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# Sizeism--What Multicultural Education & Training are Missing

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# Sizeism—What Multicultural Education and Training are Missing

Jen Rynes

A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Fall, 2022

Winona State University

College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Sizeism—What Multicultural Education and Training are Missing

This is to certify that the Capstone Project of

Jen Rynes

Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

Master of Science Degree in

Counselor Education

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Abstract

Training in multiculturalism is a major focus in most counselor education graduate programs. These programs seek to graduate competent counselors who aspire to serve all populations. The harsh reality is that many programs fail to acknowledge body diversity and sizeism in these multicultural courses and trainings. There are a multitude of reasons why body diversity needs to be a part of multicultural education and training. The literature reviewed in this paper has a purpose of discussing those reasons, dismantling the many myths associated with fatness, identifying how body size intersects with other diverse identities, and reviewing current multicultural guidelines and competencies. With a need for size-affirmative education, this writer will also include suggestions for conducting workshops on sizeism and body diversity.

Keywords: fat, body diversity, sizeism

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**Sizeism—What Multicultural Education and Training are Missing**

"Fatness, like blackness and femaleness, is a dimension of social inequality" (Saguy, 2012, p. 604). The word fat can be uncomfortable to say or hear, this word has a history of being used to negatively discriminate against individuals that reside in larger bodies; however, throughout this paper the word fat will be used as a descriptor not a discriminator. The word fat will be used instead of other commonly known terms (unless this writer is citing directly from a source that uses these words) *overweight, obesity*, and *obese,* this is because this writer believes that these words are pathologizing and they medicalize being fat. Instead of using these words people can instead say things like a fat person, a person of size, a plus size individual etc. Multicultural education and training are an essential part in many professions. This is especially apparent in the education and training of counselors, and of therapists. It should be noted that many different bodies experience sizeism, the reality though is that fat bodies experience this more often, and throughout this paper the focus is on the fat persons' experience with sizeism as this is pervasive toward the fat community (Abakoui & Simmons, 2010). In fact, sizeism is so pervasive toward the fat community that "Psychologists are seeing that the stigmatization of fat has led to symptoms of depression and anxiety, body image disturbances, and other psychological distress" (Abakoui & Simmons, 2010 ). Many studies throughout the past 30-40 years have demonstrated the prejudice held within American society toward fat people (Abakoui & Simmons, 2010). In this paper, this writer firstly, reviews literature that explains why sizeism is a problem. This writer also reviews literature that makes assumptions about health and body size. It is the hope that these assumptions/myths will be dismantled, and also to provide each reader with a new insight into their perceptions of fat bodies. This writer also identifies how

body size intersects with other diverse identities and lastly this writer reviews current multicultural guidelines and competencies in the counseling world.

## Review of Literature

### Sizeism

Sizeism describes discrimination against individuals on the basis of their body size/ weight (Chrisler & Barney, 2017). The words sizeism and fatphobia are often used interchangeably. There has been some controversy around the use of the word fatphobia. On one hand the word is self-explanatory, and it fits the same template as other phobia-suffixed terms to describe oppressive attitudes; however, phobias are mental illnesses and they are not the same as oppressive attitudes (Your Fat Friend, 2017). The word fatphobia will be used in this paper as it is used in many references this author has cited; however, this author understands this problematic language and will only use the word fatphobia when referring to or directly citing works that use this word. Sizeism can be used as a way to judge a person's health and wellbeing.

According to a fat activist and author Virgie Tovar (2017), there are three levels of fatphobia: the intrapersonal (within-person) level, the interpersonal (between-people) level, and the institutional level. The first level is all about how sizeism (fatphobia) affects an individual's self-image. This is an internalized experience which most people in society can relate to, regardless of their size. This level looks like an individual not being able to enjoy certain pleasurable life experiences because their fatphobic thoughts are so loud (Tovar, 2017; Harrison, 2019). The second level of fatphobia is the interpersonal (between-people) level, in this level it is all about how other people perceive a person and treat a person. People in smaller bodies may experience this level if someone in their life puts their own disordered views on them; however, fat individuals experience this level more often (Tovar, 2017; Harrison, 2019). The last level is institutional fatphobia, this level exclusively affects fat people. Examples of this level include seats not being large enough in different community spots such as restaurants, concerts, movie

theaters etc. Additionally, it includes stores not having clothing that will fit fat people. It also is apparent in the media when individuals cannot see their body size represented (Tovar, 2017; Harrison, 2019).

According to McHugh & Chrisler, "Both explicit and implicit studies of attitudes have shown that sizeism is common in the United States among the general public" (2018, p. 8). Studies are suggesting that sizeism has impacted medical and psychological professionals' opinions on fat individuals. When a person goes in to see a doctor, they expect to be adequately treated, just like everyone else; however, many studies suggest that physicians hold critical views of fat patients (Foster et al., 2003; Hebl & Xu, 2001). In a study conducted by Foster et al., it was indicated that (37%) of respondents reported having negative reactions toward the appearance of fat patients, and similarly, (50%) classified fat patients as awkward, unattractive, ugly, and noncompliant (2003, p. 1173). Physicians are not just judging the fat patient's physical appearance but also judging their mental health. In fact, in a study by Hebl & Xu, this is demonstrated, "results show that physicians are more likely to recommend psychological counseling to heavier individuals, suggesting a belief that those who are overweight must be unhappy and unstable" (2001, p. 1250).

According to Akoury et al., research findings suggest that mental health practitioners, perceive more negative attributes to fictious fat clients, rate fat clients as having more severe symptoms over lower weight clients and predict worse outcomes for treatment for fat fictional clients. Mental health practitioners in training develop insight in monitoring their own personal bias. For this reason, it is more likely that mental health practitioners would not exhibit weight bias in a direct way. They may, however, exhibit this more subtlety. In a study by Akourty et al., investigators sought to see how weight-related micro aggressions impact fat women in

psychotherapy. In this qualitative exploration, investigators found that one-fifth of the participants reported weight-based microaggressions (Akourtey et al., 2019). These findings suggest that maybe psychotherapists truly are making improvements in the way they work with fat clients; however, past research has demonstrated the presence of weight bias (Hassel et al., 2001); therefore, investigators suggest there is likely other reasons for these findings (Akourty et al., 2019). One explanation is that fat people internalize negative messages they receive about their body size, and this puts them at a higher vulnerability to the harmful effects of stigma (Akourty et al., 2019; Puhl et al., 2009).

**Common Myths**

Sizeism comes packaged in many different myths. The first myth is that fatness leads to a decrease in lifespan (Bacon & Aphramor, 2014). A correlation does exist between higher BMI and negative health outcomes like diabetes, heart disease, and some forms of cancer; however, the why this exists has yet to be discovered (Harrison, 2014). There are some important confounds that need to be controlled for like weight stigma, weight-based discrimination, sizeism, etc., and there is also an abundance of research suggesting that all of these are detrimental to a fat person's health (Puhl et al., 2014; Chrisler & Barney, 2017) There is also data that shows that people in the BMI "overweight" category actually have the highest longevity (Hannier & Aldhoon-Hainerova, 2013). A study conducted by Kalantar-Zadeh et al. (2004) found that patients with chronic heart failure had greater survival rate if they were considered obese, hypercholesterolemia, and if they had high blood pressure. Additionally, a study conducted by Vemmos et al. (2011) found that overweight and obese patients have significantly better survival rates after stroke than their normal-weight counterparts.

The second myth is that, “BMI is a valuable and accurate health measure” (Bacon & Aphramor, 2014, p. 12). BMI has been engrained in our heads as a standard for someone’s health status. BMI stands for body mass index, this is used today as a measure to categorize people as normal weight, overweight, and underweight (Harrison, 2019). According to the CDC website, “BMI is interpreted using standard weight status categories, these categories are the same for men and women of all body types and ages” (2022, How is BMI Interpreted for adults Section, para. 1). The following are the BMI associated with the concurrent weight status: below 18.5, underweight; 18.5-24.9, healthy weight; 25.0-29.9, overweight; 30.0 and above, obesity (CDC, 2022). In the book, *Body Respect What Conventional Health Books Get Wrong, Leave Out, and Just Plain Fail to Understand about Weight,* Bacon and Aphramor discuss, that when the United States made the standards for the BMI the data that was shown indicated that health decrement didn’t occur until BMI was at 40; however, the standard for overweight is 25 and obesity is 30. Additionally, in Christy Harrison’s book, *Anti-Diet, Reclaim Your Time Money and Well-being, and Happiness Through Intuitive Eating,* it was indicated that the equation for the BMI was developed in the 1830s by an *astronomer* named Adolphe Quetelet and it was created as a statistical exercise, not a medical instrument; therefore, was never intended for medical purposes.

The third myth is, “Fat plays a substantive role in causing disease” (Bacon & Aphramor, 2014, p.15). It is true that correlation does exist between a higher BMI and negative health outcomes; however, correlation does not equate to causation. There are many traits that differ for those in smaller bodies and larger bodies that explain the increase disease incidence much more than fatness (Bacon & Aphramor, 2014). In an article by Barry et al., investigators had an interest in quantifying a joint association of cardiorespiratory fitness and weight status, what the investigators found is that the risk of death was dependent upon cardiorespiratory fitness and not

BMI or weight status. The results also indicated that the death rate for women and men that were thin but unfit was twice as high for their fatter counterparts (Bacon & Aphramor, 2014). This evidence suggests that fitness is a key factor in protection against disease, not the size of a person's body. Weight stigma can contribute to health problems. In one of the more obvious ways, stigma causes stress which can take a physical toll on a person's body. In the case of stress, this is the allostatic load which means the cumulative effect of chronic stressors on multiple systems of the body (Harrison, 2014). The allostatic load is one of the best predictors of chronic disease. Research has indicated that those who experience weight stigma have a high allostatic load (Harrison, 2019; Vadiveloo & Mattei, 2017).

The fourth myth is, "exercise and dietary restriction are effective weight loss techniques" (Bacon & Aphramor, 2014, p. 18). The First Law of Thermodynamics, states that when the number of calories you consume is less than those you expend, you should lose weight (Bacon & Aphramor, 2014). This is a scientific fact; however, this does not mean that diet and exercise overtime lead to maintained weight loss, in fact, 90 to 95% of people generally regain as much as two-thirds of the weight they lose within one year and almost all within five years (Harrison, 2019). Dieting triggers a reduction in leptin, which increase appetite and decreases metabolism, and chronic dieting results in chronically less leptin release which can directly explain why people who diet overtime gain more weight (Bacon & Aphramor, 2014).

The last myth is, "we have evidence that weight loss improves health" (Bacon & Aphramor, 2014, p. 20). There is research that indicates short-term weight-reduction interventions can indicate some health improvements; however, in this research the participants are all doing something to change exercise and diet habits, and from the previous myth it was indicated that weight loss is not sustainable over time because dieting triggers a reduction in

leptin which will increase appetite and decrease metabolism which results in less leptin release which explains why people who diet end up gaining more weight overtime (Bacon & Aphramor, 2014). When fat people go to the doctor, they are often prescribed weight-loss as a cure for whatever health complication they are presenting with. This is considered institutional fatphobia and it has an impact on people's health (Tovar, 2017, institutional section, para. 3). In Christy Harrison's book, *Anti-Diet, Reclaim Your Time Money and Well-being, and Happiness Through Intuitive Eating,* she indicates an experience a participant in her online course had, the participant who was age 8 at the time went to the doctor because they could not keep down food after slowly recovering from the German measles, the doctor congratulated them on losing weight. The participant indicated that they thought they were dying, and the doctor congratulated them (2019). This situation is a direct form of weight stigma and as discussed within the previous myths, weight stigma is detrimental to a person's health. In a study conducted where participants had liposuction, it was found that abdominal liposuction did not improve "obesity" associated metabolic abnormalities (Klein et al., 2004). This finding is an example of how weight loss does not directly improve health.

In Oliver's book, *Fat Politics the real story behind America's obesity epidemic,* Oliver argues that, people are willing to believe inaccurate or unsubstantiated health claims about "obesity" because they coincide so well with their own bias against fat people. The reality is that people are not the problem it is the system that profits off of the fear of being or getting fat. That system is diet culture. Diet culture is, " a system of beliefs that equates thinness, muscularity, and particular body shapes with health and moral virtue…" (Harrison, 2019, p. 7).

**How Body Size Intersects with other diverse identities**

It is important to acknowledge that fat people have other diverse identities that intersect with their body size. In this portion of this paper, the research is focused on those that identify as a woman; however, as previously mentioned in this paper, every single person is affected by sizeism and every single person has diverse identities (Smith, 2018; Tovar, 2017). In our society, women experience oppression and it is important that their lived experiences are heard and recognized (Smith, 2018; Tovar, 2017).

Racial differences in body size and body dissatisfaction have been studied, in fact, it was determined that, Black women have the most positive body image and are also in the largest or fattest bodies; Asian, Latina, and White women tend to have lower body satisfaction overall, and Asian women have the lowest body weight (Smith, 2019). There is a lack of research on Native American women's body image; however, the research that is present has reported that Native American women have the highest rate of being "overweight" and "obesity" (Smith, 2019). Overall, Black women are more satisfied with their bodies. Other research suggests that African American women report a higher quality of life level than other populations, consequently, they are reporting less experiences with sizeism (Smith, 2019; Perez & Warren, 2012). Asian women in the United States are found to have lower rates of "obesity", essentially this suggests that Asian women are less likely to experience sizeism; however, Asian women do share the desire to be thinner than they are with other ethnic groups (Smith, 2019). Latinas tend to view their bodies and appearance more positively; however, higher weight did positively correlate with appearance shame (Smith, 2019). This indicates that Latina's do experience internalized sizeism.

Socioeconomic class is said to have a role in the size of a person's body. In Westernized cultures, greater body fat is more likely for those who are in the working class and for those who

are in the lower class (Smith, 2019; Ball & Crawford, 2006). In an article by Ball & Crawford, they found that socioeconomic position precedes weight gain; therefore, the authors suggest that there could be several reasons for this, some of which include, access to nutritious food, lack of group-oriented sports, and a person's occupation. Similarly, research on community poverty has indicated that across the board, White, Black, Asian, and Latina adolescent girls are in larger bodies (Smith, 2019). This research communicates what many already know, that having less money impacts a person's ability to access resources.

Sexuality is another dimension of diversity/intersectionality. In general, the research on lesbians indicate that they have a higher weight compared to heterosexual women and they also report feeling more satisfied with their bodies (Smith, 2019). This could be for a variety of reasons; one could be because they are not worried about the male gaze (Smith, 2019). Yet another reason could be because, "Westernized LGB communities promote positive messages about weight and appearance; they endorse 'healthier' body ideals than mainstream society" (Huxley et al., 2014, p. 274). While the LGB communities promote positive messages, lesbian women do not feel protected from the pressure to be thin (Smith, 2019). Research on bisexual women is limited; however, the research that has been conducted indicates similar findings to those of lesbian women (Smith, 2019).

The next dimension of diversity is disability. "Disability affects over 56 million people in the United States of America" (Armour et al., 2013, p. 852). In an article by Armour et al., investigators were determined to see the prevalence of disability across body size, what the study found out is that (41%) of "obese" individuals have a disability (2013, p. 854). Additionally, many women with disabilities report feeling physical and sexually unattractive and they are reported to have lower body esteem scores versus nondisabled peers (Taleporos & McCabe,

2001; Smith, 2019; Taleporos & McCabe, 2005). This research shows that women who are fat and have disabilities are more vulnerable to the many forms of sizeism.

The last dimension of diversity that will be discussed is aging. In Western culture, the beauty standard that women face includes a variety of expectations. Women are expected to do everything possible to prevent wrinkles, and this often means ascribing to the use of expensive products. Additionally, women are to dye their hair, wear modern clothing, and quite frankly do anything possible to not appear as if they are aging, even though it is a natural part of our lives. As people get older metabolic rates tend to slow, and this means that people gain weight (Smith, 2019). This means that older women tend to have complicated relationships with their body and overall appearance (Smith, 2019).

All of the dimensions of diversity throughout this paper can overlap with each other. The term Intersectionality was first coined by Kimberle Crenshaw who is a law professor and social theorist (YW boston, 2022). Intersectionality is a framework for conceptualizing a person, group of people, or social problem as affected by a number of discriminations and disadvantages (Crenshaw, 2016). There are many oppressive structures that limit a person's life. These oppressions include, racism, sexism, heterosexism, classism, ableism, and ageism (Smith, 2019). Sizeism is another oppression (Smith, 2019). Intersectional theory asserts that people are often disadvantaged by multiple sources of oppression (Crenshaw, 2016). Additionally, intersectionality recognizes that dimensions of diversity and identity do not exist independently from each other, each dimension informs the other which creates a complex convergence of oppression (YW boston, 2022). Kimberle Crenshaw once said, "Without frames that allow us to see how social problems impact all the members of a targeted group, many will fall through the cracks of our movements, left to suffer in virtual isolation" (Crenshaw, 2016, 4:27). Addressing

sizeism in multicultural curriculum is essential for psychologist and other mental health practitioners as size intersects with all forms of identity and diversity (Smith, 2019). This writer has included strategies for training on size and sizeism (see Appendix A).

**Current Multicultural Counseling Practices**

The American Psychological Association (APA) is a scientific and professional organization that represents psychologists in the United States. The organizations current interest in body size is on the pathology and medicalization of fatness (Bergen & Mollen, 2019; McHugh & Chrisler, 2019). The APA has held a medicalized view of body size, they use the term "obesity", which conceptualizes fat as a disease and the cure must be weight loss (McHugh & Chrisler, 2019). In 2003, the APA published the *Guidelines of Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, these guidelines provide those in the psychology field with a framework for working with diverse clients; however, the guidelines failed to mention body size as a dimension of diversity( Bergen & Mollen, 2019). Additionally, in 2008, the APA Task Force on the Implementation of the Multicultural Guidelines also failed to bring any focus on body size (Bergen & Mollen, 2019). The APA's omission of body size from multicultural guidelines is part of the problem. There are people affiliated with psychology that are showing some resistance. The Association for Women in Psychology (AWP) "is an interdisciplinary organization that attends to issues and concerns at the intersections of feminism and psychology" (The Association for Women in Psychology, 2022, Welcome Section, para. 1). In 2009, AWP established a Size Acceptance Caucus, this Caucus promotes research, clinical services, and advocates for size acceptance and seeks to end size discrimination; therefore, it challenges the medicalization of fat (McHugh & Chrisler, 2019;

Association for Women in Psychology, 2022, Caucuses section, para. 4). The AWP is creating space for all bodies.

The American Counseling Association (ACA) is a "not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession" (American Counseling Association, 2022, About ACA Section, para. 1). The ACA has Multicultural and Social Justice Counseling Competencies (MSJCC), which offer a framework for counselor professionals (Ratts et al., 2015). The ACA also provides different competencies on their website, these include, Competencies for Counseling LGBTQIA+ individuals, Competencies for Counseling Transgender Clients, Animal Assisted Therapy Competencies, ARCA Disability-Related Competencies, Competencies for Addressing Spiritual and Religious Issues, Competencies for Counseling the Multiracial population, and Exemplary Practices for Military Populations. As previously conveyed people are complex and present with many different intersectionalities. The unfortunate reality is that counseling competencies for body diverse clients do not exist. Counseling competencies are put into place to acknowledge different diverse identities and to relay a sensible framework that is inclusive of these experiences.

## Discussion

In the counseling profession every individual client has a unique combination of social, political, biological, and historical experiences (Hays & Erford, 2014). Working to understand those experiences allows for counselors to continue the lifelong journey of becoming culturally competent. Sizeism is a unique experience that deserves the opportunity to be understood. Sizeism affects people differently depending on their body size, shape, color, ability, gender, sexuality etc. (Abakoui & Simmons, 2010). "Sizeism impacts every single person because every person is harmed by systems of inequality and hierarchy ideologies" (Tovar, 2017, para 1). Including discussion around body size in multicultural education and training will benefit the entire population because it will create an opportunity to have a conversation about the harmful realties sizeism creates. Fat people experience prejudice in America, this is present in employment settings, the health profession, and even the mental health profession (Abakoui & Simmons, 2010). Counselors are expected to challenge each other to address personal biases and assumptions that prevent them from forming a therapeutic alliance (Hays & Erford, 2014). There is a need for multicultural education and training to discuss body diversity and to advocate for size-affirming education so that counselors can have that space to address personal biases related to size. Discussing sizeism in multicultural education and training allows for counselors to discuss and challenge sizeist beliefs. Counselors and counselors-in-training adhere to ethical principles and standards when working with any client, the preeminent ethic to uphold is to do no harm (Abakoui & Simmons, 2010). It is harmful to ignore the experience of an entire population.

**Author's Note**

According to the Centers for Disease Control and Prevention (CDC) I am considered "obese". This is based on the body mass index (BMI) found on the CDC website. Now there is much controversy around the use of the BMI. I have lived in a fat body pretty much my entire life, other than the times I wasn't battling an eating disorder. Some people may assume that I am not fat enough to discuss the topics in this paper. Some people may be surprised at my interest in such a taboo topic. And to both those groups of individuals I say, thank you, if it wasn't for those people throughout my entire life, I probably would not have made it to graduate school. When I was finally able to recover from my eating disorder, I was able to see how terribly fat individuals are treated. Actually one of the first experiences I had with fatphobia was when I was involved in this toxic weight-loss program (I am not going to name it), one of the health coaches made a comment about how I wouldn't be able to run a marathon because my knees would give out, what this health coach did not know what that I had been running for about ten years and regardless of my weight I had never had any issues with my knees. I remember thinking as a child the worst thing I could ever be in life was fat; however, I did not develop those thoughts overnight, they came to me through social media, family, friends' etc. Through my healing of my eating disorder (which took a very long time) came my interest in Health at Every Size and Christy Harrison's podcast, Food Psych. It was through this information that things started to make sense for me, I learned that it was okay to be fat. I also learned that I want to be able to celebrate the body that I live in and I want to be in a world where I can be accepted for who I am. I know I am not the only one who feels this way. As I am writing these last words in my capstone project I want to leave you all with some incredibly inspiring words, "The solution to fatphobia

is not me trying to be thin, I think it's dismantling fatphobia and that's what I'm going to do". – Ragen Chastain

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Appendix A

**Suggestions for Conducting Workshops on Sizeism and Body Diversity**

Bergen, M., & Mollen, D. (2019) Teaching Sizeism: Integrating Size into Multicultural Education and Clinical Training. *Routledge. 42*(1-2),164-180. https://doiorg.wsuproxy.mnpals.net/10.1080/02703149.2018.1524065

1. Include relevant and accurate information (Bergen & Mollen, 2019, p. 170). In teaching or conducting any workshop it is essential to have the correct information and as referenced in the literature reviewed there is a lot of misinformation when it comes to the health of fat individuals and this misinformation perpetuates fatism/sizeism. There is a body of research on Health at Every Size Movement (HAES) that dismantles these perpetuations of fatism and sizeism. Health at every size is a "weight-inclusive, anti-diet approach, to health care that's designed to help you take care of your body without trying to shrink it" (Harrison, 2019, p. 244). HAES is a method that allows for health care professionals to focus on a person's overall well-being and not the size of their body.
2. Consider experiential activities (Bergen & Mollen, 2019, p. 170). These authors suggest that experiential activities are indicative of increasing empathy and compassion in regard to size oppression (Bergen & Mollen, 2019). These writers suggest a privilege walk based on McIntosh, 1998, and 2015 as this can illustrate the discrimination, oppression, and harassment that fat people experience (Bergen & Mollen, 2019). The reality is that smaller bodied individuals may not realize their privilege and this exercise can help open that conversation. This can also allow for intersectionality to be discussed. In the literature reviewed intersectionality was discussed. This is an important topic to address

with not only the entire community but particularly counselors in training, and current professionals as sizeism may be a form of intersectionality that has been forgotten.

3. Use language intentionally ( Bergen & Mollen, 2019, p. 171). The word, “fat” receives a lot of scrutiny, when really it is just a word. If this word were simply used in conversation and normalized as an appropriate word and not one to demonize people that fall in this criterion, well, that would change a lot of perception. The word “obesity” is not helpful, as mentioned before this word medicalizes, pathologizes being fat. This writer would like to mention, that some individuals may struggle with this, the word “obesity” has been appropriated in our society (with the negative connotations) and is widely used. Dismantling the use of this word requires intention and this is likely to make some uncomfortable. Additionally, the word, “fat” is not favored by many the word has been widely used as a negative descriptor; however, again with intention our society can overcome this.
4. Utilize media and online resources (Bergen & Mollen, 2019, p. 171). There are a variety of online resources that discuss fat-shaming, microaggressions, myths, and stereotypes. Some of which include, National Association to Advance Fat Acceptance (NAAFA), The Association for Size Diversity and Health (ASDAH), Nash’s “Fat Rant” video (2007), and Ragen Chastain’s media presence and advocacy work. Online resources are essential to provide when teaching a course as it offers those taking the courses more information to continue the learning process after the workshop or class is finished.
5. Consider the audience (Bergen & Mollen, 2019, p. 172). According to Bergen & Mollen it is important to consider the interests of the general public and use that to your advantage (p. 172). It is important for those teaching the workshop to discuss the

common myths associated with diet, exercise, weight loss etc. Bergen & Mollen suggest sharing the "Food for Thought" pyramid as a useful illustration of holistic health (McKibbin, 2008). Bergen & Mollen suggest that when considering the audience, it is important to think of where college students are at with their developmental level, and unique life contexts. There is a lot of pressure and different life stressors that make an impact on how college students view weight and health. Bergen & Mollen suggest that is essential to discuss the pressures associated with age, gender, and dating relationships. Intersection of size is important to discuss, and the authors suggest even bringing a resource like The Body Project program to campus.

Lastly, the authors suggest that when speaking with graduate students include information from Fat Studies and Fat Acceptance Movement that challenges the dominate medical paradigm. For counselors in training it would be important to include applications for practice, especially case conceptualization and ethical considerations (Bergen & Mollen, 2019). In regard to future research this would be a good opportunity to discuss some HAES research and how a size positive approach can provide an impact on stigma of physical health (Bergen & Mollen, 2019).

6. Be cognizant of size diversity in the audience and in the leaders (Bergen & Mollen, 2019, p.173). "In any diversity-related workshop or presentation, especially when the focus is on a sensitive topic like size, we encourage leaders to reflect on diversity variables among audience members" (Bergen & Mollen, 2019, p. 173). The writers Bergen & Mollen, suggest that making an opening statement that acknowledges the complexity and difficulty of the topic with normalize the various emotional reactions that will be brought forward based on the topic (2019). Additionally, the writers suggest that "attention to the

size of the workshop leaders is also a key consideration" (Bergen & Mollen, 2019, p. 173). Reflecting on the presenter's body size is important because it allows for participants to answer questions like: "What is the impact of a within-group member speaking about size marginalization? What might it mean for a person with thin privilege to speak about sizeism?" (Bergen & Mollen, 2019, p.173). There is a potential for those with thin privilege to use that privilege and share some insight on an important topic and on the other hand if the presenter resides in a fat body, they can discuss their experience with this.

7. Be prepared for varied audience reactions (Bergen & Mollen, 2019, p. 174). Discussing sizeism/ fatphobia and body size in general is a sensitive topic, this means that people are bound to react in a variety of different ways. It is possible that members of the audience will feel emotionally triggered, and struggle with internalized sizeist beliefs (Bergen & Mollen, 2019). Thankfully, there are some strategies to manage resistance. It is important to keep trying, this is a hard battle to fight especially in a society that constantly oppresses fat individuals but planning these trainings and speaking out against this oppression will make an impact. Bergen & Mollen suggest that when challenging interactions are encountered during the training's individuals should keep a sense of curiosity. By keeping a sense of curiosity this allows for the speaker to gently challenge different perspectives and open the floor to more conversation (Bergen & Mollen, 2019).

**Strategies and Suggestions for Size-Affirmative Clinical Practices**

**(Bergen & Mollen, 2019)**

1. Address size alongside other diversity variables (Bergen & Mollen, 2019, p. 175). As this writer has mentioned in the entirety of this paper, the problem is that size is not being addressed in multicultural education and training and this includes as a diversity variable. When we intentionally use this as a diversity variable it will elicit change.
2. Explore biases about size within supervision (Bergen & Mollen, 2019, p. 175).
3. Provide accurate information regarding health and size (Bergen & Mollen, 2019, p.175).
4. Consider size in case conceptualization (Bergen & Mollen, 2019, p. 176).
5. Avoid pathologizing size or overestimating the importance of size in case conceptualization (Bergen & Mollen, 2019, p. 176).
6. Reflect on the ethics of size-related beliefs and weight loss counseling in clinical work (Bergen & Mollen, 2019, p. 176).

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