplace and interpersonal spheres, suggests that an attractive and thin appearance affects women's ability to handle pressure. In some ways, Western society traps women with the Superwoman concept, encouraging perfectionism in work, home, and personal expression (e.g., nurturance and appearance). This association with overall success and dieting, thinness, and physical attractiveness makes women more vulnerable to body disturbance and eating problems.

Objectification Theory

Objectification theory provides a framework to determine when women have internalized ideals about their appearances and bodies that impact their psychological functioning. This internalization can manifest into shame, anxiety, depression, distorted body image, EDs, DE, sexual dysfunction, and other physical and mental health concerns. Body surveillance entails assessing one's appearance based on someone else's perspective (Cash & Smolak, 2011). Body surveillance is the main criterion or variable in most objectification studies.

Comparing one's body image to the ideal body image coupled with the objectification of women has led to self-objectification. Fredrickson and Roberts (1997)

asserted, “Objectification theory takes as a given that women exist in a culture in which their bodies are—for whatever reason—looked at, valued predominately for its use to (or consumption by) others” (p. 177). Individuals display self-objectification when they continuously assess their attributes and ensure their body image is acceptable to others (Fredrickson & Roberts, 1997). According to Choate (2005), influences of negative body image perceptions include media, family and peer influences, cultural factors, and hypervigilance of one’s body. Choate proposed several factors to increase body image resilience, including physical activity for fitness and health, effective coping strategies, holistic wellness and balance, family-of-origin support, and gender role satisfaction. Individuals can develop these elements with a counselor’s support through psychoeducation, building a support system, and increasing positive self-worth.

Self-Objectification and Appearance-Culture

Westernized beauty ideals have altered appearance-culture, suggesting the importance of diet culture and modifying one’s appearance. Several countries have proposed legislation to govern the promotion of certain body ideals and appearance-culture (Agrell, 2008; Carey et al., 2011). According to Fredrickson and Roberts (1997), women continuously evaluate themselves, creating thoughts of shame and guilt that impair their mental health. These impairments can lead to EDs, DE, and altered body images. Fuller-Tyszkiewicz et al. (2012) researched factors, such as direct positive comments, that could counteract or repress the harmful effects of self-objectification and reduce its impact on individuals’ mental health. This study indicated that individuals surveyed reported triggers for their self-consciousness in either appearance or level of

attractiveness. The findings of the study suggested that friendship networks could counteract these triggers.

Physical Appearance

Physical appearance in media and advertising contributes to negative body image among men and women. Diedrichsand Lee (2011) found a link between average-sized body images in advertising and media and positive body image, even among individuals who had internalized physical beauty ideals. Holland and Haslam (2013) suggested that the objectification and sexualization of thin women can lead to the objectification of all women.

Nevertheless, comparing one's physical self to others can have positive outcomes. Diverse physical appearances within social circles can positively impact the ramifications of physical comparison by promoting a positive view of body image. Posture could contribute to the correlation between physical appearance and DE, EDs, and body image concerns. Certain postures could connect a sense of powerlessness and a decrease in confidence to restrained eating to project a sense of not taking up space (Allen et al., 2013).

Development of Body Image

Body image develops through a process of "awareness and experiences of the body" (Kinsbourne, 2002, p. 27). Body image is multidimensional in scope and reflected through an individual's self-perception, cognition, affect, and behavior regarding the appearance of one's body (Cash & Henry, 1995; Slaviero, 2006). According to Daly (2016), clinicians should address body image as reflected in physical appearance and comfort in one's body. The historical roots of body image stemmed from the 1900s when

neurologists began treating clients reporting bizarre body experiences (e.g., phantom limbs; Cash & Pruzinsky, 2002; Thompson, 1992). Body image gained further consideration as a mental construct during the 1950s (Kinsbourne, 2002; Schilder, 1950; Starkman, 2005) when Schilder (1950) identified body image as comprising unconscious and conscious mental processes, including contributions from attitudes, feelings, and interpersonal relationships, and shifted the focus of body image from a neurological perspective to an individual psychological awareness of personal body image (Thompson et al., 1999).

Thompson et al. (1999) defined body image as how individuals perceive their looks, how they believe others view them, and how they feel about their appearances. Hutchinson (1994) defined body image as the self-image individuals use to regulate their emotions, appetite, health needs, and internal dialogue about their appearance. Slade's (1988) definition of body image focused more on the pictorial representations a person creates or envisions and the emotions attached to these representations. Grogan (2008) expanded Slade's definition by determining that the individual's perceptual factors and attitudes were both compromised.

According to Schwartz (1986), the increased focus on body image correlates with growing attention to fashion, clothing size awareness, and eyesight concerns. During the 1920s, a boy-like body shape was the ideal for women, whereas in the 1930s and 1940s, big-chested women were seen as ideal. Curvy shapes were later heralded until the emphasis shifted to waif features (Fallon, 1990, as cited in Cash & Pruzinsky, 1990). Moreover, Thompson et al. (1999) discovered that an increase in body image

dissatisfaction correlated with the changes in ideal body image seen after the 1950s (Fallon, 1990, as cited in Cash & Pruzinsky, 1990).

Body image development has received extensive research over the past few decades because of its impact on women. Hutchinson (1994, as cited in Fallon et al., 1994) described body image as the "keystone to women's identity, an intersection of mind, body and culture" (p. 153). In 1998, Thompson et al. reported that the incidence of body image issues across cultures was growing. These two studies indicate how common it is for women to struggle with body image concerns. Because of their prevalence, it is essential to look at the factors that lead to the development of body image–related problems.

Fisher and Cleveland (1958) identified three main areas impacting body image: (a) a person's early life, including areas of structure, availability of money, and consistency; (b) work; and (c) marriage and children. Fallon (1990, as cited in Cash & Pruzinsky, 1990) reported that the cultural standards in place during youth might influence one's body image development. Cultural influence might also include Thompson et al.'s (1998) factors of the parents' beliefs and attitudes toward their own bodies, modeling of behaviors, quality of relationships, and peers.

Thompson et al. (1999) found that the media, gender, disabilities, and weight prejudice were additional factors in body image development. Miller (2000) suggested that an individual's body image changes in relation to their surroundings and where they are developmentally. Miller also discussed how the media and cultural ideals related to attraction influence body image. Thompson et al. argued that comparisons between siblings, social relationships, and romantic relationships could significantly affect body

image. In line with Haimovitz et al. (1993), Miller, and Smolak (2004) identified the sociocultural influences of parents, peers, toys, and the media. Dittmar (2008) also highlighted the importance of social comparison in body image dissatisfaction.

These researchers support Fisher and Cleveland's (1958) idea that various factors influence an individual's body image throughout life. Cash (1990, as cited in Cash & Pruzinsky, 1990) discussed how individuals are motivated to change their bodies to align with their interpersonal relationships, even at a young age. Similarly, Haimovitz et al. (1993) found that participants' satisfaction with their bodies was influenced by situational factors, such as the people they are around, how much of the body is visible, and the presence of a mirror. Fallon (1990, as cited in Cash & Pruzinsky, 1990) reported that cultural standards have a high impact on body image views and can include shape, weight, and skin tone. Further, Fallon found a relationship between maintaining a negative body image and individuals' status within their social group. Furthermore, Kinsbourne (2002) noted that as individuals learn that their culture encourages certain body types over others, they focus more on a sense of physical self.

Body image is a continuously changing construct, making it difficult to identify the factors influencing body image and body image concerns (Gleaves et al., 1995); however, research has shown some influences. Before individuals reach the age of 10, they understand certain body ideals and the benefits of being perceived as good-looking (Miller, 2000). By this time, children know that being overweight is typically correlated with being a "villain" (p. 441). Further, during adolescence, individuals have a general idea of how their peers perceive their own and others' bodies. Rieves and Cash (1996) examined other social factors influencing body image, including social teasing, social

comparison, and maternal modeling. Shisslak et al. (1989) noted that certain situations could affect individuals' body image later in their professional lives. Lerner and Jovanovic (1990, as cited in Cash & Pruzinsky, 1990) discussed how people's body image affects their social relationships and psychological characteristics. Cash (2002, as cited in Cash & Pruzinsky, 2002) identified physical characteristics and personality as additional factors relevant to body image.

Hayslip et al. (1997) found that having a romantic relationship was a factor in appearance-related decisions; thus, involvement with a partner can positively or negatively affect individuals' views of their bodies. Thompson et al. (1999) also found a connection between having romantic partners and body image development, specifically the fear of being negatively viewed by one's partner or not meeting the partner's beauty standards. Therefore, based on the various factors discussed in the literature, body dissatisfaction in women is due to the influence of cultural, familial, developmental, and personality factors (Cash & Pruzinsky, 2002). Psychodynamic and sociocultural perspectives of body image dissatisfaction receive discussion in the following section to help construct the questions posed in this study.

Body Image Disturbances

Past body image researchers have primarily defined and measured body image dissatisfaction (Thompson et al., 1999). Thompson defined dissatisfaction as a significant universal measure of distress due to the essence of the individual's subjective interpretation. Counselors measure body image disturbance along a continuum ranging from severe to minimal (Costin, 2009). Extreme disturbances are associated with DE with

a comorbidity of depression. In addition, extreme body image disturbance can contribute to occupational and social impairment (Thompson, 1992).

Body image concerns and dissatisfaction are the primary contributors to the development of DE (Bruch, 1962). Bruch (1962) recognized that disturbed body image contributes to anorexia symptomatology. Several experimental researchers have supported Bruch's theory of overestimated body size and fear of fatness as key components of anorexia (Russell, 1970; Slade & Russell, 1973). Similarly, 1980s research on bulimia nervosa (which led to its inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. [*DSM-III-R*]; APA, 1987) showed high levels of dissatisfaction and overestimation of body size in participants (Thompson et al., 1999).

Previous research also suggests that women display moderate amounts of body image disturbance (Cash & Henry, 1995; Rodin et al., 1985). Rodin et al. (1985) devised the term "normative discontent" to describe women's experiences with their physical appearance and their negative feelings toward it. In a nationwide survey, Cash et al. (1986) found that only 7% of women expressed little concern with their appearance. Cash and Henry (1995) administered a survey to 803 American women aged 18 to 70, with more than half reporting being dissatisfied with their bodies and unhappy with their appearances. Racial differences were apparent, as African-American women exhibited greater satisfaction with their bodily appearance than Caucasian and Latina participants. In a meta-analysis of gender differences in levels of body satisfaction, Feingold and Mazzella (1998) examined 222 studies from the pre-1970s to 1995, finding that body image worsened over time for women but not men.

To test the reliability of previous studies, Cash et al. (2004) used a cross-sectional study design to evaluate body image in 3,127 college-aged women and men. Several significant findings emerged from their analysis of archival data from 22 published and unpublished studies on body image published between 1983 and 2001 and the validated Multidimensional Body-Self Relations Questionnaire. There was an increase in body image dissatisfaction in non-Black women from 1983 until the mid-1990s. After this time, both Black and non-Black women reported a more favorable body image and a diminished preoccupation with being overweight; few body image changes were apparent in men over the same period. However, the researchers did not expect their findings to extend to other populations. Cash et al. (2004) viewed their results as possible evidence of a shift in norms reflecting a more "casual or unadorned appearance among college students rather than a change in internalized standards related to body weight or shape per se" (p. 1087).

Sociocultural Factors Affecting Body Image

The sociocultural theory of body image suggests societal and cultural forces that impact women (Stice, 1994). This sociocultural perspective links DE and body image problems in certain cultures to that culture's elevation of thinness as a significant aspect of beauty (Striegel-Moore & Smolak, 2001; Twamley & Davis, 1999). Theorists posit that body dissatisfaction results from women psychologically internalizing the thin ideal. This outcome is prevalent among women in Western industrialized societies where thinness is idealized (Rodin et al., 1985; Stice, 1994). The average woman in Western society has some degree of body dissatisfaction; however, those who develop diagnosed EDs likely exhibit greater psychological vulnerability (e.g., low self-esteem and identity

confusion; Becker, 2003). The three major sociocultural pressures in Western and postindustrial societies that contribute to DE are the thin-ideal body for women, the significance of appearance in societal success, and the centrality of appearance in the female gender role (Stice, 1994).

Several studies of American culture have shown the thin-ideal body image in women. Using data from mass media (e.g., visual and written images in popular culture, TV, radio, and the internet) as indicators of the shift in the thin ideal for women, scholars have found images of women becoming thinner over the last few decades (Stice, 1994). Studies tracing shifts in bust-to waist, bust-to-hip, and weight ratios in *Playboy*, beauty pageant contestants, and models in women's magazines from 1959 to 1978 indicate decreasing ratios (Garner et al., 1980; Stice, 1994). Simultaneously, there has been an increase in dieting and weight-loss articles and advertisements in women's magazines since the 1950s. According to sociocultural theorists, the media's increased focus on the thin ideal actively promotes body dissatisfaction, which, in turn, contributes to DE (Garfinkel et al., 1980; Rodin et al., 1985; Stice, 1994).

Although mass media messages are the strongest in promoting the thin ideal of female beauty, other social and cultural sources convey and reinforce this image. Sociocultural investigations have addressed the influences of family members, peers, athletic groups, and school environments on EDs in women (Groesz et al., 2002; Stice, 2001). Numerous studies suggest that thin ideal body pressures are most significant in subgroups such as athletics, modeling, and dance (Garner & Garfinkel, 1985; Stice, 1994).

Acculturation

Acculturation is the modification of the culture or a group due to encounters with different cultures (Winkelman, 1994). Assessing and measuring acculturation occurs across several domains, including language, identity, behavior, and values (Willgerodt et al., 2002). Furthermore, acculturation is a complex concept that requires adopting and maintaining behaviors that reflect a balance of new and native cultures. Numerous studies have shown that Western body shape ideals have infiltrated other cultures. Despite a lower incidence of anorexia and bulimia in Japanese women than in American women, third-generation Japanese-American young adult women revealed higher levels of body dissatisfaction than American women (Becker, 2003; Suematsu et al., 1985). Similarly, in a 1999 study of Chinese university students living in the United States, David and Katzman found greater acculturation associated with significantly higher Eating Disorders Inventory scores.

In the United States, the prevalence of eating pathology is higher among Hispanics and Native Americans than non-Latino Whites or Black people (Becker, 2003; Dorian & Garfinkel, 1999; Le Grange et al., 1998). The risk for eating pathology increases among minority women in the United States who are heavier, better educated, and more closely identified with middle-class White culture (Akan & Grilo, 1995; Crago et al., 1996; Dorain & Garfinkel, 1999). Black women in the United States tend to weigh more but exhibit less body dissatisfaction, fewer weight concerns, and a more positive body image (Dorian & Garfinkel, 1999; Hsu, 1990; Root, 1990). However, White, Black, Asian, and Hispanic women with a history of dieting express similar weight concerns and weight control behaviors as other groups of women (Dorian & Garfinkel, 1999; Melin et

al., 1992). Body image causes significant distress for many in Western societies. It is a multidimensional construct that reflects individuals' attitudes toward and perceptions of their physical appearance (Cash & Pruzinsky, 2002). Often, body image is a reflection of how individuals view their bodies in comparison to cultural norms and ideals, not their actual body proportions (Ayala et al., 2007).

Watson et al. (2013) illustrated a relationship between a strong multicultural identity and creating a buffer from internalizing beauty ideals. Western cultures emphasize physical appearance as an element of personal and social value (Thompson et al., 1999). Western culture presents the predominant belief system and value orientation of many economically stable countries, including Western Europe, Australia, and the United States (American Psychological Association, 2003; Thompson et al., 1999). Bem (1981) suggested that minorities living in places identified as part of the Western culture evaluate and alter their physical appearance as they adjust to new cultural contexts. Although many theorists have postulated that a higher level of acculturation to Western cultures would correlate with increased body image problems in minorities, research does not support a simple relationship (Ayala et al., 2007; Joiner & Kashubeck, 1996; Nieri et al., 2005; Pepper & Ruiz, 2007).

Body Image and Media Portrayal

The ideal body image is often globally accepted and idealized as the beauty norm. The concept of the ideal body image has changed dramatically over time, as is apparent over 80 years of popular media and celebrities of the time, such as Marilyn Monroe, Twiggy, Jennifer Aniston, and the Kardashians (Frith et al., 2005).

Media is a frequent agent of globalization and socialization, projecting Western beauty standards worldwide (Levin & Murnen, 2009). Western standards of beauty, which include light skin tone, thin female figures, and visual perceptions of male masculinity, are now globally pervasive and culturally integrated (Frith et al., 2005). For example, various magazine covers outside the United States, such as in Singapore, India, and China, include White models, despite a majority Asian readership. As Western appearance continues to define ideal beauty standards, individuals who do not genetically possess those traits might struggle to conform to the subjective ideal of the era.

Influx of Cosmetic Surgeries

Cosmetic surgeries have become normalized outpatient procedures to conform to an ideal body image. Ethnic women might pursue cosmetic medical procedures to change the facial features genetically associated with their race and ethnicity, reflecting a level of body dissatisfaction as they strive to appear more Caucasian (Heyes, 2009). One of the most common plastic surgeries in South Korea is blepharoplasty, or double eyelid surgery, which involves lifting the eyelids to widen the eye (Holiday & Elfving-Hwang, 2012). Residents of East Asian countries elect to have rhinoplasty (“nose jobs”) to attain a more Westernized appearance (Heyes, 2009). White individuals do not typically seek to change markers of racial identity. Instead, a larger portion of the U.S. Caucasian population pursues breast augmentations, liposuction, or wrinkle removal procedures.

Negative Implications of Body Dissatisfaction, Disordered Eating, and Eating Disorders

Body Dissatisfaction

Body dissatisfaction and the attempt to redefine oneself to reflect the normative ideal can contribute to many mental health concerns, including depression, anxiety, and DE. The APA (2013) defines body dissatisfaction as having negative cognitions, subjective perception, and overvaluation of personal body weight, shape, and size that may contribute to an ED.

Bessenoff and Snow (2006) found that individuals who perceive themselves as outside the projected ideals could suffer more significant psychological consequences. Individuals' perceptions of their appearance and the disparity with Western ideals can lead to substantial body dissatisfaction, especially among those from various ethnicities. Body dissatisfaction is apparent in the beginning stages of young girls' development, as body image concerns arise in accordance with the outward body changes related to physical shape. For example, a desire to lose weight can be based on bullying or attempts to assimilate into the majority's ideal (Bessenoff & Snow, 2006).

When identifying body image disturbances, it is vital to explore an individual's preoccupation with appearance and how it interferes with daily functioning and builds distress (Kearney-Cooke & Tieger, 2015). The *DSM-5* (APA, 2013) does not categorize body dysmorphic disorder as an ED but recognizes it within the obsessive-compulsive disorder diagnosis. The symptomology is similar to EDs, which could lead to its addition in future versions of the *DSM*. Symptomology for body dysmorphic disorder is not just a preoccupation with appearance but with a perceived defect in their imagined appearance.

Although the defective image could be partially accurate, exaggerations of minor imperfections or nonexistent defects contribute to preoccupation (Phillips et al., 2012). Impairment with daily functioning results from preoccupations of 3 to 8 hours a day, during which the individual focuses on trying to correct or change the defect. Vitousek and Brown (2015) stated, "The idea that patients' beliefs about weight and eating form the core psychopathology of these disorders, once radical, is now commonplace, represented in diagnostic criteria and built into standard symptom inventories" (p. 321).

Disordered Eating

Individuals who engage in food avoidance behavior may begin by limiting foods, leading them to feel "healthier" and ultimately motivating them to avoid certain foods altogether (Musolino et al., 2015). Food avoidance can begin as well-intentioned modifications to promote health but can become extreme over time. Individuals who engage in food avoidance could attribute their eating choices to health, intolerances, or ethical reasons (Musolino et al., 2015; Zuromski et al., 2015). For example, Musolino et al. (2015) found that vegetarians or individuals engaging in socially accepted food avoidances or exaggerated intolerances of certain foods or food groups (e.g., diets with no or low carbohydrates, sugar, or red meat) obtained increased control over their eating choices without being questioned by others. DE behaviors illustrate restrained eating patterns, and EDs can be masked by socially accepted lifestyle choices, such as vegetarianism (Klopp et al., 2003; Musolino et al., 2015).

Some have identified vegetarianism, veganism, and similar lifestyle-based food avoidances as markers for DE behavior (Timko et al., 2012; Zuromski et al., 2015). Bardone-Cone et al. (2012) compared vegetarianism among those with and without an

ED history; most participants with a history reported becoming vegetarian after the onset of ED symptoms. Further, many participants reported that vegetarianism helped them maintain their ED, lose weight, and feel in control.

Dieting behaviors, specifically those that involve restraint, such as skipping meals or lowering energy intake, can develop into problematic patterns of eating that include low caloric intake or unrealistic long-term dietary changes (Haynos et al., 2016). College women who reported dieting to lose weight or identified themselves as dieters had an increased risk for DE patterns and weight gain (Delinsky & Wilson, 2008; Pliner & Saunders, 2008). In a study of 560 college women, Ackard et al. (2002) found that students' engagement in dieting was positively correlated with displays of DE behaviors and traits, as well as with negative effects, such as depression. In a longitudinal study, Delinsky and Wilson (2008) found that dietary restraint and concerns about gaining weight predicted increases in DE. Additionally, elevated dietary restraint at the start of the academic year was predictive of increased weight and shape concerns 7 months later. Polivy et al. (1988) posited that restrained eaters with low self-esteem were more susceptible than unrestrained eaters to external and internal cues (e.g., stress; anxiety; the smell, sight, or thought of food) that triggered disinhibited eating via feeling a lack of control over overeating, including binge eating.

Eating Disorders

EDs have been present in society for centuries; however, the APA (1980) did not introduce EDs until the *DSM-III*. During the 1980s, EDs became a common topic of conversation among the public, with expanded awareness among the health care community and the general public through the media.

Anorexia and bulimia are types of body image disorders. In this context, body image is multidimensional because it involves perceptual, behavioral, and attitudinal disturbances (Rosen, 1990, 1992; Thompson, 1992). Numerous studies support the notion that body dissatisfaction is the most consistent predictor of the development of anorexia and bulimia (Cattarin & Thompson, 1994; Killen et al., 1996; Rosen, 1990; Thompson et al., 2002). Body dissatisfaction might be normative among Western women; however, the distorted body image of anorexic and bulimic women is at the far end of this normative spectrum. In the *DSM-5-TR* (APA, 2013), the diagnostic criteria for anorexia nervosa include an extreme fear of fatness and weight gain, despite the client being underweight, and "disturbance in the way in which [her] body weight or shape is experienced, undue influence of body weight or shape on [her] self-evaluation, or denial of the seriousness of [her] current low body weight" (Garner, 2004, p. 589). The diagnostic criteria for bulimia nervosa also include a focus on body image: "self-evaluation is unduly influenced by body shape and weight" (APA, 2013, p. 345).

In the *DSM–5*, the APA (2013) defined an ED as an illness in which individuals experience severe disturbances in their eating behaviors related to thoughts and emotions. The *DSM-5* chapter "Feeding and Eating Disorders" presents individuals diagnosed with an ED as consumed with thoughts related to food and body weight. According to NEDA, around 30 million men and women will be diagnosed or have symptoms of an ED that affect people of all different cultural, ethnic, religious, sexual orientations, gender, and ages. Currently, there is no definitive cause for EDs; however, research indicates that biological, psychological, and sociocultural factors can be attributed to the development of ED symptomology (National Eating Disorder Association, 2022).

Eating disorders are associated with a wide range of medical complications, comorbid psychopathologies, and psychosocial impairments (Smink et al., 2012). Individuals who present with DE often show or demonstrate a range of irregular eating patterns, and those who meet the criteria for or are in partial or full remission from DE are at a greater risk of developing an ED. Disordered eating can include various eating patterns, including (a) frequent dieting, (b) skipping meals, (c) chronic weight fluctuation, (d) rigid rituals and routines around food and exercise, (e) feelings of guilt and shame associated with eating, (f) preoccupation with food, and (g) weight and body image that negatively impacts the quality of life (APA, 2013). Individuals suffering from DE might feel a consistent sense of loss of control around food, practice compulsive eating habits, use exercise as compensatory behavior, restrict food intake, and fast or purge to make up for "bad" foods they have consumed (Gaudiani, 2018).

Body Image in Counselors

Despite the attention women's body image has received in the literature, there has been little research on the body image of the female counselor (Lowell & Meader, 2005). As members of the general female population, counselors who identify as women are also influenced by the same sociocultural factors discussed in the previous sections. These sociocultural factors impact the clinician's psyche and can foster countertransference, especially when working with DE, EDs, and body image clients (DeLucia-Waack, 1999). Gutwill (1994) theorized that both client and counselor are in the same "culture home or culture parent" (p. 146). Thus, counselors experience cultural countertransference to societal symbols, and one of the key symbols is the ideal female body. Female counselors are at various stages and levels of awareness about the effects of the culture in which they

live, other interpersonal factors, and familial factors on their body image (DeLucia-Waack, 1999; Gutwill, 1994; Rabinor, 1995).

In an anecdotal account, Burka (1996) discussed managing clients' reactions to her larger body size, framing her understanding from a postmodern psychoanalytic perspective. Within this context, the counselor and client are co-creators of their interpersonal relationship in the treatment room; the counselor's physical and symbolic body is one aspect of this relationship. The client often uses the counselor's body as a transference object; it is a container and carrier of conscious and unconscious symbolic meanings for the client. In the article, Burka acknowledged the role her body image played in this interaction and recognized the shifting experiences of her body image when faced with various conscious and unconscious communications from the client. Burka reflected on her ability as a well-seasoned counselor to tolerate and welcome her clients' myriad feelings about her overweight body. The more comfortable Burka became with her body image, the more she could invite authentic communication about clients' reactions to her body and the personal meanings this had for them.

Lowell and Meader (2005) explored the dynamics in clinical treatment with a thin counselor and a client with an ED. Depending on the client's transference reactions, the thin counselor can experience shifting body images. The counselor might desire a fuller and rounder body in response to a client who longs to be engulfed and protected. Lowell and Meader recommended that counselors strive toward ongoing awareness of their body image, which helps to foster exploration of the client's feelings about her own body image and her counselor's. Similarly, Orbach (2004) identified the counselor's body as a transference object, stating, "It is a body that represents the imaginative and cross

transference needs of the counselor and the client. It is not a ‘natural’ or ‘neutral’ body. It expressed the relational complexities between the two people in the room” (p. 149).

Several theorists acknowledged the intersubjective field previously discussed while attempting to quantify personal aspects that counselors bring to the treatment relationship. Few, however, have examined the prevalence of EDs among professionals who specialize in treating eating-disordered clients (Barbarich, 2002; Bloomgarden et al., 2003; Costin & Johnson, 2002; Johnston et al., 2005).

Clients who have faced weight stigma from health care providers and the assumptions made about themselves and their habits might begin to distrust mental health care providers and avoid treatment (Alberga et al., 2019). Stigmas can be explicit, conscious, and personal opinions and beliefs or implicit, automatic, and subconscious thoughts and attitudes (Phelan et al., 2015). Pearl et al. (2018) and Levin et al. (2018) suggested counselors would benefit from exploring their stigmas and body image concerns to shift their attitudes, beliefs, and bias when working with clients on body image, helping decrease weight stigmas.

The prevalence of EDs among professionals is relevant to this study to determine the frequency of body image distortion experienced in counselors’ personal lives. This can be a factor in the clinician’s ability to manage her countertransference reactions when treating clients with similar body disturbances. Bloomgarden et al. (2003) reported the results of a survey given to 150 staff members of a large treatment program. Thirty-one percent of the respondents had a personal history of an ED an average of 12 years ago. Thirteen percent had a family member with an ED, and 44% of the staff reported some personal connection with an ED prior to entering the field as a professional.

Barbarich (2002) conducted a large-scale study assessing the lifetime prevalence of EDs among professionals in this field. Using a nonvalidated questionnaire (the Eating Disorders Background Survey), Barbarich surveyed 823 members of the Academy for Eating Disorders, a multidisciplinary group of national (including Canada and Mexico) clinical and academic professionals. The results suggested a significantly higher lifetime prevalence of an ED among the professional group than the general female population. Like Bloomgarden et al. (2003), Barbarich found a 31% prevalence rate of EDs. Barbarich recommended further research to address how this rate might affect the treatment relationship between clinicians and clients with EDs.

External factors, such as the counselors' supervision, education, and professional clinical experience, are crucial components of effective psychotherapeutic treatment for clients with EDs (DeLucia-Waack, 1999; Hamburg & Herzog, 1990). Providing treatment to the ED population is complex and engenders a myriad of countertransferential reactions in counselors, especially among female counselors negotiating their own body image within Western culture (Gutwill, 1994; Orbach, 2004). Supervisors who allow counselors to discuss and explore their reactions to an eating-disordered client provide a vital "source of support and a reality check" (DeLucia-Waack, 1999, p. 77).

The counselor's personal ED experience is another external factor that may impact counselor countertransference management when working with clients with EDs. Personal ED experience refers to the counselor's history of having a diagnosis or symptoms of an ED. Johnston et al. (2005) examined this variable in terms of a clinician's "fitness to practice in a health care profession" (p. 301). The researchers

administered a nonstandardized questionnaire to a representative sample of 202 adults from the Eating Disorders Association in the United Kingdom. Johnston et al. (2005) found that a counselor with a history of an ED would be more understanding, empathetic, and sympathetic, often serving as an expert and a role model. Further, statistically significant findings were apparent among all respondents with a history of ED. The respondents identified disadvantages of receiving treatment from a professional with an ED history, such as "concerned [with] the potential for over-involvement or 'enmeshment,' followed by counselor vulnerability and subjectivity" (p. 308). This study shows how the counselor's personal ED experience might influence several factors related to countertransference management, specifically empathy, self-insight, conceptualizing ability, self-integration, and anxiety management.

Summary

This literature review provided a framework for conceptualizing counselor body image concerns when treating clients with body image concerns. Chapter II included in-depth discussions of the following topics: therapeutic alliance in counseling, feminist and objectification theory, development and disturbances in body image, sociocultural factors, media portrayal of body image, increase in cosmetic surgery, DE and EDs and their relationship to body image concerns, and counselors' personal experiences with body image. Gaps in the literature indicated the need for this study, as previous researchers focused on client treatment by counselors with a personal history or current diagnosis of an ED or DE. Growing insight into a counselor's body image experiences and how these experiences influence their work with clients with body image concerns highlights the need for further research and improved practices. Chapter III will present

the study's methodology, including the purpose of the study, research design, means of participant selection, data collection procedures, and the instruments used to measure variables in the study.

CHAPTER III

Methodology

Moustakas's (1994) transcendental phenomenology was the approach used to explore the experiences of LPCs with their body images when working with clients with body image distortions. The focus of the study was the experiences of clinicians who have worked or currently work with clients addressing body image struggles in their therapeutic work. This chapter includes the following sections: (a) research design, (b) bracketing, (c) participant selection, (d) informed consent, (e) data collection, (f) data organization, (g) data analysis, and (h) trustworthiness. Chapter III concludes with a summary.

Much of the literature on body image concerns and treatment focuses on the clients' concerns. The minimal research about counselor body image is thus far limited to professionals with an ED or a history of ED. Thus, there was a gap in the literature regarding typical counselors' experiences of their body image and how its impacts their treatment when working with clients who exhibit body image concerns, indicating the need for this study. By exploring the role of the counselor's body image and its impact on the therapeutic alliance, I gained a better understanding of how counselors' body image relates to their clinical work with this population and could provide recommendations for continued research and improved practice.

Research Design

Qualitative methodology is appropriate when researchers seek a better understanding of the participants' specific, individual experiences of a shared event (Creswell & Poth, 2018). Phenomenological qualitative studies allow the researcher to

take part in the process of making sense of the phenomenon based on the participants' perspectives. Exploring the similarities of participants' experiences enables a better understanding of what was experienced and how (Creswell & Poth, 2018). Creswell (2007) stated, "A phenomenological study describes the meaning for several individuals of their lived experiences" (p. 57). By utilizing this method, the investigation focused on the phenomenon of participants' experiences when the topic of body image arises when working with clients.

Bracketing

I continuously assessed my influences, biases, and preconceptions to achieve transcendental subjectivity within the research process. My experiences did not affect the participants. Before starting the study, I reflected and used bracketing to set aside preconceived understandings and judgments about the phenomenon under investigation. In utilizing the transcendental approach, I will also reflect and strive to recognize how certain experiences throughout this process could elicit various responses.

Additionally, phenomenology creates a readiness to understand experiences unobstructedly, not threatened by the customs, beliefs, and prejudices of normal science, the habits of the natural world, or knowledge based on unreflected everyday experience. Moustakas (1994) recommended identifying bias before beginning participant interviews, which helps the researcher to approach the interviews with open eyes and mind. However, Creswell and Poth (2018) stated that full bracketing is rare, as it is difficult to fully abandon personal biases. As Moustakas (1994) explained, phenomenologists must *attempt* to eliminate all prejudgment by setting aside presuppositions and reaching a transcendental state of freshness and openness.

I used epoche as a form of bracketing before each interview. Epoche is a required part of phenomenological research (Moustakas, 1994). In practicing epoche, I wrote a reflection or narrative about my feelings and thoughts prior to each participant interview. This process helped me enter each conversation open to the participants' experiences without the interference of my personal reflections and feelings. I used journaling throughout the data collection process, reflecting on my experiences before, during, and after each interview to maintain distance from the data and strive to remove any of my subjective influence.

I am a 29-year-old Pakistani-American woman born and raised in Houston, Texas. After graduating from a public university in Texas, I obtained clinical experience working with clients with body image concerns in a residential setting. The residential center included an ED track in which clients received ED diagnoses, often with comorbid body distortions. As a behavioral health counselor, I ran a body image group and a dialectical behavioral therapy group for the track. During this time, I decided to go to graduate school to attain my professional counseling license. I became a full-time counselor at a partial hospitalization/intensive outpatient ED center, where I worked with clients and their families on individual and group bases who had a primary diagnosis of an ED. I then completed my certified ED specialist certification through the International Association of Eating Disorder Professionals. Throughout the process, I attained over 1,500 hours direct hours working with clients struggling with an ED and 50 hours of supervision. In addition, I completed coursework aimed at understanding the complexities of EDs from therapeutic, medical, and dietary standpoints. Throughout the certification process, I continued to work as both a full-time counselor at an outpatient

ED facility as well as in a private practice specializing in EDs, where I supervised and consulted with other clinicians. My interest in body image work was an integration of my interest in working with clients struggling with EDs and trauma and observing how counselors often set aside body image struggles, not fully integrating them into sessions. As I have consulted and supervised clinicians over the years, I began to notice their struggles with perceptions of their own body image and their views of the ideal body image.

Participants

Recruitment

I recruited participants using criterion sampling, an approach used to find participants who could provide rich information about the phenomenon under study (Creswell & Poth, 2018). Because the focus of this study was LPCs currently working with clients on body image concerns, it was necessary to purposefully sample individuals who meet a specific, predetermined set of criteria. Once I received approval from Sam Houston State University's Institutional Review Board (IRB), I posted recruitment requests on social media that included the purpose of the study, sampling criteria, time commitment, and contact information.

To be eligible to participate in the study, individuals must have been actively working LPCs fully licensed for a minimum of 2 years. Participants needed to be within the age range of 25 to 60 years. To merit consideration for this study, LPCs must have currently worked with body image clients in private practice, intensive outpatient, partial hospital, residential, or inpatient levels of programming.

If needed, I would have used snowball sampling in addition to criterion sampling. This approach entails asking initial participants to refer qualified others who might be interested in taking part in the study (Creswell & Poth, 2018). If I had an insufficient number of interview participants, I would have asked the interviewees to provide my contact information to other individuals who could also provide rich data related to the topic. This study was a means to explore the phenomenon of body image of counselors in working with clients with body image concerns. I followed Creswell and Poth's (2018) recommendation of eight to 10 participants to achieve qualitative saturation, which occurs when collecting additional data no longer provides new insight (Creswell & Poth, 2018). In qualitative research, saturation is of greater importance than sample size (Peoples, 2020). In this study, the saturation point was reached when no new themes presented themselves.

Screening Criteria

The initial email included screening questions and the eligibility criteria for the study. The criteria for participation were (a) full state licensure status as an LPC for a minimum of 2 years, (b) previous or current professional counseling experience with a client with body image concerns, and (c) previous or current struggles with personal body image. Negative body image characteristics include negative feelings, cognitions, behaviors, and perceptions regarding one's body image (Thompson et al., 1999).

I used the definition of body image as the mental representation individuals have of their bodies (Schilder, 1999), which can have cognitive, affective, and behavioral components (Cash & Pruzinsky, 2002). I used this representation in the screening criteria to determine how participants saw themselves regarding their body image. In addition,

potential participants must have counseled or been counseling clients on their body image-related concerns. Their clients would have struggled with cognitive distortions of their bodies and self-worth related to their body image and tried to alter their physical shape or form through exercise, surgery, and food restriction. Body image concerns might have caused the clients distress in their daily lives, preventing them from participating in relationships, activities, or experiences.

I screened potential participants by asking the following questions:

1. Are you a licensed professional counselor (LPC)?
2. Have you been fully licensed for at least 2 years?
3. Have you struggled with body image concerns in the past?
4. Do you currently struggle with body image concerns?
5. Have you discussed or worked on body image concerns with a client?

Individuals who met the study criteria and agreed to an interview date and time were eligible to take part in the study. I emailed participants a reminder and a virtual meeting link 24 to 72 hours prior to their scheduled times. Participants also received an informed consent document, which they completed before the interviews. I conducted the interviews via Zoom, using a personal ID and password to ensure protection and a digital audio recorder for data analysis. After confirming there were no copies of the recordings on Zoom's cloud-based server, I sent the recordings to a HIPAA-compliant service for transcription. Upon receipt of the transcripts, I stored the password-protected files on a password-protected external hard drive, which I will keep in a lockbox for 3 years before destroying the data. All emails between the participants and me were encrypted to maintain confidentiality.

Informed Consent

Before beginning the interview, I reviewed the human-subjects informed consent form with each participant and confirmed their consent to participate in the study. I also requested verbal consent to record the interview. I reviewed the procedures used to safeguard their information, maintain their confidentiality, and ensure their privacy and addressed any questions or concerns they had. I informed participants of the potential emotional risks of participation and their right to withdraw at any point without consequence or question. Before beginning the semistructured interviews, I again asked if they had any questions or required further understanding of the process.

Data Collection

Participants first responded to a demographic questionnaire to answer the following:

1. What is the title of your professional license?
2. What state are you licensed in?
3. How many years have you been fully licensed?
4. What are your specialty areas (if any)?
5. What is/are your current practice setting(s) (e.g., private practice, PHP, residential, inpatient)?
6. What setting(s) did you complete your training in?
7. What is your ethnicity?
8. What is your age?

Semistructured interviews were the primary means of data collection. Semistructured interviews are common in qualitative research, allowing participants to

respond to preconceived questions and discuss other information relevant to their personal experiences. I used open-ended questions to gain a better understating of each participant's full experience (see Moustakas, 1994).

Creswell and Poth (2018) noted that web-based interviews are more cost-effective and time-efficient for the researcher while offering comfort and flexibility to the participant. Each interview lasted 1 hour or less, and I asked follow-up questions as needed to obtain rich data. At the conclusion of each interview, I asked participants if they would like to take part in member checking.

The intent of the semistructured interview was to explore the counselor's body image perceptions and views when working with clients seeking treatment for body image concerns through questions developed during the exploration of previously published literature. To construct the interview questions, I drew upon existing literature and my observations of events and situations with people having different degrees of body image acceptance. Before participant interviews, I piloted the questions with a group of licensed counselors who specialize in EDs, incorporating their suggestions and changes as appropriate. I developed an interview protocol in line with Creswell and Poth (2018), which allowed me to address each research question and gain further insight to "ensure information directly from the source" (McMillan & Schumacher, 2010, p. 322). The aim was to create a protocol to explore how the LPCs felt about how they looked, their thoughts and beliefs about their body, and what they do about how they look amid continuing sociocultural influence. I asked follow-up questions before ending the interviews to obtain a deeper understanding and clarity when applicable.

The interview questions were:

1. Tell me about your experience working with body image concerns with clients.
2. What are some treatment modalities or treatment interventions you use when working with clients with body image concerns?
3. How do you feel about your body (e.g., body shape/size/weight)?
4. Tell me about your own body image health beliefs.
5. How do you think or imagine your own body image beliefs about health impact the way you provide treatment?
6. How have your beliefs around your own body image originated or been formed?
7. How has your relationship with your body image changed because of working with this client group?
8. Describe your relationship with food or eating. How has it changed when working with this client group?
9. Describe any changes in your weight that you may have encountered or noticed when working with this client group.
10. How has your clinical relationship with your client been impacted based on body types (e.g., body shape/size/weight)?
11. Tell me about any personal experiences of how your body image may have interacted in individual sessions with clients. How do you feel about your own body image while working with clients with body image concerns?
12. What are your thoughts on how training can be attained or improved for counselors around their own body image?

13. What else, if anything, would you like to share that you have not had the chance to?

At the end of the interview, I turned off the audio recording device, password-protected and saved the digital file to the password-protected external hard drive, and submitted the files to a HIPPA-complaint transcription service. After comparing the transcript wording to the recordings to ensure accuracy, I deleted the audio files. Participants who agreed to the member-checking process received their interview transcript via email to review, made any modifications they saw fit, and sent me the updated transcript. Member checking is a way to reduce potential threats to validity. In member-checking, the participants can alter, clarify, or add data to the transcripts if needed or approve them as is. This process limits the researcher from misunderstanding or misrepresenting the data. Allowing the participants to evaluate and clarify their experiences and the surrounding meaning decreases the potential of researcher bias influencing the data.

Data Analysis

The data analysis steps in qualitative research include data organization, identifying and condensing themes, and representing data effectively (Creswell & Poth, 2018). I analyzed the data using Moustakas's (1994) modified van Kaam (1959, 1966) method, which contains seven steps:

1. Listing and grouping—This preliminary step involved the horizontalization of significant statements. I developed a list of every expression relevant to the topic from the transcripts.

2. Reduction and elimination—I reduced the data to meaning units or invariant constituents. I began this step by answering two questions for each individualized statement or quote identified in the first step, as proposed by Moustakas (1994):
    a. "Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?"
    b. "Is it possible to abstract and label it?" (p. #121)

    If the answer to either or both questions was "no," I removed the statement. Also removed were statements considered vague, overlapping, or repetitive, leaving only the invariant constituents.
3. Clustering and thematizing—After I clustered and sorted the invariant constituents from Step 2 into themes based on their relevance, I assigned a thematic label to each group.
4. Validation—Validation entails identifying the invariant constituents and themes by application. I reviewed each invariant constituent and theme against the source data, which ensured the themes were representative of the participants' experience.
5. Individual textural description—I created textural descriptions from the experience using verbatim quotes and excerpts from each participant's interview.
6. Individual structural description—I used imaginative variation to see possible meanings, which allowed me to explore the connection between participants' reports.

7. Textural-structural description—I created composite textual descriptions of each participant, outlining the words from the transcripts representing pronounced, relevant, and reoccurring themes. To examine connections across participants, I developed structural descriptions, which ultimately guided the exploration of elements that influence and contribute to the participants' experience of the phenomena. Finally, I integrated the textural and structural composites to develop the textual-structural description that reflected the full phenomenon.

Credibility

To ensure the study's credibility and decrease threats to validity, I implemented respondent validation, or member checking. Through member checking, participants could provide feedback about the collected, recorded, and transcribed data from the interviews. Member checking in an effective method to limit the researcher's potential misrepresentation of the data (Peoples, 2020). Allowing participants to edit any part of the interview or reflection of their experience decreased the likelihood of researcher bias. I also checked with participants throughout the interviews to confirm my understanding of their experiences. Following the interview, I provided each participant with a copy of their transcript to modify as they saw fit.

Transferability

Transferability means that the finding or results from one study can be applied to similar situations or people (Maxwell, 2013). The semistructured interviews and demographic questionnaire used for data collection elicited detailed accounts of participants' training, educational experience, practice, and potential factors influencing

their personal body image when working with clients with body image concerns. Responding to the open-ended questions, the participants provided insight and a depth of information on the study phenomenon. The study's findings could further inform practice in various clinical settings and training programs, indicating transferability.

Thick Description

Researchers use thick or rich description to capture details of a phenomenon, providing context by encompassing feelings, thoughts, perceptions, and sensory information (Moustakas, 1994). By gathering a holistic picture of a phenomenon, I strove to gain a holistic view of the individual. I created the interview questions to elicit information about the participants' experiences and used direct quotes to capture a holistic view by illustrating the authentic reflection of each participant's story. Thick, detailed description reveals a researcher's interpretation and allows "readers to make decisions regarding transferability…[to]…other settings" (Creswell, 2007, p. 209).

Member Checking

Member checking can decrease the likelihood of researcher bias or data misinterpretation and ensure accuracy (Moustakas, 1994). I implemented member checking by allowing participants to review their interview transcripts and make corrections or clarifications as needed.

Coding

I utilizing a coding team for this qualitative study in addition to I discussed the coding and analysis progress with my committee members. These discussions created opportunities to guide the internal process and new emerging themes and insights within and about the data. Member checking is part of the coding process that allows for

validation. Saldaña discussed Ezzy's (2002) recommendations for using multiple strategies during the analysis process. Ezzy's recommendations to ensure trustworthiness are:

1. Initially code as you transcribe interview data.
2. Maintain a reflective journal on the research project with copious analytic memos.
3. Check your interpretations developed thus far with the participants themselves.

Dependability

To ensure and maintain dependability, I thoroughly documented all study processes. Dependability means that a researcher replicating the study with similar phenomena will achieve similar results.

Bracketing

I engaged in epoche to bracket my biases. First, a committee member interviewed me using the participant interview questions to create a baseline. Because I am a counselor specializing in EDs, this step was essential to create awareness of any bias I might have had before working with participants. In addition, I documented my reflections through journaling and memoing, primarily during data collection and analysis, to ensure that personal predispositions did not interfere with the participants' narratives. I discusssed any worrisome thoughts with my committee members.

Ethical Considerations

To ensure confidentiality, I used no participant names during the study. If any participant experienced distress during the study, I paused the interview and reminded

them of the option to withdraw their consent at any time. Member checking is one way to ensure the accurate capture and interpretation of participants' experiences (Moustakas, 1994). I stored all data on a password-protected computer and kept all transcripts and hard copies of notes in a locked file cabinet.

Potential risks for participating in this study included feelings of distress related to the participants' own body image concerns. In addition, participants might have recalled a difficult experience from working with clients or in their own lives that they needed to process. If necessary, I referred those participants to a counselor in the community who specializes in body image issues.

Summary

This qualitative phenomenological study was a means to better understand and explore body image in counselors working with clients with body image concerns. I conducted semistructured interviews and collected data from 11 licensed clinicians. After receiving transcripts of the audio-recorded interviews, I analyzed the text to develop themes and descriptions to interpret the licensed professionals' lived experiences with the phenomenon. I implemented several methods to reduce threats to validity.

CHAPTER IV

Results

This transcendental phenomenological study was an exploration of the lived experiences of licensed professional counselors (LPCs) in Texas working with clients with body image concerns. The participants were 11 LPCs who worked with clients with body image concerns and identified a history of body image struggles themselves. This chapter presents the findings, with pseudonyms used to ensure participant confidentiality.

Data collection from 11 semistructured interviews and a self-report demographic questionnaire (see Appendix C) occurred over 2 weeks. To bracket biases and develop further insights into participants' experiences, I took field notes before, during, and after each interview. The audio-recorded interviews took place via Zoom, a HIPAA-compliant audio-visual platform, and lasted from 25 to 45 minutes. After a HIPAA-compliant service transcribed the interviews, I reviewed each transcript. Next, I sent each participant their transcript via encrypted email to review for accuracy, a process known as member checking. A table in Appendix D presents each participant's pseudonym, gender, licensure type and state, specialty areas, current practice setting, and training setting.

The study's methodology and data analysis were in accordance with the transcendental phenomenological approach. Using Moustakas's modified van Kaam (1959, 1966) analysis method, I removed excess language and filler statements from the participants' transcripts. Horizontalization allowed me to identify salient descriptions, color code them, and sort them by themes. A researcher uses participant interview quotes to establish and support descriptions, thus gaining insight into their experiences (Creswell & Poth, 2018).

The use of a coding team of two licensed professional counselors was a means to increase validity and obtain the essence of each interview. Each coder received the interview audio recordings and transcripts through an encrypted email. Although the coders were licensed counselors, they did not meet the criteria for the study and were not currently or had not previously worked with clients with body image concerns. After each coder analyzed the data individually, they got together to discuss their findings.

Participant Demographics

Before scheduling the interview, participants submitted a prescreening document, reviewed the consent form (see Appendix A), gave verbal consent to participate, and completed a short demographic survey (see Appendix C). The demographic questionnaire required participants to provide their licensure type, state of licensure, gender, years in practice, specialty areas, current practice setting, and previous settings where they had worked and trained. Participants' experiences with counseling ranged from 2 to 8 years. All participants identified as female, and all were LPCs. One participant reported working toward full licensure at the time of the interview. (See Appendix D for the participant demographics summary.)

Participant Profiles

All participants met the study's criteria as determined by the prescreening document. The interviews took place over 2 weeks, with all data collected during this time. Data saturation ensured sufficient evidence to identify the emergent themes. A summary of each participant follows. (See Appendix F for a summary table.)

Participant 1

Dolly identified as a 33-year-old Caucasian female LPC with licensure in Texas, Illinois, and New Jersey. She had been practicing as a fully licensed counselor for 4 years and reported a specialty of EDs. Although she currently works full time in private practice, Dolly received training in PHP, IOP, residential, and inpatient settings.

Participant 2

Jasmine identified as a 31-year-old Middle Eastern female and an LPC in the state of Texas. She reported practicing as a fully licensed counselor for 4.5 years and specializing in EDs, relationships, anxiety, and trauma. Jasmine currently works in a private practice setting and received training in PHP, IOP, and nonprofit settings.

Participant 3

Raelynn identified as a 32-year-old Caucasian female and an LPC in Texas. She reported practicing as a fully licensed counselor for 4 years and specializes in EDs, trauma, and OCD. She completed her training in inpatient hospital, school, residential, and IOP settings before becoming fully licensed.

Participant 4

Megan identified as a 32-year-old Caucasian female and an LPC with licensure in Texas and Michigan. Megan has been a fully licensed counselor for 5 years and has predominantly worked with clients struggling with EDs, OCD, and anxiety. Megan is a clinical supervisor and currently practices and supervises counselors in a private practice setting. She completed her training in private practice and IOP settings.

Participant 5

Addie identified as a 36-year-old Caucasian, Native American, and German female and an LPC in Texas. Addie has been practicing as a fully licensed counselor for 1 year and reported not having any specialty areas. She practiced and trained in juvenile probation detention center, outpatient substance abuse, and school settings and currently works full time in a private practice setting.

Participant 6

Lila identified as a 30-year-old Caucasian female and an LPC in Texas. She has been practicing as a fully licensed counselor for 3 years, and her specialty areas include relational trauma and women's issues. Lila currently works in a private practice setting; however, she received training in various settings, including substance abuse, IOP, academic career counseling, community mental health, and college counseling.

Participant 7

Peace identified as a 48-year-old Black female and an LPC supervisor in Texas. She has practiced as a fully licensed counselor for 8 years and specializes in trauma and couples. She currently practices in a private practice setting. Peace received training in various settings, including a school, community counseling center, and clinical private practice.

Participant 8

Rose identified as a 35-year-old Caucasian/Hispanic female and an LPC and licensed chemical dependency counselor in Texas for 2.5 years. She specializes in trauma, EDs, and addiction. At the time of the interview, she was working full time in a

private practice setting. Her training settings included substance abuse disorder treatment facilities and a family counseling center.

Participant 9

Trina identified as a 37-year-old African American female. She is an LPC in Texas and has been fully licensed for 4 years. She reported specialty areas of EDs and mood disorders. Trina currently works full time in private practice and completed her training in PHP, IOP, and nonprofit outpatient mental health clinics.

Participant 10

Hannah identified as a 32-year-old Caucasian female and an LPC of 5 years. Her specialty areas include child abuse, sexual assault, and domestic violence. She received her training in a nonprofit children's advocacy center, where she continues to work full time.

Participant 11

DNW identified as a 37-year-old Black female and an LPC in Texas for 2 years. DNW reported a specialty of working with clients with grief. She currently serves as a supervisor in a mental health agency and completed her training in inpatient and private practice settings.

Emergent Themes

Answering the research question was a means to understand the lived experiences of counselors working with clients with body image concerns. Data analysis indicated three significant themes: (a) seeking congruence, (b) lack of formal training, and (c) counselors' self-awareness. A discussion of the themes follows, including a summary of the participants' experiences with direct quotes used to provide specific examples of the

themes. The three themes reflect the participants' experiences with the study phenomena affecting their clinical work with body image clients. Figure 1 shows the themes that emerged from data analysis; Table 1 presents a summary of the themes and their definitions.

Figure 1

Themes

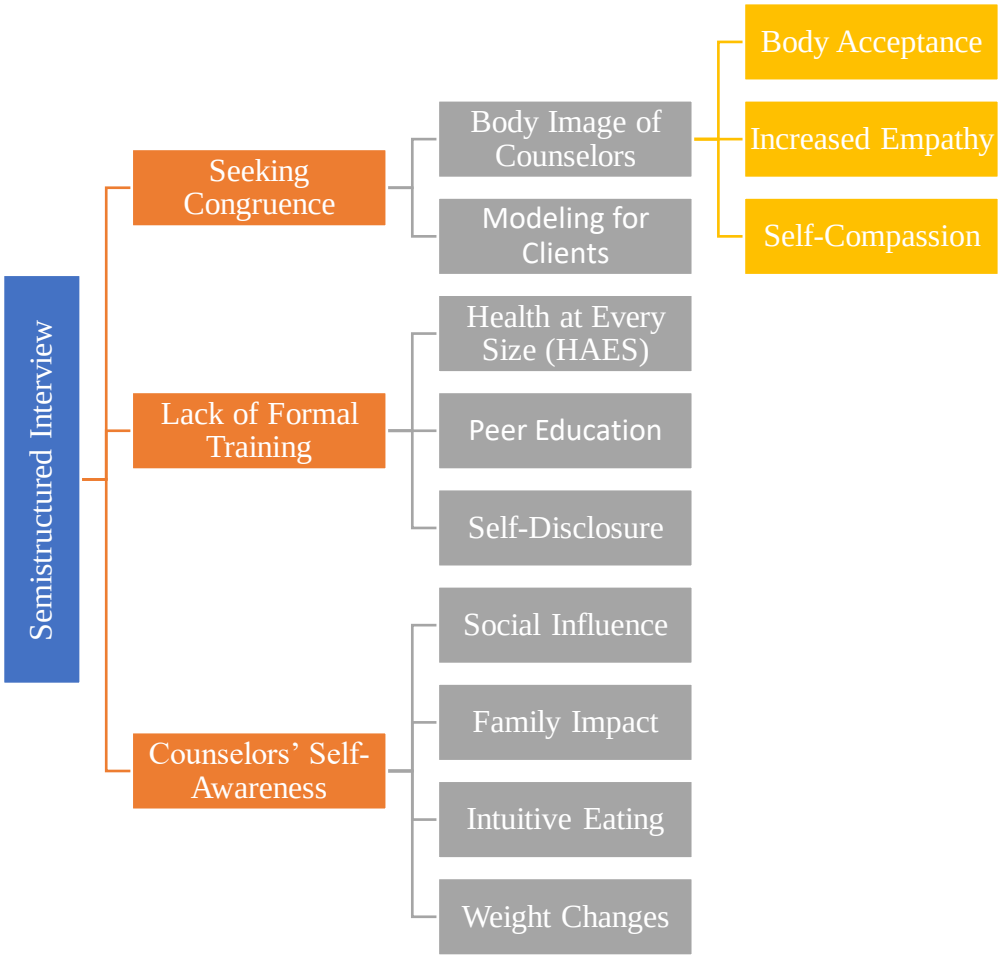

Table 1

Summary of Themes

Theme	Subtheme	Description of theme
Seeking congruence	Body image of counselors	Participants reported having a history of some sense of body image dissatisfaction.
	Body acceptance	Participants reported an overall more positive body image, the ability to identify an appreciation for their body, and the ability to decipher from the idea of negative body image.
	Increased empathy	Participants reflected on feeling a sense of empathy for what their clients go through based on their personal experiences and understanding of their individual body image struggles, past and present.
	Self-compassion	Participants reflected that working with body image concerns overall had improved their body image.
	Modeling for clients	Participants reported actively working on self-awareness around thoughts about their own body image and eating behaviors.
Lack of formal training	Health at Every Size (HAES)	Participants indicated beliefs of working from a Health at Every Size approach by acknowledging the diversity of all body shapes and sizes and not pathologizing solely by an individual's weight.
	Peer education	Participants reported feeling underprepared to address body image issues due to a lack of empirically based interventions. Most interventions were based on trainings received in settings they had previously worked in. Participants actively sought out information to improve their practice.
	Self-disclosure	Participants reflected that the body of the counselor is not a secret and therefore should be addressed with the client and used as a tool.

(continued)

Theme	Subtheme	Description of theme
Counselors' self-awareness	Social influence	Participants reflected their awareness of social influences by challenging their views of body image from a cultural/societal perspective.
	Family impact	Participants described their early messages within their own family systems that established their body image narrative and how they are actively working to dismantle negative body image messages.
	Intuitive eating	Participants reported increased awareness and understanding of responding to hunger and fullness cues appropriately.
	Weight change	Participants reflected on having a greater sense of awareness regarding their own body shape and managing weight fluctuations.

Theme 1: Seeking Congruence

Body Image of Counselors and Body Acceptance. All participants interviewed in the study reported experiencing some aspect of body image dissatisfaction in their lives. Counselors reflected that while working with clients with body image concerns, they experienced acceptance and a greater sense of awareness about their personal image. Trina reflected,

> I think, being a human being in society, it would be very difficult to not be bit by the body image bug, to be honest with you. So, for me, I just try to stay aware. I focus a lot of my energy and healing toward how my body feels, what it does for me.

Jasmine spoke about her journey with body image and her current place of acceptance, saying,

> I just want to come to some peace with it. I think that where I'm at right now is more acceptance around it. I think my belief around it now is that my body is

> going to be where it needs to be. …I believe that more wholeheartedly now because it's been about the same shape, size for the past [decades]. I've emphasized or kind of built in my belief system [that body image is] going to fit where it needs to land, and that's kind of where I am.

Similarly, Lila shared,

> I have my own history with disordered eating…and body image concerns. It's hard. …Some days are better than others. I'm at a place now where I'm learning to accept my body and appreciate it for what it is and listen to my own internal cues, practice intuitive eating, all those things.

Increased Empathy. The theme of empathy for their clients emerged from the participants' experiences. Counselors reported finding some sense of empathy for what their clients go through due to their personal experiences and understanding of body image struggles. Megan stated,

> I think it has…reinforced very strongly the power of having a positive relationship with your body. Those were things that, once I learned about them, made sense to me, and I liked and started to include in just in my own life. But the more I talk about it and then the more that I see it [in] work for my clients, it's just a continuous reinforcement of "this is a better way to approach health and body image" than what I grew up with. In general, I feel pretty good about my body image. I guess something that comes up for me when working with clients who have a lot of body hatred is…a lot of empathy, but also almost some sadness of knowing that it's kind of easy for me to feel good in my body and it's so hard for them.

Trina said that being an athlete enabled her to empathize with athletic clients. She expressed, “I grew up as an athlete where body image was at the forefront or…was placed at the forefront of our minds…having our body fat percentage taken and shamed and so on.”

Self-Compassion. Counselors discussed on practicing self-compassion consistently as they navigated their body image concerns. Megan reflected on how she practices self-compassion:

> I feel I’m pretty content with my body now. I’m definitely spending as much time talking about body positivity or even just body neutrality and taking care of your body inside and out. I think talking about that so constantly is a wonderful reminder of how to treat myself and how to approach my own body image. For the most part, I would say my body image is pretty positive. [It] helped me to just treat my body better and be kinder to my body. Just because I appreciated what my body was allowing me to do, I could dance. I could jump. I could run.

Lila discussed expressing gratitude for her body, stating,

> In recent years, I’ve recognize[d] that I need to just thank my body for providing what it does for me, and keeping me safe, and keeping me healthy, and all those things. [The sessions are] definitely focused on [client’s] work, but I think [it’s important to]…offer them compassion, so they have compassion for themselves. We can model that for [ourselves] as well.

Rose reported,

> I have to be a little gentler to myself, and I have to remind myself that it’s okay to— You know, whatever I look like, that’s fine, that I’m more than that. So

> that's a skill. Most days, I'm pretty confident. …I have found that I'm much kinder in the way that I frame messages to myself.

Dolly shared a similar sentiment, as she is able to utilize self-compassion on negative body-image days:

> I get to a space where, on bad body-image days, I can handle it much better. Like, if I'm feeling really bloated 'cause I'm on my period or something, instead of being mean to myself or catastrophizing that my pants feel tighter, I have learned [to manage struggles] through Health at Every Size and working with my own clients on self-compassion.

Modeling for Clients

Working with clients with body image issues had an impact on the LPCs. Several participants reported that their overall body image had improved since they started working in the field. Outside sessions, counselors reflected on the importance of modeling and practicing what they instilled in clients. Hannah reflected on the importance of her mindset before entering a session. She said,

> If I'm not in a healthy mindset on a personal level, that definitely can reflect and impact the kind of work that I do with my clients. I think it's…helped remind me to be very, very intentional with how I talk with myself. Again, I tried to practice what I preached. I probably would say that as I've gotten more experience with this group, I think I really want to model or [consider] what…I was saying [to] the clients, as far as meeting yourself in that moment, just doing a lot of self-grace and compassion.

Trina spoke about the importance of staying aware of her body and mindset when she stated, “I love [awareness]. It keeps me on my toes. I have to practice what I’m preaching, you know. So I’m aware.” Raleyn expressed a similar idea about the importance of awareness, saying, “I would say it’s definitely made me a lot more aware and, in general, has pushed me so much harder to…come to a place of acceptance with myself and really practice what I preach.” Jasmin said that clients assess her as soon as she shows up:

> [I need to consider] how I’m showing up in the room. …As they’re talking about these things, I [recognize how I’m] position[ing] intuitive eating and being mindful and treating your body with respect. Although those are…healthy principles, [it] can come off to clients as, “That’s what I’m supposed to do. That’s the right thing to do, and I’m doing it wrong,” or “I don’t care that much if I’m not doing it this way,” and so I recognize that sometimes the language [has a negative effect].

Dolly discussed how her beliefs about body image could directly impact the therapeutic alliance. She shared,

> If didn’t feel super great in my body, and I think if I hadn’t been able to get to a place where I feel comfortable—you know, eating a variety of foods and exercising in a way that feels comfortable to me and just moving on from my day when I am having a bad body image day—I think it would be much more difficult to [do this work]. I really endorse that belief to clients. I think it would be hard to not be living [like] that and still trying to say, “This is the way you should be doing it.”

Theme 2: Lack of Formal Training

Participants reflected on the importance of training and consultation around body image. The participants attributed being affected by the field to the lack of formal training and relying on peers and past work experiences. Because of this impact and increased awareness, they each reported a desire for a place to openly address and discuss these issues. The overall comments focused on the necessity of supervision and training to address body image counseling's impact, countertransference, transference, and triggers. Participants also expressed a desire for open discussions around their own body image.

Health at Every Size. Participants used the Health at Every Size (HAES) philosophy to guide their psychoeducation around body image. They used HAES as a standard for how they practiced and referred clients to other clinicians. Megan elaborated,

> Concepts like intuitive eating or Health at Every Size…say that your body size is not a predictor of how healthy or unhealthy you are, and you are capable of being healthy and more or less anybody's size, extremes aside. But then, at the same time, [using the] Health at Every Size approach, I'm not going to tell somebody that they need to change their body aside from changing behaviors that are going to be harmful to their bodies.

Raleyn used a similar approach. She shared,

> I didn't even really know that I believe[d] this until working at an eating disorder treatment center, but [now] I definitely believe in Health at Every Size. Basically, somebody's body size, their weight, the type of body that they have does not determine health. Diet culture very much typically aligns with, "Oh, if somebody

> is in a smaller body, then they're automatically healthy, and if somebody is in a larger body, then they're automatically unhealthy," where the research behind Health at Every Size really disproves that.

Peer Education. All of the participants noted the need for education. Although a few recalled some experiences during intern and job sites, these experiences did not fulfill the counselors' required education around body image. Lila noted,

> I don't think I teach body image or anything around weight or disordered eating in a way that is actually helpful. I think I don't do a good job of training. Future counselors or counselor education students [need] to recognize those concerns because, in my experience, they're there, but they're just not what presents on the surface a lot of times, or at least clients don't say it again because of a lot of that internalized shame or stigma.

Peace said she "didn't get any formal training about body image issues. Any types of dysmorphia, really. I don't know what the training [should] look like, but I feel like there need[s] to be [some]."

Because of this impact and increased awareness, each participant wanted a place to address and discuss these issues openly. Trina expressed needing a space for "trainings, whether in-person conferences, online trainings. questionnaires—not just body image and eating disorders, really, like, across the board. …Platforms where I can check in." Dolly stated, "I think that it would be helpful if therapists had more training on…how to have those hard conversations about their own body in relation to the room and who's in the room, and how that shows up for action."

Raelyn and Rose supported the need for counselors to have a safe space to process internal body image concerns, similar to any other mental health condition a counselor might struggle with. Raelyn reflected, “I don’t think that I’ve ever seen… I’m not familiar with any continuing education on our body image. It’s more like how to work with body image and things like that.” Rose wanted to be “able to talk about it without feeling like I’m a bad therapist because…I think that there is this really unhealthy narrative.”

The participants also recognized the potential harm clients could encounter in therapeutic settings if counselors were not adequately trained for body image concerns. Jasmine stated,

> I wish that there were more trainings on experiential work or process work…techniques to do with this group. I hope people know the techniques, [although] I don’t think that’s what I’m looking for. I’m looking for the process part, like, how can I incorporate ourselves into the therapeutic process in a constructive [manner]…and not just spew out some of this stuff accidentally without any awareness with clients who are struggling.”

Megan spoke about the potential for client harm when therapists have inadequate training around body image. She suggested,

> Talking about your relationship to yourself a little bit more globally rather than just focusing on appearance for just your average counselor would probably be really helpful. I have found that a lot of therapists outside of the eating disorder world take a very surface-level approach to body image. …They tend to talk to their clients about, “Oh, you know, if you feel bad about your body— Do you

> want to go on a diet, or do you want to start exercising, or do you want to put more of an emphasis on changing your body?" Because they think that, culturally, that's how the average American views body image, like, if you have a negative body image, you should exercise and change your body so you like it more. And I know that that can actually be a very harmful approach for a lot of people. Maybe not everybody, but for a lot of people, it's really harmful.

Like Megan and Jasmine, Dolly also emphasized the potential consequences of a lack of training and understanding. She shared,

> I've [had] many clients tell me that they had a previous therapist who was not a specialist to…attempt to be helpful to them. [The therapist] ultimately ended up suggesting that they go on a diet or track their food in a journal. While that is probably from a helpful place, you and I and specialists know that that's really not something I would recommend.

The following subthemes indicate the need for therapists to be aware of their thoughts and beliefs before going into a session and the potential impacts on clients, especially around body image.

Self-Disclosure. Participants remarked that their appearance is not a secret; thus, they should acknowledge their body with the client and use it as a tool. The counselors reflected on discussing their bodies in sessions as a way to acknowledge and recognize differences in their clients' experiences and lifestyles. Megan shared,

> I'm somebody in a smaller body, and if I'm working with a client who's in a larger body, I want to make sure that the difference in our life experiences is being acknowledged and discussed. I really make an effort to not just assume that

> I know what life is like for somebody else in their body, I guess just in general, but particularly when their body is pretty different from mine. Sometimes I will pull on personal experiences to discuss or reflect back with clients, particularly if I're problem-solving [and coming up with] things for them to be doing differently.

Dolly shared a similar idea:

> [With] those who've struggled maybe with binge-eating disorder or [who] are in larger bodies, I've tried to have pretty open conversations about how they perceive my body and if that's affecting our relationship or their viewpoints. I've always found those conversations to be really helpful in their relationship so that there's not kind of this…elephant in the room, so to speak. Like, "Oh well. I'm in a smaller body than them, and I'm here to talk to them about binge eating."

Lila reported discussing her body size as a tool for a positive therapeutic alliance. She said,

> I'm a fat therapist, like, who's going to come to me for body image? But the truth is I have a lot of clients who seek me out because I am a fat, that friendly therapist. …Most clients have given me the feedback [that] they like working with a fat-positive therapist who is in a larger body size herself. It kind of reduces that stigma.

Lila continued,

> I've definitely noticed that some clients are cautious to bring up body image stuff first until I can normalize and be…a woman in a larger body. You know, "These are some messages I'm familiar with. What are you familiar with?" …I have

> noticed sometimes clients are very, like, "Is this okay to talk about?" Almost like they're worried about me and how I will respond if they bring up body image, even [for] clients who are thinner than me.

Theme 3: Counselors' Self-Awareness

The third theme relates to the counselors' self-awareness in working with body image versus the impact on their clients. This theme focused on how the counselors noticed themselves outside of session as they navigated their personal body image narratives and beliefs.

Social Influence. Participants reflected on their awareness of social influences growing up in Western culture and acknowledged having to address and challenge their views of body image from a cultural/societal perspective. Megan noted,

> I think I have a somewhat typical relationship with my body for a young American woman, which is just feeling like no matter how I look, it's never quite good enough, and there's always something I could be doing differently to make it look better.

Raelyn reported being

> Very influenced by media, which I know it's even way worse now than it was when I was a teenager. And even just like…things being passed down, generation to generation, or like clothing. When I was a teenager, Abercrombie & Fitch was the place to go and, yeah, that was a lot of pressure.

Jasmine addressed the "belief system of 'thin equals beautiful' or 'thin equals good,' and then exercise…that's what you do to maintain [a healthy weight]. I think that

held for pretty much middle school to high school." Dolly presented a similar perspective of sociocultural standards, noting,

> I think [adolescence is] when I did start to buy into some of the diet culture beliefs, and I thought, "Oh, I need to eat healthier in order to be healthy and look better, and I need to be working out a certain amount." …Culturally…the messages I was getting from TV and magazines…[and] being a dancer, the people that I was around— We're also in that same mindset, like, "Oh, I've got to eat healthy so that [I] will look good."

Family Impact. The participants' earliest messages about body image came from their family systems. They discussed having to actively work to dismantle negative body image narratives from family members. Rose reported,

> My mother was very much image-based. She was very focused on [body image], and she definitely passed that on to my sister and [me]. I started taking diet pills at 7 years old because, you know, I needed to be small. I didn't stay on them consistently, but I took them off and on until I was like 20; [it was] not good for my heart. I heard her constantly talking about how big she was, how fat she was, how ugly she was—all of these things. And then, when I would eat very little, I would get praised. "Oh my gosh, I wish I could eat like that. Look at her. She's so this or [the] other." I got a lot of attention and a lot of praise for being very small.

Megan recalled,

> When I was younger, growing up, I definitely just—both from the media and my own parents—picked up the idea that the sooner, the better. Like, the thinner you are, the better it is. The more attractive you are and, to a lesser degree, the

> healthier you are, [the better]. But, again, health never factored very much into my teenage quest for thinness.

Lila shared, “Very often, women in my family of origin would make comments about their own bodies or other women’s bodies, associating being in a larger body as being undesirable or not good enough or unworthy in some way.”

Intuitive Eating. Participants reported that working with clients gave them an increased awareness and understanding of responding to hunger and fullness cues appropriately. Jasmine recalled,

> I think [working in a treatment center for eating disorders] helped me recognize different facets of what it means to be mindful or intuitive, and then I think that just propelled [me] into more thinking about it. I would say my relationship with food now is the healthiest it’s ever been.

Lila shared a similar perspective of intuitive eating, saying, “It’s been very helpful, of course, for clients, but also for myself, really understanding my hunger cues but also what triggers me when I want to eat certain foods and why.” Megan said that working with clients with EDs led her to

> Mak[e] an effort to eat more regularly… That’s something that I really encourage working with body image and eating disorder clients. [I tell them], “Make sure that you’re eating three meals and a couple of snacks per day.” Having worked on that professionally makes me more aware of making an effort to get up early enough to eat breakfast or make sure I’m reserving time in the afternoon for a snack or something like that.

Hannah changed her perspective after working with clients who struggle with body image concerns. She reported

> Eating when I feel comfortable eating and not shaming myself for whatever that might look like. So that is a little bit of what that looks like for me in high school. I was definitely more so counting calories and whatnot. And now I don't have any restrictions, I guess, when it comes to food.

Weight Changes. Participants reported having a greater sense of awareness about their body shapes. They managed weight fluctuations positively, not using a scale or a number to identify changes. Lila stated, "If anything, I just think I have a better relationship with my body: taking care of it, working out, eating healthier. But I notice I also don't weigh myself, which is something I recommend for clients as well." Addie shared,

> A lot of times, I get so fixated on the scale that it becomes an unhealthy obsession. [I] typically don't weigh myself and don't pay attention to how much I weigh or how it fluctuates and that kind of thing. I go based on where and how my body feels. …I also noticed more of how my clothes fit while [I'm] getting dressed in the morning.

Similarly, Raleyn said, "I do know that since working with this group [of clients], I don't weigh myself, so I will say that's the biggest change…I can see." Trina noted being "able to reconnect with myself and get back to [not] weigh[ing] myself. I don't have a scale. I don't do that. I just go by how I feel in my body."

Summary

Chapter IV included information from the participants' demographic screener and their responses to the open-ended question on the prescreening document. I presented the three superordinate themes and 12 subordinate themes that emerged from the interviews with 11 professional counselors. The themes and subthemes were as follows:

1. Seeking congruence
    a. Body image of counselors
    b. Body acceptance
    c. Increased empathy
    d. Self-compassion
    e. Modeling for clients
2. Lack of formal training
    a. HAES
    b. Peer education
    c. Self-disclosure
3. Counselor's self-awareness
    a. Social influence
    b. Family impact
    c. Intuitive eating
    d. Weight changes

I gave descriptors to support each theme and provided a synthesis of the participants' interview responses.

Chapter V will be a summary of the study, including a discussion of the findings, limitations, and recommendations for future research. I present the implications and recommendations for professional counselors and counseling students to apply in their

practice, including effectively incorporating body image interventions. There are specific interventions and approaches for training, counselor education, and supervision.

CHAPTER V

Discussion

The purpose of this transcendental phenomenological study was to explore the lived experiences of professional counselors who had concerns about their body images and work with clients with body image concerns in a clinical setting to better understand the impacts of LPCs' body image on clients. Eleven counselors engaged in semistructured interviews to share their experiences and insights into the phenomenon, with the transcripts subsequently analyzed using Moustakas's (1994) modified van Kaam (1959, 1966) approach. Chapter V presents a summary of the study; the theoretical framework analysis, including its application to the phenomenon; the research findings; implications for future research; recommendations for counselor education, supervision, and training; and a conclusion.

Summary of the Study

A transcendental phenomenological approach was appropriate to understand the experiences of counselors who reported concerns with their body image and working with clients with body image concerns in clinical practice. The findings indicate strategies to reduce counselor discomfort when integrating issues of body image concerns into clinical practice. Potential participants completed prescreening questionnaires to ensure they met the criteria to participate. Eleven LPCs comprised the sample and took part in semistructured interviews via Zoom, a HIPAA-compliant platform.

Bracketing was necessary during data collection and analysis to eliminate researcher bias and ensure accuracy. Because I fit the participation criteria and have experience related to the phenomenon, I first asked myself the same questions the

participants would hear. I journaled before, during, and after each interview. In the first interview, I had to consciously use phrases such as “Thank you for sharing” not to redirect the interview into a counseling session that would lead to a process. After each interview, I debriefed the participants for 5 to 20 minutes, discussing later steps and providing resources if asked. I also engaged in nonverbal affirmations, such as nodding and smiling in agreement. After data collection, I journaled throughout the analysis and interpretation. Member checking and peer debriefing were additional ways to decrease researcher bias. After all interviews, two LPCs not in the study coded the data using Moustakas’s (1994) modified van Kaam (1959, 1966) analysis process. The use of a coding team was another form of bracketing. Creswell and Poth’s (2018) and Moustakas’s (1994) recommendations were the foundations for the data collection and organization processes.

Three themes and 11 subthemes emerged from data analysis, each supported by eight to 11 participants. The first theme was seeking congruence, which had five subthemes: body image of counselors, body acceptance, increased empathy, self-compassion, and modeling for clients. The second theme, lack of formal training, included the subthemes of HAES, peer education, and self-disclosure. Four subthemes supported the third theme, counselor self-awareness: social influence, family impact, intuitive eating, and weight changes.

Theoretical Framework

Feminist Theory

According to feminist psychodynamic theory, internalizing culture is part of developing individual perspectives on body image. Psychoanalytic theories do not

account for culture and play a minimal role in individuals' development (Bloom et al., 1994). Consumer and public culture have conscious and subconscious effects on the social symbols representing the thin female ideal, EDs, and DE.

Overt and covert messages from Western society present thinness as the key to happiness and success. The media stigmatize obesity as ugliness and failure (Striegel-Moore & Smolak, 2001). Feminist theory helps individuals of all genders explore the individuality and interconnectedness of their ethnicity, culture, gender, and race. Social connections, media, cultural norms, and gender roles impact individuals' self-esteem, social-emotional health, and awareness. There are implications from the relationship between thinness and beauty standards promoted worldwide (Dorian & Garfinkel, 1999; Groesz et al., 2002). The use of psychoeducation could increase awareness of the disparities of unrealistic ideals, promote body positivity and appreciation, and celebrate individual and cultural differences (Kinser, 2004; Snyder, 2008; Tong & Botts, 2009).

The counselors in this study universally identified thinness as a message they received in childhood and their developmental years. They found the thinness message promoted through standards and idealizations of beauty within their culture and different forms of media, social interactions, and familial pressures. One participant discussed growing up with marketing that stressed thinness, saying,

> I was very influenced by media, which I know is even way worse now than it was when I was a teenager. I remember Abercrombie & [Fitch] had shirtless models walking 'round in the store and blatantly showed if you did not look like that, you were not welcomed or supposed to shop in the store. That was a lot of pressure.

Objectification Theory

Self-Objectification and Appearance-Culture. Diet culture and altered appearances to meet Westernized beauty standards and ideals have led to body image concerns and legislation proposals in several countries (Agrell, 2008; Carey et al., 2011). (Revise for clarity about legislation) Thoughts of shame and guilt and hyperawareness of their appearance impact women's health, leading to EDs, DE, and altered body images. Fuller-Tyszkiewicz et al. (2012) researched factors, such as direct positive comments, that could counteract or repress the harmful effects of self-objectification and reduce its impact on individuals' mental health. The objectification and sexualization of thin women become the objectification and sexualization of all women (Holland & Haslam, 2013).

Counselors familiar with HAES reported that body size did not correlate with health, which significantly differed from their past beliefs. From a clinical standpoint, the participants addressed that individuals' BMI and body size did not directly correlate to their health. A HAES provider, Raelyn said,

> The type of body that they have does not determine health, so diet culture very much typically aligns with if somebody is in a smaller body, then they're automatically healthy, and if somebody is in a larger body, then they're automatically unhealthy, where the research behind health at every size really disapproves that.

All 11 counselors interviewed had received covert and overt messages about their bodies from friends, family, and media throughout their lives, including before working

with clients with body image concerns. These messages led to increased empathy and understanding as the LPCs helped clients navigate their body image concerns.

Discussion of Findings

The themes that arose out of this study led to three key findings: (a) working with clients who struggle with body image concerns affects counselors' body image awareness, (b) working with clients who struggle with body image increases counselors' positive body image, and (c) education and supervision are needed to address body image when working with clients with body image concerns.

Thompson et al. (1999) identified body image as how individuals perceive their looks, believe others view them, and feel about their appearance. Hutchinson (1994) defined body image as the self-image individuals use to regulate their emotions, appetite, health needs, and internal dialogue about their appearance. Comparatively, Slade (1988) focused more on the pictorial representations a person creates or envisions and the emotions attached to those representations. Expanding on Slade's definition, Grogan (2008) suggested that body image comprised perceptual factors and attitudes and compromised individuals' perceptual factors and attitudes. Grogan's definition was pertinent to this study, which showed that greater body image awareness allows counselors to address and challenge negative views in session.

- Examining the therapeutic alliance between clients and counselors with personal experiences with body image concerns was vital to understanding how the counselor selects and applies modalities and techniques within the therapeutic process.
- Counselor preparation must address EDs and the continuum of acuity.

- Exposing counselors-in-training to material regarding EDs, DE, and body image concerns could prevent later harm by counselors unprepared to address such issues with clients in a therapeutic setting.

Counselors who work with body image concerns see a wide variety of body shapes, from those considered medically underweight to those perceived as medically obese. Working with clients with vastly different body types could lead counselors to question their beliefs, perceptions, and attitudes about their own body image. This idea emerged in the interviews as participants discussed noticing clients' weights and heights and making comparisons to themselves. Rose shared that if a client expressed feeling "gross, inadequate, or ugly and they were a similar shape as me, I would have to consciously bracket and process that later." Similarly, other participants stated that if a client with a smaller body than them expressed a strongly negative body image, they would question how the client felt about them.

One experience shared by all participants was a sense of empathy and understanding for the struggles that clients with body image concerns endure. This perception led to overall increased positivity and understanding of the counselors' own body image. DeLucia-Waack (1999) emphasized the importance of therapists being comfortable with their bodies when working with clients with body image concerns. In their interviews, Megan and Dolly reflected this idea, saying they need to model positive body image at work. Dolly endorsed neutral body image, stating, "I think it would be hard to not be living that and still trying to say, 'This is the way you should be doing it.'"

Ten of the eleven participants reported improving their body image while advocating for and empathizing with clients with body image concerns. In working with

clients and challenging their beliefs around body image, diet culture, and media, the LPCs processed the cultural and social perspectives that dictated views of women's bodies. This phenomenon showed that as counselors reflected on the oppressive societal attitudes around body image, they gained a greater sense of awareness around ways to address their body image more neutrally or positively. For example, Dolly discussed hard body image days, saying,

> I no longer feel the need to be mean to myself or catastrophizing that, like, my pants feel tighter. I have learned, through Health at Every Size and working with my own clients on self-compassion, how to talk to myself and get myself into a better mindset on those days.

Counselors' feelings about food and weight can directly affect the clients' therapeutic process (DeLucia-Waack, 1999). Counselor supervision is vital to address beliefs around body image and prevent therapists' struggles with body image from affecting client treatment. DeLucia-Waack (1999) suggested that if therapists do not have a healthy body image, they could unintentionally validate clients' DE beliefs. In this study, Lila expressed, "I just think I have a better relationship with my body: taking care of it, working out. …[I'm] eating healthier, but I notice I also don't weigh myself, which is something I also recommend for clients." Similarly, Trina shared, "I don't weigh myself. I don't have a scale. I don't do that. I just go by how I feel in my body." Some of Megan's clients told her about their previous therapists working on goals to lose weight or eat fewer calories without addressing the intent, putting them in a potentially harmful situation.

Counselors must acknowledge their clients' bodies as well as their own when working with clients with body image concerns (Lowell & Meader, 2005). At the time of Lowell and Meader's (2005) study, there had been little research on this topic, a gap that remains almost 2 decades later. Koenig (2008) emphasized the need for openness to address clients' assumptions about the therapist's weight, shape, and size. Seven of the 11 participants said they had openly discussed their body image with clients. Megan said she would bring up "thin privilege" and discuss how her experiences could be different from her larger-bodied clients. Lila defined herself as fat and reflected on how being a therapist in a larger body could be difficult. She recalled,

> When they see your weight, …they're always like, "Oh, you're obese." It's moments like that when you're kind of triggered, or you get a lot of messages, or people bring…obesity and BMI. It's hard not to get stuck back. It's kind of like that cognitive dissonance of I know it for myself, but sometimes there is a little part of me that subscribes to the belief that being thinner would be equated to help here, if that makes sense.

Jasmine said some of her longer-term clients would notice her body changes and ask about her health. In those cases, she would address their questions before redirecting the discussion to the client. This study showed that disclosure was a common way to create a therapeutic alliance with clients with body image concerns. DNW talked about using her body image struggles to build rapport with a client who shared a chronic illness diagnosis requiring medication with weight gain as a side effect.

All 11 counselors reflected on the need for supervision when working with clients with body image concerns. Many participants' graduate studies did not address body

image. The counselors trained in higher levels of ED care said that despite their consistent work with clients struggling with body image, they had no opportunity to process their own body image. Rose said, "When working with clients who express thoughts of depression, anxiety, self-harm, or SI, I are expected to process our thoughts. But the fact our clients are struggling with body image— We aren't given or asked about the space." Megan suggested that allowing early-career counselors to process their beliefs about their bodies could lead to increased awareness. She said,

> If grad schools were going to do one thing differently, it would be [to] include some talk about body image and how it has not very much to do with how you look, but a lot to do with just how comfortable or uncomfortable you are with the way your body is shaped.

Receiving supervision around their own body image concerns will allow counselors to effect positive change in their clients. By having a safe space to process their body image, counselors can create an atmosphere to do the same for their clients.

Implications for Clinicians, Counselor Educators, and Supervisors

The themes and findings emerging from the semistructured interviews and data analysis have implications for direct therapeutic work for clinicians, counselor educators, and supervisors. The clinical implications indicated the harm that not directly working on body image concerns could have on clients. Many participants reported that body image was not an area discussed or covered during their graduate program or supervision, especially their own body image.

This study showed that counselors' avoidance or reluctance to address their body image could disrupt the therapeutic process. Because body image is a significant

component of ED and DE treatment, not addressing it could limit or block treatment progression. Supervision could benefit counselors by allowing them to learn more about processing their body image and working with clients on this issue.

Lack of training, continuing education, and supervision in working with the body image of both counselor and client emerged as areas of needed clinical improvement. Body image issues can co-occur with EDs or DE. Supervisors could help clinicians determine appropriate disclosure and offer support if relationship ruptures occur.

Through supervision and consultation, clinicians could have personal growth surrounding their body image, opening a space for clients to learn and grow as well. Additionally, supervision and consultation could provide further resources for supporting clients with body image concerns. As one of the participants mentioned, growth and more resources could help create a greater sense of counselor awareness when treating clients.

The need for counselor growth, space, supervision, and consultation for the clinician emerged in the interviews. Nine of the eleven participants talked about their body image in sessions, yet still struggled to determine if it was appropriate to disclose. Four participants addressed body image changes they had observed in themselves over time due to life changes. They also discussed the strain of determining how to address these changes within session. These barriers could pose harm to clients.

Limitations

This study had several limitations. The main limitation was the lack of prior research on body image interventions and effective practices not just focused on EDs and DE. Having various resources and data points could help strengthen counselors' and researchers' insight and understanding of this phenomenon (Peoples, 2020). This study

was limited to data from the demographic questionnaire and semistructured interviews with eleven counselors. Additional data points could have provided different themes for future research.

Although I promoted the study through multiple platforms to obtain a national sample, all selected participants were in Texas and spoke English. Due to geographic similarities, the findings might not generalize to other regions or cultures. Further research into other regions and cultures could indicate whether the themes are generalizable.

The studied phenomenon is personal and could be challenging to express or limit within the therapeutic setting, creating vulnerability between clinician and client. Thus, the participants could have had response bias during the interviews. Additionally, the community of body image counselors is small, which could have limited my ability to hide identities. Knowing the size of the community, I did not ask demographic questions to help protect confidentiality when giving information to the coding team.

The participants engaged in a single interview; thus, their responses were limited to their current perspectives. Without a follow-up interview, I could not explore their changes through discovery, awareness, or education. Finally, my relationship with the participants could have been a limitation. I had previous involvement with most participants due to my role in the community of EDs, DE, and body image counselors. Although the semistructured interview questions allowed participants to provide detailed and personal responses, they could have perceived the queries as challenging based on our shared experiences.

Recommendations for Future Research

The findings of this study indicated several key areas of future research. There had been limited research on body image related to clinicians' own body image and how it impacts the therapeutic process. This study was a means to address the literature gap, identify themes to address, and create opportunities for further research. One suggestion would be to conduct a mixed methods study, Body Image Questionnaire (BIQ) Scale which evaluates an individual's body image allowing for further investigation through analysis to supplement self-reporting.

Follow-up research with this study's participants would be an opportunity to determine if they made any changes due to increased awareness of this phenomenon. Potential changes could include seeking supervision, additional training, or certifications or discussing their body more often in their work. Further research into counselors' physical attributes and the impact on their work with clients with body image issues could produce additional themes and insight. A close assessment of different body types and how they change the work or relationship between counselor and client could indicate beneficial approaches to working with clients with body image concerns.

Conclusion

This transcendental phenomenological study was an exploration of the lived experiences of professional counselors working with clients with body image concerns. The participants used various methods and processes to gain experience and competence when addressing body image concerns with clients. The 11 counselors discussed how their personal and professional experiences motivated and shaped their awareness, biases, and perceptions of their body image. The findings of this study indicated several

implications for counselors and the counseling profession. Counselors who reported success working with clients with body image concerns had a space to address barriers, both past and present.

Recommendations based on the themes identified in the study were for counseling and training programs to address the counselor's and the client's body image within a therapeutic setting. The findings showed that educational and clinical programs should create a better understanding of body image concerns through discussions, attitude assessments, case scenarios, and experiential activities. These teaching additions would benefit counselors, supervisors, counselor educators, and clients.

REFERENCES

22 Tex. Admin. Code § 681.2 (18) (2022)

Ackard, D. M., Croll, J. K., & Kearney-Cooke, A. (2002). Dieting frequency among college females: Association with disordered eating, body image, and related psychological problems. *Journal of Psychosomatic Research, 52*(3), 129–136. https://doi.org/10.1016/s0022-3999(01)00269-0

Agrell, S. (2008). Thin police. *Canadian Medical Association Journal*, *179*(2), Article 204. https://doi.org/10.1503/cmaj.080894

Akan, G. E., & Grilo, C. M. (1995). Sociocultural influences on eating attitudes and behaviors, body image and psychological functioning: A comparison of African-American, Asian-American and Caucasian college women. *International Journal of Eating Disorders, 18*(2), 181–187. https://doi.org/10.1002/1098-108X(199509)18:2%3C181::AID-EAT2260180211%3E3.0.CO;2-M

Alberga, A. S., Edache, I. Y., Forhan, M., & Russell-Mayhew, S. (2019). Weight bias and health care utilization: A scoping review. *Primary Health Care Research & Development, 20*, Article E116. https://doi.org/10.1017/S1463423619000227

Allen, J., Gervais, S. J., & Smith, J. L. (2013). Sit big to eat big: The interaction of body posture and body concern on restrained eating. *Psychology of Women Quarterly, 37*(3), 325–336. https://doi.org/10.1177/0361684313476477

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.).

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Ayala, G. X., Mickens, L., Galindo, P., & Elder, J. P. (2007). Acculturation and body image perception among Latino youth. *Ethnicity and Health*, *12*(1), 21–41. https://doi.org/10.1080/13557850600824294

Barbarich, N. C. (2002). Lifetime prevalence of eating disorders among professionals in the field. *Eating Disorders*, *10*(4), 305–312. https://doi.org/10.1080/10640260214505

Bardone-Cone, A. M., Fitzsimmons-Craft, E. E., Harney, M. B., Maldonado, C. R., Lawson, M. A., Smith, R., & Robinson, D. P. (2012). The inter-relationships between vegetarianism and eating disorders among females. *Journal of the Academy of Nutrition and Dietetics*, *112*(8), 1247–1252. https://doi.org/10.1016/j.jand.2012.05.007

Becker, A. E. (2003). Eating disorders and social transition. *Primary Psychiatry*, *10*(6), 75–79.s

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review*, *88*(4), 354–364. https://doi.org/10.1037/0033-295X.88.4.354

Berg, M. (2008). Experiential knowledge. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 322–323). SAGE Publications.

Berry, J. W., Trimble, J. E., & Olmedo, E. L. (1986). Assessment of acculturation. In W. J. Lonner & J. W. Berry (Eds.), *Field methods in cross-cultural research* (pp. 291–324). SAGE Publications.

Bessenoff, G. R., & Snow, D. (2006). Absorbing society's influence: Body image self-discrepancy and internalized shame. Sex Roles: *A Journal of Research*, *54*(9–10), 727–731. https://doi.org/10.1007/s11199-006-9038-7

Bloom, C. (2002). Cultural countertransference. *Psychoanalysis & Psychotherapy*, *19*(1), 41–57.

Bloom, C., Gitter, A., Gutwill, S., Kogel, L., & Zaphiropoulos, L. (1994). *Eating problems: A feminist psychoanalytic treatment model*. Basic Books.

Bloomgarden, A., Gerstein, F., & Moss, C. (2003). The last word: A recovered enough therapist. *Eating Disorders*, *11*(2), 163–167. https://doi.org/10.1080/10640260390199370

Bruch, H. (1962). Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic Medicine*, *24*(2), 187–194.

Burka, J. B. (1996). The therapist's body in reality and fantasy: A perspective from an overweight therapist. In B. Gerson (Ed.), *The therapist as a person: Life crises, life choices, life experiences, and their effects on treatment.* (pp. 255–275). Analytic Press.

Calogero, R. M., & Pina, A. (2011). Body guilt: Preliminary evidence for a further subjective experience of self-objectification. *Psychology of Women Quarterly*, *35*(3), 428–440. https://doi.org/10.1177/0361684311408564

Carey, R. N., Donaghue, N., & Broderick, P. (2011). What you look like is such a big factor: Girls' own reflections about the appearance-culture in an all-girls' school. *Feminism & Psychology*, *21*(3), 299–316. https://doi.org/10.1177/0959353510369893

Cash, T. F. (2004). Body image: Past, present, and future. *Body Image*, *1*(1), 1–5. https://doi.org/10.1016/S1740-1445(03)00011-1

Cash, T. F., & Henry, P. E. (1995). Women's body images: The results of a national survey in the USA. *Sex Roles*, *33*(1), 19–28. https://doi.org/10.1007/BF01547933

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

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

Cash, T. F., & Smolak, L. (Eds.). (2011). *Body image: A handbook of science, practice, and prevention*. Guilford Press.

Cash, T. F., Melnyk, S. E., & Hrabosky, J. I. (2004). The assessment of body image investment: An extensive revision of the Appearance Schemas Inventory. *International Journal of Eating Disorders*, *35*(3), 305–316. https://doi.org/10.1002/eat.10264

Cash, T. F., Winstead, B. A., & Janda, L. H. (1986). Body image survey report: The great American shape-up. *Psychology Today*, *20*(4), 30–44.

Cattarin, J. A., & Thompson, J. K. (1994). A three-year longitudinal study of body image, eating disturbance, and general psychological functioning in adolescent females. *Eating Disorders*, *2*(2), 114–125. https://doi.org/10.1080/10640269408249107

Choate, L. H. (2005). Toward a theoretical model of women's body image resilience. *Journal of Counseling & Development*, *83*(3), 320–330. https://doi.org/10.1002/j.1556-6678.2005.tb00350.x

Costin, C. (2009). The embodied therapist: Perspectives on treatment, personal growth, and supervision related to body image. In M. Maine, W. Davis, & J. Shure (Eds.), *Effective clinical practice in the treatment of eating disorders: The heart of the matter* (pp. 179–192). Routledge.

Costin, C., & Johnson, C. L. (2002). Been there, done that: Clinicians' use of personal recovery in the treatment of eating disorders. *Eating Disorders*, *10*(4), 293–303. https://doi.org/10.1080/10640260214506

Crago, M., Shisslak, C. M., & Estes, L. S. (1996). Eating disturbances among American minority groups: A review. *The International Journal of Eating Disorders*, *19*(3), 239–248. https://doi.org/10.1002/(SICI)1098-108X(199604)19:3<239::AID-EAT2>3.0.CO;2-N

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). SAGE Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). SAGE Publications.

Dalley, S. E., Buunk, A. P., & Umit, T. (2009). Female body dissatisfaction after exposure to overweight and thin media images: The role of body mass index and neuroticism. *Personality and Individual Differences*, *47*(1), 47–51. https://doi.org/10.1016/j.paid.2009.01.044

Daly, S. B. (2016). The intersubjective experience of the physical body in the clinical setting of eating disorders. *Clinical Social Work Journal*, *44*(1), 47–56. https://doi.org/10.1007/s10615-014-0475-4

Davis, C., & Katzman, M. A. (1999). Perfection as acculturation: Psychological correlates of eating problems in Chinese male and female students living in the United States. *International Journal of Eating Disorders*, *25*(1), 65–70. https://doi.org/10.1002/(SICI)1098-108X(199901)25:1<65::AID-EAT8>3.0.CO;2-W

Delinsky, S. S., & Wilson, G. T. (2008). Weight gain, dietary restraint, and disordered eating in the freshman year of college. *Eating Behaviors*, *9*(1), 82–90. https://doi.org/10.1016/j.eatbeh.2007.06.001

DeLucia-Waack, J. L. (1999). Supervision for counselors working with eating disorders groups: Countertransference issues related to body image, food, and weight. *Journal of Counseling & Development*, *77*(4), 379–388. https://doi.org/10.1002/j.1556-6676.1999.tb02463.x

Diedrichs, P. C., & Lee, C. (2011). Waif goodbye! Average-size female models promote positive body image and appeal to consumers. *Psychology and Health*, *26*, 1273–1291. https://doi.org/10.1080/08870446.2010.515308

Dittmar, H. (2008). *Consumer culture, identity and well-being: The search for the good life and the body perfect*. Psychology Press.

Dorian, B. J., & Garfinkel, P. (1999). The contributions of epidemiologic studies to the etiology and treatment of the eating disorders. *Psychiatric Annals*, *29*(4), 187–192. https://doi.org/10.3928/0048-5713-19990401-05

Engeln-Maddox, R., Salk, R. H., & Miller, S. A. (2012). Assessing women's negative commentary on their own bodies: A psychometric investigation of the Negative Body Talk Scale. *Psychology of Women Quarterly*, *36*(2), 162–178. https://doi.org/10.1177/0361684312441593

Epstein, L., & Feiner, A. H. (1988). Countertransference: The therapist's contribution to treatment. In B. Wolstein (Ed.), *Essential papers on countertransference* (pp. 282–303). New York University Press. (Original work published 1945)

Ezzy, D. (2002). *Researching health: Methodical traditions and innovations, second opinion*. Oxford University Press.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, *41*(5), 509–528. https://doi.org/10.1016/S0005-7967(02)00088-8

Fallon, P., Katzman, M. A., & Wooley, S. C. (Eds.). (1994). *Feminist perspectives on eating disorders*. The Guilford Press.

Feingold, A., & Mazzella, R. (1998). Gender differences in body image are increasing. *Psychological Science*, *9*(3), 190–195. https://doi.org/10.1111/1467-9280.00036

Fisher, S., & Cleveland, S. E. (1958). *Body image and personality*. Van Nostrand.

Franko, D. L., & Rolfe, S. (1996). Countertransference in the treatment of patients with eating disorders. *Psychiatry*, *59*(1), 108–117. https://doi.org/10.1080/00332747.1996.11024753

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

Frith, K., Shaw, P., & Cheng, H. (2005). The construction of beauty: A cross-cultural analysis of women's magazine advertising. *Journal of Communication*, *55*(1), 56–70. https://doi.org/10.1111/j.1460-2466.2005.tb02658.x

Fuller-Tyszkiewicz, M., Reynard, K., Skouteris, H., & McCabe, M. (2012). An examination of the contextual determinants of self-objectification. *Psychology of Women Quarterly*, *36*(1), 76–87. https://doi.org/10.1177/0361684311426721

Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology*, *57*(8), 983–991. https://doi.org/10.1002/jclp.1065

Garfinkel, P. E., Moldofsky, H., & Garner, D. M. (1980). The heterogeneity of anorexia nervosa: Bulimia as a distinct subgroup. *Archives of General Psychiatry*, *37*(9), 1036–1040. https://doi.org/10.1001/archpsyc.1980.01780220074008

Garner, D. M. (2004). *Eating Disorder Inventory-3 (EDI-3): Professional manual*. Psychological Assessment Resources.

Garner, D. M., & Garfinkel, P. E. (1985). *Handbook of psychotherapy for anorexia nervosa and bulimia*. Guilford Press.

Garner, D. M., Garfinkel, P. E., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. *Psychological Reports*, *47*(2), 483–491. https://doi.org/10.2466/pr0.1980.47.2.483

Gaudiani, J. L. (2018). *Sick enough: A guide to the medical complications of eating disorders*. Routledge.

Gilbert, S., & Thompson, J. K. (1996). Feminist explanations of the development of eating disorders: Common themes, research findings, and methodological issues. *Clinical Psychology: Science and Practice*, *3*(3), 183–202. https://doi.org/10.1111/j.1468-2850.1996.tb00070.x

Gleaves, D. H., Williamson, D. A., Eberenz, K. P., Sebastian, S. B., & Barker, S. E. (1995). Clarifying body-image disturbance: Analysis of a multidimensional model using structural modeling. *Journal of Personality Assessment*, *64*(3), 478–493. https://doi.org/10.1207/s15327752jpa6403_7

Greenberg, J. A., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Harvard University Press.

Groesz, L. M., Levine, M. P., & Murnen, S. K. (2002). The effect of experimental presentation of thin media images on body satisfaction: A meta-analytic review. *The International Journal of Eating Disorders*, *31*(1), 1–16. https://doi.org/10.1002/eat.10005

Grogan, S. (2008). *Body image: Understanding body dissatisfaction in men women and children*. Routledge.

Gutwill, S. (1994). Transference and countertransference issues: The impact of social pressures on body image and consciousness. In C. Bloom, A. Gitter, S. Gutwill, L. Kogel, L. & Zaphiropoulos (Eds.), *Eating problems: A feminist psychoanalytic treatment model*. Basic Books.

Haimovitz, D., Lansky, L. M., & O'Reilly, P. (1993). Fluctuations in body satisfaction across situations. *The International Journal of Eating Disorders*, *13*(1), 77–84. https://doi.org/10.1002/1098-108X(199301)13:1%3C77::AID-EAT2260130110%3E3.0.CO;2-N

Hamburg, P., & Herzog, D. (1990). Supervising the therapy of patients with eating disorders. *American Journal of Psychotherapy*, *44*(3), 369–380. https://doi.org/10.1176/appi.psychotherapy.1990.44.3.369

Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research*, *14*(1), 21–36. https://doi.org/10.1093/ptr/kph002

Hayes, J. A., Yeh, Y. J., & Eisenberg, A. (2007). Good grief and not-so-good grief: Countertransference in bereavement therapy. *Journal of Clinical Psychology*, *63*(4), 345–355. https://doi.org/10.1002/jclp.20353

Haynos, A. F., Watts, A. W., Loth, K. A., Pearson, C. M., & Neumark-Stzainer, D. (2016). Factors predicting an escalation of restrictive eating during adolescence. *Journal of Adolescent Health*, *59*(4), 391–396. https://doi.org/10.1016/j.jadohealth.2016.03.011

Haynos, A. F., Watts, A. W., Loth, K. A., Pearson, C. M., & Neumark-Stzainer, D. (2016). Factors predicting an escalation of restrictive eating during adolescence. *Journal of Adolescent Health*, *59*(4), 391–396. https://doi.org/10.1016/j.jadohealth.2016.03.011

Hayslip, B., Cooper, C. C., Dougherty, L. M., & Cook, D. B. (1997). Body image in adulthood: A projective approach. *Journal of Personality Assessment*, *68*(3), 628–649. https://doi.org/10.1207/s15327752jpa6803_10

Heyes, C. J. (2009). All cosmetic surgery is "ethnic": Asian eyelids, feminist indignation, and the politics of Whiteness (1st ed.). In C. J. Heyes & M. Jones (Eds.), *Cosmetic surgery: A feminist primer* (pp. 191–205). Routledge.

Holiday, R., & Elfving-Hwang, J. (2012). Gender and westernizing cosmetic surgery in Korea. *Body and Society*, *18*(2), 58–81.

Holland, E., & Haslam, N. (2013). Worth the weight: The objectification of overweight versus thin targets. *Psychology of Women Quarterly*, *37*(4), 462–468. https://doi.org/10.1177/0361684312474800

Hsu, L. G. (1990). *Eating disorders*. The Guilford Press.

Hutchinson, M. G. (1994). Imaging ourselves whole: A feminist approach to treating body image disturbance. In P. Fallon, M. A. Katzman, & S. C. Wooley (Eds.), *Feminist perspectives on eating disorders* (pp 152–168). Guilford Press.

Israeli, A. L., & Santor, D. A. (2000). Reviewing effective components of feminist therapy. *Counseling Psychology Quarterly*, *13*(3), 233–247. https://doi.org/10.1080/095150700300091820

Jacobs, J. M., & Nye, S. (2010). The therapist's appearance and recovery: Perspectives on treatment, supervision, and ethical implications. *Eating Disorders*, *18*(2), 165–175. https://doi.org/10.1080/10640260903585649

Johnston, C., Smethurst, N., & Gowers, S. (2005). Should people with a history of an eating disorder work as eating disorders therapists? *European Eating Disorders Review*, *13*(5), 301–310. https://doi.org/10.1002/erv.659

Joiner, G. W., & Kashubeck, S. (1996). Acculturation, body image, self-esteem, and eating-disorder symptomatology in adolescent Mexican American women. *Psychology of Women Quarterly*, *20*(3), 419–435. https://doi.org/10.1111/j.1471-6402.1996.tb00309.x

Kearney-Cooke, A., & Tieger, D. (2015). Development of eating disorders. In L. Smolak & M. P. Levine (Eds.), *The Wiley handbook of eating disorders: Basic concepts and foundational research* (pp. 285–296). John Wiley & Sons.

Killen, J. D., Taylor, C. B., Hayward, C., Haydel, K. F., Wilson, D. M., Hammer, L., Kraemer, H., Blair-Greiner, A., & Strachowski, D. (1996). Weight concerns influence the development of eating disorders: A 4-year prospective study. *Journal of Consulting and Clinical Psychology*, *64*(5), 936–940. https://doi.org/10.1037//0022-006x.64.5.936

Kinsbourne, M. (2002). The brain and body awareness. In T. F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research, and clinical practice* (pp. 22–29). Guilford Press.

Kinser, A. E. (2004). Negotiating spaces for/through third-wave feminism. *NWSA Journal*, *16*(3), 124–153. https://doi.org/10.1353/nwsa.2004.0075

Klopp, S. A., Heiss, C. J., & Smith, H. S. (2003). Self-reported vegetarianism may be a marker for college women at risk for disordered eating. *Journal of the American Dietetic Association*, *103*(6), 745–747. https://doi.org/10.1053/jada.2003.50139

Koenig, K. R. (2008). *What every therapist needs to know about treating eating and weight issues*. W. W. Norton & Company.

Land, P. (2004). Thinking about feelings: Working with the staff of an eating disorders unit. *Psychoanalytic Psychotherapy*, *18*(4), 390–403. https://doi.org/10.1080/1474973042000297344

Latts, M. G., & Gelso, C. J. (1995). Countertransference behavior and management with survivors of sexual assault. *Psychotherapy: Theory Research and Practice*, *32*(3), 405–415. https://doi.org/10.1037/0033-3204.32.3.405

Le Grange, D., Telch, C. F., & Tibbs, J. (1998). Eating attitudes and behaviors in 1,435 South African Caucasian and non-Caucasian college students. *The American Journal of Psychiatry*, *155*(2), 250–254. https://doi.org/10.1176/ajp.155.2.250

Levine, M. P., & Murnen, S. K. (2009). "Everybody knows that mass media are/are not [pick one] a cause of eating disorders": A critical review of evidence for a causal link between media, negative body image, and disordered eating in females. *Journal of Social and Clinical Psychology, 28*(1), 9–42. https://doi.org/10.1521/jscp.2009.28.1.9

Levin, M. E., Potts, S., Haeger, J., & Lillis, J. (2018). Delivering acceptance and commitment therapy for weight self-stigma through guided self-help: Results from an open pilot trial. *Cognitive and Behavioral Practice*, *25*(1), 87–104. https://doi.org/10.1016/j.cbpra.2017.02.002

Levitt, D. H. (2006). Eating disorders training and counselor preparation: A survey of graduate programs. *Journal of Humanistic Counseling, Education & Development, 45*(1), 95–107. https://doi.org/10.1002/j.2161-1939.2006.tb00008.x

Lowell, M. A., & Meader, L. (2005). My body, your body: Speaking the unspoken between the thin therapist and the eating-disordered patient. *Clinical Social Work Journal, 33*, 241–257. https://doi.org/10.1007/s10615-005-4941-x

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach*. SAGE Publications.

McMillan, J. H., & Schumacher, S. (2010). *Research in education: Evidence-based inquiry*. Pearson.

Melin, L. M., Irwin, C. E., Jr., & Scully, S. (1992). Prevalence of disordered eating in girls: A survey of middle-class children. *Journal of American Dietetic Association, 92*(7), 851–853.

Metcalf, L. M. (2003). Countertransference among play therapists; Implications for therapist development and supervision. *The International Journal of Play Therapy, 12*(2), 31–48. https://doi.org/10.1037/h0088877

Miller, G. F. (2000). *The mating mind: How sexual choice shaped the evolution of human nature*. Doubleday & Co.

Moustakas, C. E. (1994). *Phenomenological research methods*. SAGE Publications.

Musolino, C., Warin, M., Wade, T., & Gilchrist, P. (2015). 'Healthy anorexia': The complexity of care in disordered eating. *Social Science & Medicine, 139*, 18–25. https://doi.org/10.1016/j.socscimed.2015.06.030

National Eating Disorder Association. (2022). *Our work*. https://www.nationaleatingdisorders.org/about-us/our-work

Netten C. (2003). *Training tot HC Ervaringsprofessional: "De behandeling van eetstoornissen"* [Training to become an experiential recovered therapist: The treatment of eating disorders]. Stichting Human Concern. Unpublished manuscript.

Nieri, T., Kulis, S., Keith, V. M., & Hurdle, D. (2005). Body image, acculturation, and substance abuse among boys and girls in the Southwest. *American Journal of Drug & Alcohol Abuse*, *31*(4), 617–639. https://doi.org/10.1081/ADA-200068418

Orbach, I. (2006). The body-mind of the suicidal person. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 193–214). American Psychological Association. https://doi.org/10.1037/11377-009

Orbach, S. (2004). What can we learn from the therapist's body? *Attachment & Human Development*, *6*(2), 141–150. https://doi.org/10.1080/14616730410001695349

Pearl, R. L., Wadden, T. A., Tronieri, J. S., Chao, A. M., Alamuddin, N., Bakizada, Z. M., Pinkasavage, E., & Berkowitz, R. I. (2018). Sociocultural and familial factors associated with weight bias internalization. *Obesity Facts*, *11*(2), 157–164. https://doi.org/10.1159/000488534

Peoples, K. (2020). *How to write a phenomenological dissertation: A step-by-step guide*. SAGE Publications.

Pepper, A. C., & Ruiz, S. Y. (2007). Acculturation's influence on antifat attitudes, body image and eating behaviors. *Eating Disorders*, *15*(5), 427–447. https://doi.org/10.1080/10640260701667912

Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & Van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews*, *16*(4), 319–326. https://doi.org/10.1111/obr.12266

Phillips, K. A., Pinto, A., Hart, A. S., Coles, M. E., Eisen, J. L., Menard, W., & Rasmussen, S. A. (2012). A comparison of insight in body dysmorphic disorder and obsessive-compulsive disorder. *Journal of Psychiatric Research*, *46*(10), 1293–1299. https://doi.org/10.1016/j.jpsychires.2012.05.016

Pliner, P., & Saunders, T. (2008). Vulnerability to freshman weight gain as a function of dietary restraint and residence. *Physiology & Behavior*, *93*(1–2), 76–82. https://doi.org/10.1016/j.physbeh.2007.07.017

Polivy, J., Heatherton, T. F., & Herman, C. P. (1988). Self-esteem, restraint, and eating behavior. *Journal of Abnormal Psychology*, *97*(3), 354–356. https://doi.org/10.1037//0021-843x.97.3.354

Posavac, H. D., Posavac, S. S., & Weigel, R. G. (2001). Reducing the impact of media images on women at risk for body image disturbance: Three targeted interventions. *Journal of Social and Clinical Psychology*, *20*(3), 324–340. https://doi.org/10.1521/jscp.20.3.324.22308

Rabinor, J. (1995). Overcoming body shame: My patient myself. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 89–99). John Wiley & Sons.

Rieves, L., & Cash, T. F. (1996). Social developmental factors and women's body-image attitudes. *Journal of Social Behavior & Personality*, *11*(1), 63–78.

Rodin, J., Silberstein, L., & Striegel-Moore, R. (1985). Women and weight: A normative discontent. In T. Sonederegger (Ed.), *Psychology and gender: Nebraska Symposium on Motivation, 1984*(32). University of Nebraska Press.

Root, M. P. P. (1990). Disordered eating in women of color. *Sex Roles*, *22*(7), 525–536. https://doi.org/10.1007/BF00288168

Rosen, J. C. (1990). Body-image disturbances in eating disorders. In T. F. Cash & T. Pruzinsky (Eds.), *Body images: Development, deviance, and change* (pp. 190–214). The Guilford Press.

Rosen, J. C. (1992). Body image disorder: Definition, development, and contribution to eating disorders. In J. H. Crowther, D. L. Tennenbaum, S. E. Hobfoll, & M. A. P. Stephens (Eds.), *The etiology of bulimia nervosa: The individual and family context* (pp. 151–177). Hemisphere Publishing.

Rosenberger, E. W., & Hayes, J. A. (2002). Therapist as subject: A review of the empirical countertransference literature. *Journal of Counseling and Development*, *80*(3), 264–270. https://doi.org/10.1002/j.1556-6678.2002.tb00190.x

Russell, G. F. M. (1970). Anorexia nervosa: Its identity as in illness and its treatment. *Modern Trends in Psychological Medicine*, *2*(1), 56–62.

Saldaña, J. (2021). *The coding manual for qualitative researchers*. SAGE Publications.

Schilder, P. (1950). *The image of appearance of the human body*. International Universities Press.

Schilder, P. (1999). *The image and appearance of the human body: Studies in the constructive energies of the psyche*. Routledge.

Schwartz, H. (1986). *Never satisfied*. Free Press.

Shisslak, C. M., Gray, N., & Crago, M. (1989). Health care professionals' reactions to working with eating disorder patients. *International Journal of Eating Disorders, 8*(6), 689–694. https://doi.org/10.1002/1098-108X(198911)8:6%3C689::AID-EAT2260080610%3E3.0.CO;2-H

Singer, B. A., & Luborsky, L. (1977). Countertransference: The status of clinical versus quantitative research. In A. Gurman & A. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 433–451). Pergamon.

Slade, P. D. (1988). Body image in anorexia nervosa. *The British Journal of Psychiatry, 153*(S2), 20–22. https://doi.org/10.1192/S0007125000298930

Slade, P. D., & Russell, G. F. (1973). Awareness of body dimensions in anorexia nervosa: Cross-sectional and longitudinal studies. *Psychological Medicine, 3*(2), 188–199. https://doi.org/10.1017/S0033291700048510

Slaviero, D. L. (2006). *An exploration of feminist ideology as a protective factor for body image disturbance* (Publication No. 3229846) [Doctoral dissertation, Southern Illinois University Carbondale]. ProQuest Dissertations and Theses Global.

Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports, 14*(4), 406–414. https://doi.org/10.1007/s11920-012-0282-y

Smolak L. (2004). Body image in children and adolescents: Where do we go from here? *Body Image, 1*(1), 15–28. https://doi.org/10.1016/S1740-1445(03)00008-1

Smolak, L., & Murnen, S. K. (2004). A feminist approach to eating disorders. In J. K. Thompson (Ed.), *Handbook of eating disorders and obesity* (pp. 590–605). John Wiley & Sons.

Snyder, R. C. (2008). What is third-wave feminism? A new directions essay. *Signs: Journal of Women in Culture and Society, 34*(1), 175–196.

Starkman, H. B. (2005). *A qualitative study of binge-eating disorder in women: Experiences of body and self* (Publication No. 3167561) [Doctoral dissertation, New York University]. ProQuest Dissertations and Theses Global.

Stice, E. (1994). Review of the evidence for a sociocultural model of bulimia nervosa and an exploration of the mechanisms of action. *Clinical Psychology Review, 14*(7), 633–661. https://doi.org/10.1016/0272-7358(94)90002-7

Stice, E. (2001). A prospective test of the dual-pathway model of bulimic pathology: Mediating effects of dieting and negative affect. *Journal of Abnormal Psychology, 110*(1), 124–135. https://doi.org/10.1037/0021-843X.110.1.124

Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin, 128*(5), 825–848.

Striegel-Moore, R. H., & Smolak, L. E. (2001). *Eating disorders: Innovative directions in research and practice*. American Psychological Association.

Suematsu, H., Ishikawa, H., Kuboki, T., & Ito, T. (1985). Statistical studies on anorexia nervosa in Japan: Detailed clinical data on 1,011 patients. *Psychotherapy and Psychosomatics, 43*(2), 96–103. https://doi.org/10.1159/000287865

Thompson, J. K. (1992). Body image: Extent of disturbance, associated features, theoretical models, assessment methodologies, intervention strategies, and a proposal for a new DSM diagnostic category – body image disorder. *Progress in Behavior Modification, 28*, 3–54.

Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance*. American Psychological Association.

Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (2002). *Exacting beauty: Theory, assessment, and treatment of body image disturbance*. American Psychological Association.

Timko, C. A., Hormes, J. M., & Chubski, J. (2012). Will the real vegetarian please stand up? An investigation of dietary restraint and eating disorder symptoms in vegetarians versus non-vegetarians. *Appetite, 58*(3), 982–990. https://doi.org/10.1016/j.appet.2012.02.005

Timko, C., Striegel-Moore, R. H., Silberstein, L. R., & Rodin, J. (1987). Femininity/masculinity and disordered eating in women: How are they related? *International Journal of Eating Disorders*, *6*(6), 701–712. https://doi.org/10.1002/1098-108X(198711)6:6%3C701::AID-EAT2260060603%3E3.0.CO;2-D

Tong R. (2009). *Feminist thought: A more comprehensive introduction*. Westview Press.

Twamley, E. W., & Davis, M. C. (1999). The sociocultural model of eating disturbance in young women: The effects of personal attributes and family environment. *Journal of Social and Clinical Psychology*, *18*(4), 467–490. https://doi.org/10.1521/jscp.1999.18.4.467

van Kaam, A. L. (1959). Phenomenological analysis: Exemplified by a study of the experience of "really feeling understood." *Journal of Individual Psychology, 15*(1), 66–72.

van Kaam, A. L. (1966). *Existential foundations of psychology*. University Press of America.

Vitousek, K. M., & Brown, K. E. (2015). Cognitive-behavioral theory of eating disorders. In L. Smolak & M. P. Levine (Eds.), *The Wiley handbook of eating disorders* (pp. 222–237). John Wiley & Sons.

von Ranson, K. M., & Robinson, K. E. (2006). Who is providing what type of psychotherapy to eating disorder clients? A survey. *International Journal of Eating Disorders*, *39*(1), 27–34. https://doi.org/10.1002/eat.20201

Walker, S., & Lloyd, C. (2011). Barriers and attitudes health professionals working in eating disorders experience. *International Journal of Therapy and Rehabilitation, 18*(7), 383–390. https://doi.org/10.12968/ijtr.2011.18.7.383

Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. The Guilford Press.

Warren, C. S., Crowley, M. E., Olivardia, R., & Schoen, A. (2009). Treating patients with eating disorders: An examination of treatment providers' experiences. *Eating Disorders*, *17*(1), 27–45. https://doi.org/10.1080/10640260802570098

Warren, C. S., Schafer, K. J., Crowley, M. E. J., & Olivardia, R. (2013). Treatment providers with a personal history of eating pathology: A qualitative examination of common experiences. *Eating Disorders*, *21*(4), 295–309. https://doi.org/10.1080/10640266.2013.797318

Watson, L. B., Ancis, J. R., White, D. N., & Nazari, N. (2013). Racial identity buffers African American women from body image problems and disordered eating. *Psychology of Women Quarterly, 37*(3), 337–350. https://doi.org/10.1177/0361684312474799

Willgerodt, M. A., Miller, A. M., & McElmurry, B. J. (2002). Becoming bicultural: Chinese American women and their development. *Health Care for Women International, 23*(5), 467–480. https://doi.org/10.1080/073993302760190074

Wilrycx, G., Croon, M., Van den Broek, A., & van Nieuwenhuizen, C. (2014). Evaluation of a recovery-oriented care training program for mental health care professionals: Effects on mental health consumer outcomes. *The International Journal of Social Psychiatry, 61*(2), 164–173. https://doi.org/10.1177/0020764014537638

Winkelman, M. (1994). Cultural shock and adaptation. *Journal of Counseling & Development, 73*(2), 121–126. https://doi.org/10.1002/j.1556-6676.1994.tb01723.x

Wooley, S. C. (1991). Uses of countertransference in the treatment of eating disorders: A gender perspective. In C. L. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 245–294). The Guilford Press.

Worell, J., & Etaugh, C. (1994). Transforming theory and research with women. *Psychology of Women Quarterly*, *18*(4), 443–450. https://doi.org/10.1111/j.1471-6402.1994.tb01041.x

Yamamiya, Y., Cash, T. F., Melnyk, S. E., Posavac, H. D., & Posavac, S. S. (2005). Women's exposure to thin-and-beautiful media images: Body image effects of media-ideal internalization and impact-education interventions. *Body Image*, *2*(1), 74–80. http://dx.doi.org/10.1016/j.bodyim.2004.11.001

Zuromski, K. L., Witte, T. K., Smith, A. R., Goodwin, N., Bodell, L. P., Bartlett, M., & Siegfried, N. (2015). Increased prevalence of vegetarianism among women with eating pathology. *Eating Behaviors*, *19*, 24–27. https://doi.org/10.1016/j.eatbeh.2015.06.017

APPENDIX A

Participant Recruitment Email

A Qualitative Exploration of Licensed Professional Counselors' Therapeutic Relationships Working With Clients With Body Image Concerns

Sehrish Ali
Sam Houston State University
Department of Counselor Education

My name is Sehrish Ali, and I am a doctoral candidate in the Department of Counselor Education at Sam Houston State University. My dissertation research is a phenomenological study exploring the lived experiences of licensed professional counselors working with body image concerns in a clinical practice setting. I am conducting this research under the facilitation of my director Dr. Jeffrey Sullivan, and dissertation committee members Dr. Timothy Brown and Dr. Lauren Mclean in partial fulfillment of the requirements for a Ph.D. in Counselor Education.

I am currently seeking participants who meet the criteria for this study and are willing to participate in the interview and data collection process. Participants will be eligible to participate in this study if they meet the following conditions: (a) full state licensure status as an LPC for a minimum of 2 years, (b) previous or current professional counseling experience with a client with body image concerns

Negative body image characteristics can include negative feelings, cognitions, behaviors, and perceptions regarding one's body image (Thompson et al., 1999). In addition to the eligibility criteria, I am looking for potential participants that have previously or are currently exploring body image–related concerns with one or more of their clients. These clients may have struggled with cognitive distortions about their bodies, self-worth-related concerns about their body image, and tried to alter their physical shape or form through exercise, surgery, and/or food restriction. Body image concerns can lead to distress in their daily lives, which impacts their relationships, daily activities, and experiences and become the focus of the therapeutic process. The goal of the study is to gain an understanding and learn about the experiences of professional counselors who are comfortable initiating, exploring, and addressing client body image issues, which could contribute helpful information to support other counselors and students.

This study is voluntary, and your participation will be kept confidential. Individuals who consent to participate in this study will be asked to complete a demographic questionnaire. Based on responses, those who meet the criteria will move on to the study's second phase, consisting of a 60-minute semistructured interview. The interview will be conducted online via a secure videoconferencing platform. The research is relatively straightforward, and I do not expect the study to pose any risk to any volunteer participants other than the usual discomfort of exploring thoughts and emotions.

If you are interested in participating in this study, please click on the following link:

APPENDIX B

Sam Houston State University

Consent for Participation in Research

KEY INFORMATION FOR: *A Qualitative Exploration of Licensed Professional Counselors' Therapeutic Relationships Working With Clients With Body Image Concerns*

Your participation is requested in a research study about licensed professional counselors who have experience working with or are currently working with clients addressing body image concerns in their therapeutic work. This therapeutic work could include initiating discussions, feeling comfortable, exploring, and addressing body image issues with clients as they come up. You have been asked to participate in the research because you are a professional counselor who has reported working with body image concerns and may meet the eligibility requirements to participate in this study.

WHAT ARE THE PURPOSE, PROCEDURES, AND DURATION OF THE STUDY?

The purpose of this study is to gain an understanding of the experiences professional counselors have with discussing body image with clients. Professional counselors who can comfortably initiate, explore, and address client body image issues may contribute helpful information to support other counselors and counseling students. By doing this study, I hope to learn from the experiences of professional counselors who already discuss body image with clients and help improve treatment outcomes. Your participation in this research consists of a virtual interview lasting between 1 and 2 hours.

WHAT ARE REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?

By participating in this study, you will be contributing to the growing body of research on body image in clinical practice. While there may not be a direct benefit, this study may increase your insight into how integral your role can be in supporting the professional development of other counselors and providing comprehensive client care. For a complete description of benefits, refer to the Detailed Consent.

WHAT ARE REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?

Time limitation may be a factor to consider for this study. Your participation will require about 1 to 2 hours of interview time. For a complete description of risks, refer to the Detailed Consent.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you want to volunteer. You will not lose any services, benefits, or rights you would normally have if you chose not to volunteer.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, OR CONCERNS?

The person in charge of this study is Sehrish Ali, a doctoral student of the Sam Houston State University Department of Counselor Education and Training who is working under the doctoral supervision of Dr. Jeffery Sullivan for her dissertation. If you have questions, suggestions, or concerns regarding this study or want to withdraw from the study, their contact information is [redacted] and [redacted], respectively. If you have any questions, suggestions, or concerns about your rights as a volunteer in this research, contact the Office of Research and Sponsored Programs – Sharla Miles at [redacted] or email ORSP at [redacted].

Sam Houston State University Consent for Participation in Research

DETAILED CONSENT*:* *A Qualitative Exploration of Licensed Professional Counselors' Therapeutic Relationships Working With Clients With Body Image Concerns*

Informed Consent

My name is Sehrish Ali, and I am a doctoral student in the Department of Counselor Education and Supervision at Sam Houston State University. I would like to take this opportunity to invite you to participate in a research study focusing on professional counselors' experiences working with body image in their clinical practice. I am completing this study for my doctoral dissertation under the direction and guidance of my dissertation chair, Dr. Jeffery Sullivan, in the Department of Counselor Education and Supervision. I hope that data from this research will introduce the voices of professional counselors who work with body image into research and discussions about body image in the clinical community. You have been asked to participate in the research because you are a professional counselor of at least 2 years who discusses body image with your clients comfortably and effectively.

The research is relatively straightforward, and I do not expect the research to pose any risk to any of the volunteer participants. If you consent to participate in this research, you will be asked to complete an interview with me which will last about one to two hours. During this time, I will ask questions about your experience with working with body image concerns in your clinical practice and, if you'd like, check in to make sure I am collecting information that is an accurate report of your experience (member checking).

Any data obtained from you will be used only for the purpose of understanding the experiences of professional counselors to ultimately improve counselor education and

training. Under no circumstances will you or any other participants in this research be identified. In addition, your data will remain confidential.

This research will require about 1 to 2 hours of your time. Participants will not be paid or otherwise compensated for their participation in this project. Participant interviews will be audio-recorded for transcription. The transcripts are available for you to review and will be destroyed 3 years after the project's completion. Until then, they will be stored on a password-protected, encrypted flash drive and in a secure location.

Your participation in this research is voluntary. Your decision whether to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. If you have any questions, please ask me using the contact information below. If you are interested, the study's findings will be available at the conclusion of the project.

If you have any questions about this research, please contact me, Sehrish Ali, or my dissertation committee chair, Dr. Jeffery Sullivan. If you have questions or concerns about your rights as research participants, please contact Sharla Miles, Office of Research and Sponsored Programs, using her contact information below.

Sehrish Ali SHSU Department of Counselor Education and Training Sam Houston State University	Dr. Jeffery Sullivan Dissertation Chair SHSU Department of Counselor Education and Training Sam Houston State University	Sharla Miles Office of Research and Sponsored Programs Sam Houston State University

☐ I understand the above and consent to participate.
☐ I do not wish to participate in the current study.

AUDIO/VIDEO RECORDING RELEASE CONSENT

As part of this project, an audio/video recording will be made of you during your participation in this research project for transcription purposes only. This is completely voluntary. In any use of the audio/video recording, your name will not be identified. You may request to review the recording. Additionally, the recording will be destroyed after three years of the project's completion, along with the transcription of your recording. You may request to stop the recording at any time or to erase any portion of your recording.

☐ I consent to participate in the audio/video recording activities.

☐ I do not wish to participate in the audio/video recording activities

APPENDIX C

Interview Questions

1. Tell me about your experience working with body image concerns with clients.
2. What are some treatment modalities or treatment interventions you use when working with clients with body image concerns?
3. How do you feel about your body (e.g., body shape/size/weight)?
4. Tell me about your own body image health beliefs.
5. How do you think or imagine your own body image beliefs about health impact the way you provide treatment?
6. How have your beliefs around your own body image originated or been formed?
7. How has your relationship with your body image changed because of working with this client group?
8. Describe your relationship with food or eating. How has it changed when working with this client group?
9. Describe any changes in your weight that you may have encountered or noticed when working with this client group.
10. How has your clinical relationship with your client ever been impacted based on body types (e.g., body shape/size/weight)?
11. Tell me about any personal experiences of how your body image may have interacted in individual sessions with clients. How do you feel about your own body image while working with clients with body image concerns?
12. What are your thoughts on how training can be attained or improved for counselors around their own body image?

13. What else, if anything, would you like to share that you have not had the chance to?

APPENDIX D

Demographic Questions

1. What would you like your interview alias/pseudonym to be?
2. How do you currently describe your gender identity?
3. What is your age?
4. How do you describe your racial and ethnic identity?
5. What is the title of your professional license?
6. What state are you licensed in?
7. How many years have you been fully licensed?
8. What are your specialty areas (if any)?
9. What is/are your current practice setting(s) (e.g., private practice, PHP, residential, inpatient)?
10. What setting(s) did you complete your training in?

APPENDIX E

Participant Demographics

Participant	Gender	Age	Ethnicity	License	State	Years	Specialty	Current setting	Training setting
Dolly	Female	33	Caucasian	LPC	TX, NJ, IL	4	Eating disorders	Private	PHP, IOP, residential and inpatient
Jasmine	Female	31	Middle Eastern	LPC	TX	4.5	Eating disorders, relationships, anxiety, and trauma	Private	PHP, IOP, nonprofit
Raelynn	Female	32	Caucasian	LPC	TX	4	Eating disorders, trauma, and OCD	Agency	Inpatient hospital, schools, residential and IOP
Megan	Female	32	Caucasian	LPC	TX, MI	5	Eating disorders, OCD, and anxiety	Private	Private practice and IOP
Addie	Female	36	Caucasian, Native American, and German	LPC	TX	1		Private	Juvenile probation detention center, outpatient substance uses and school setting

Participant	Gender	Age	Ethnicity	License	State	Years	Specialty	Current setting	Training setting
Lila	Female	30	Caucasian	LPC	TX	3	Relational trauma and women's issues	Private	Including substance abuse IOP, academic career counseling, community mental health and college counseling
Peace	Female	48	African American	LPC-S	TX	8	Trauma and couples	Private	School, community, private
Rose	Female	35	Caucasian/ Hispanic	LPC, LCDC	TX	2.5	Trauma, eating disorders, and addiction	Private	Substances use disorder treatment facilities and family counseling center.
Trina	Female	37	African American	LPC	TX	4	Eating disorders and general support	Private	PHP, nonprofit
Hannah	Female	32	Caucasian	LPC	TX	5	Child abuse, sexual assault, and domestic violence	Nonprofit agency	Nonprofit children's advocacy center
DNW	Female	37	African American	LPC	TX	2	Grief	Mental health agency	Inpatient and private practice settings

APPENDIX F

IRB Letter

Sam Houston State University

Date: Jul 26, 2022 3:26:00 PM CDT

TO: Sehrish Ali Jeffrey Sullivan
FROM: SHSU IRB
PROJECT TITLE: A Qualitative Exploration of Licensed Professional Counselors' Therapeutic Relationships Working with Clients with Body Image Concerns
PROTOCOL #: IRB-2022-166
SUBMISSION TYPE: Initial
ACTION: Exempt - Limited IRB
DECISION DATE: July 22, 2022
EXEMPT REVIEW CATEGORIES: Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

OPPORTUNITY TO PROVIDE FEEDBACK: To access the survey, click **here**. It only takes 10 minutes of your time and is voluntary. The results will be used internally to make improvements to the IRB application and/or process. Your feedback will be most appreciated.

Greetings,

On July 22, 2022, the Sam Houston State University Institutional Review Board (IRB) determined the proposal titled A Qualitative Exploration of Licensed Professional Counselors' Therapeutic Relationships Working with Clients with Body Image Concerns to be Exempt with Limited IRB Review pursuant to 45 CFR 46. This determination is limited to the activities described in the Initial application, and extends to the performance of these activities at each respective site identified in the Initial application. Exempt determinations will stand for the life of the project unless a modification results in a new determination. You may initiate your project.

Modifying your approved protocol:
No changes may be made to your study without first receiving IRB modification approval. Log into Cayuse Human Ethics, select your study, and add a new submission type (Modification).

Study Closure:
Once research enrollment and all data collection are complete, the investigator is responsible for study closure. Log into Cayuse Human Ethics, select your study, and add a new submission type (Closure) to complete this action.

Reporting Incidents:
Adverse reactions include, but are not limited to, bodily harm, psychological trauma, and the release of potentially

damaging personal information. If any unanticipated adverse reaction should occur while conducting your research, please log into Cayuse Human Ethics, select this study, and add a new submission type. This submission type will be an adverse event and will look similar to your initial submission process.

Reminders to PIs: Based on the risks, this project does not require renewal. However, the following are reminders of the PI's responsibilities that must be met for IRB-2022-166 A Qualitative Exploration of Licensed Professional Counselors' Therapeutic Relationships Working with Clients with Body Image Concerns.

1. When this project is finished or terminated, a **Closure submission** is required (**NOTE:** see the directive above related to **Study Closures**).

2. Changes to the approved protocol require prior board approval (**NOTE:** see the directive above related to **Modifications**).

3. Human subjects training is required to be kept current at citiprogram.org by renewing training every 5 years.

Please note that all research records should be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact the Sharla Miles at [redacted] or irb@shsu.edu. Please include your protocol number in all correspondence with this committee.

Sincerely,
SHSU Institutional Review Board

VITA

Sehrish Ali

Education

Doctor of Philosophy (August 2022)
Major: Counselor Education
Sam Houston State University, Huntsville, TX (CACREP-accredited program)

Master of Arts (May 2018)
Major: Counseling
Houston Baptist University, Houston, TX

Bachelor of Science (December 2013)
Major: Psychology – Clinical/Counseling Track, Political Science
University of Houston, Houston TX
Scholarly Associations: Psi Chi, Psychology Club

Professional Licenses and Certifications

Licensed Professional Counselor #80100 (Expires: 02/29/24)
Department of State Health Services, Austin, TX

Certified Eating Disorder Specialist
International Association of Eating Disorder Specialists

Eye Movement Desensitization and Reprocessing (EMDR) Certification

Professional Experience

Primary Therapist and Founder, *Guided Growth Therapy*

- Provide therapy for individual and family counseling services in addition to consultation with clinicians working with eating disorders
- April 2021–present

Primary Therapist, *Center for Discovery*

- Completed diagnostic assessments, provided individual counseling services, and assisted in managing the counseling program
- Provided crisis consultations as needed
- Supervisor: Sarah Benefiel
- October 2018 – June 2021

Behavioral Health Counselor/IOP Therapist, *Eating Recovery Center*

- Completed diagnostic assessments, provided individual counseling services, and

assisted in managing the counseling program
- Provided crisis consultations as needed
- Managed the milieu, assisted with unit activities, and worked with patients at both IOP and PHP levels
- Facilitated group discussions, co-led sessions with primary therapists, and assisted patients with meal planning and processing
- Supervisor: Rebecca Wagner
- October 2016 – October 2018

Mental Health Associate, *Menninger Clinic*
- Assisted with unit activities and worked with patients in the Eating Disorder Program
- Led group discussions and assisted patients with wellness planning and goal-keeping
- Supervisor: Jamie Lovelace
- March 2015 – June 2016

Practicum and Internship Experience

Teaching Internships, *Sam Houston State University,* The Woodlands, TX
Graduate-Level Courses:
- Sexual Concerns, Fall 2021 Semester
- Supervised Practicum, Summer 2021 Semester
- Supervised Practicum, Spring 2021 Semester

Practicum Student, *Sam Houston State University,* Jack Staggs Clinic, Huntsville, TX
Advanced Supervised Practicum, *Sam Houston State University,* SHSU Clinic – The Woodlands Center, The Woodlands, TX
Conducted counseling sessions with adult and child clients
Supervisor: Dr. Rick Bruhn
Fall 2019 Semester

Practicum Student, *Eating Recovery Center,* Houston, TX
Advanced Supervised Practicum, *Houston Baptist University*
Conducted counseling sessions and groups with adult and child clients
Supervisor: Dr. Stephanie Ellis
Fall 2017–Spring 2018 Semesters

Presentations

- Watts, R., Young, N., & **Ali, S**. (2019). Key Ethical Issues in Working with Spiritual and Religious Values in Counseling. Presented at Texas Counseling Association (TCA) Conference, Dallas, TX
- **Ali, S.**, Branch, T., & Young, N.(2020). Vanishing the Vaping. Scheduled to Present at American Counseling Association (ACA) Conference, San Diego, CA. Cancelled

- **Ali, S.** (2020). Acculturation and Eating Disorders. Presented at Center for Discovery National CEU Webinar.
- **Ali, S**. (2020). Acculturation and Higher Levels of Care in Eating Disorders. Presented at Center for Discovery National CEU Webinar.
- Bassir, A., & **Ali, S.** (2021). The Intersectionality of Eating Disorder and Acculturation. Presented at the Houston Eating Disorders Specialist Professional Conference, Houston, TX.
- Sullivan, J., & **Ali, S.** (2022). Supervision in the Counseling Relationship: Ethical Considerations. Presented at the Texas Association for Counselor Education and Supervision (TACES) Conference, Dallas, TX.

Trainings Attended

- 2021 *Gottman Method Couples Therapy Level 1 and 2.* The Gottman Institute, Houston, TX
- 2021 Certified Eating Disorder Specialist (CEDS). Presented by International Association of Eating Disorder Specialists (IADEP)
- 2019 Eye Movement Desensitization Reprocessing Therapist Training. Presented by Jordan Shafer, LPC. Compassion Works. Houston, TX

Skills

- Program Development
- Online Course Development: Blackboard, Zoom, Kaltura, and Canvas
- Proficient with Microsoft Office
- Proficient with basic web development and mental health marketing

Scholarships and Awards

- 2022 SHSU Graduate Scholarship
- 2021 SHSU Counseling Student Scholarship
- 2021 ROAD to PhD Scholarship
- 2020 Special Scholarship - Education
- 2020 Special Scholarship - Education
- 2020 SHSU Counseling Student Scholarship
- 2020 ROAD to PhD Scholarship
- 2019 SHSU Counseling Student Scholarship
- 2019 ROAD to PhD Scholarship

Service and Affiliations

- American Counseling Association (ACA)
- Texas Counseling Association (TCA)
- Texas Association for Counselor Education and Supervision (TACES)
- International Association of Eating Disorder Professionals (IADEP)

- Houston Eating Disorder Professionals (HEDS)

Community Service

- 2019–2021 Rhodes Scholar Mentorship
- 2017 Volunteer Intake Coordinator/Triage following Hurricane Harvey in Houston, TX