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Normative Does Not Mean Inclusive: A Diverse Approach to Size in CMHC Training

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Abstract

The medicalized model of weight and weight loss upholds a Weight Normative Approach which assumes that: (a) weight and disease are positively and causally related, (b) weight loss correlates to better health, (c) bodyweight is controllable, and (d) significant weight loss is possible and sustainable. This approach contributes to harmful societal standards that increase prejudice against fat people. This study examined counselor educators' (n=88) training, values, and implementation of size and fat phobia-related content in their CACREP-accredited counseling courses. Results indicated that many participants include size and sizeism in their courses; however, participants also reported agreement with tenants of Weight Normative Models. This research is a call to action for educators to adopt and advocate for a Weight Inclusive Model.

Keywords

sizeism, fatphobia, body diversity, weight normative, weight inclusive

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This manuscript will review the history and negative impact of utilizing a Weight Normative Approach (WNA) in counselor education programs. This includes a review of the tenants of the WNA, a discussion of sizeism, fat phobia, weight stigma, and the lack of diversity training among practitioners. We will then introduce and advocate for the adoption of a Weight Inclusive Approach (WIA). This call to action includes reviewing tenants of the WIA, discussing an empowerment-based approach to conceptualizing size as a component of intersectionality, and providing implications for educators and clinicians.

Weight Normative Approach

Western cultures, such as the United States, adhere to the medicalized model of weight and weight loss (Kasardo, 2019; Matacin & Simone, 2019). The medicalized model upholds a WNA which assumes that (a) weight and disease are positively and causally related, (b) weight loss correlates to better health, (c) bodyweight is controllable, and (d) significant weight loss is possible and sustainable for the majority of people (Calogero et al., 2019). Although this model masquerades itself as effective in the literature, in reality, it stigmatizes fat people, creates socialized internal weight stigmas, and shows little efficacy over time (Calogero et al., 2019). The mass implementation of the WNA inadvertently contributes to harmful societal standards that increase prejudice against fat people (weight stigma) and endorses harmful dieting behaviors, like yo-yo dieting (Casazza et al., 2015; Tylka et al., 2014). Weight stigma includes two constructs, weight self-stigma (internal weight stigma) and enacted weight stigma. Weight self-stigma refers to “the devaluation of oneself due to weight or body size,” while enacted weight stigma encompasses negative attitudes, stereotyping, bias, and discriminatory behaviors based on body size or weight (Prunty et al., 2022, p. 33). Individuals in larger bodies experience weight stigma in many facets of life, including healthcare, resulting in numerous adverse mental and physical health

consequences (Puhl et al., 2021). Moreover, weight bias and stigma have worsened over time (Puhl et al., 2021). The negative health consequences of weight bias and stigma include increased blood pressure, anxiety, depression, low self-esteem, body dissatisfaction, and increased eating disorder risk (Nutter et al., 2020; Prunty et al., 2022). Additionally, weight stigma is associated with reduced physical activity, maladaptive eating patterns, and delay or avoidance of healthcare (Prunty et al., 2022). The adverse health outcomes related to weight stigma are so profound that researchers consider them more harmful than having a larger body (Nutter et al., 2020).

Additionally, in counseling practices, internalized weight stigma and fat phobia are associated with the misdiagnosis of disordered eating in higher-body weight clients (Veillette et al., 2018). McVay et al. (2019) examined the correlation between weight loss and weight-intervention counseling and found that weight-loss interventions did not contribute to sustained weight loss over time. Rather, the study found that empathy observed by the counselors had the strongest effect on weight loss over time. These findings suggest that combating shame placed on those with higher body weight helps increase healthier lifestyles, with weight loss as its byproduct (McVay et al., 2019). The WNA to weight loss shames those with higher body weight; shame has been linked to increased eating and weight gain (Duarte et al., 2017).

A lack of diversity training still exists regarding size and weight normative interventions. These harmful tenants have been observed in several training programs for helping professionals (e.g., social work, nursing, and counseling programs) (Kasardo, 2019; Rothblum & Gartrell, 2019; Veillette et al., 2018). For example, Kasardo (2019) found that many of the textbooks used in graduate psychology courses to teach students about multiculturalism fail to include size as a component of diversity. Additionally, the 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards that inform curriculum in accredited

counselor preparation programs exclude weight as an intersection of difference; the standards limit differences to those related to race, ethnicity, culture, gender, sexuality, religion, political, physical abilities, age, and socioeconomic status (CACREP, 2016). Finally, despite the American Counseling Association (ACA) *Code of Ethics* (2014) advocating for non-harmful societal standards - "The fundamental principles of professional ethical behavior are... nonmaleficence or avoiding actions that cause harm" (p. 3) – WNAs and the harmful beliefs associated with those models still permeate training curriculum.

It is necessary that training programs across health professions include size as a component of diversity and teach students how to conceptualize size when considering intersectionality. This lack of training, and the detrimental health outcomes associated with WNA, require a call to action for educators within these training programs to advocate and include size, sizeism, and fat phobia in their diversity courses and across the curriculum to avoid further internalized weight stigma and misdiagnosis. To do this, we advocate teaching a Weight Inclusive Approach (WIA) - an approach that sees size as a natural expression of diversity and is linked with greater positive health outcomes (Calogero et al., 2019) - within health and wellness training programs, specifically CACREP-accredited mental health counseling programs.

A Weight Inclusive Call to Action

The Weight Inclusive Approach (WIA), termed by Tylka et al. (2014), encourages medical practitioners to (a) see body diversity as natural, human diversity; (b) promote health and wellness; (c) view morality as independent of weight; and (d) to utilize interventions that do no harm (i.e., encourage sustainable, maintainable, and client-centered tools that support health and wellness for people across the weight spectrum) (Calogero et al., 2019). Additionally, the WIA promotes that individuals have a right to be fat without prejudice, that health can be cared for independent of

weight, and that social determinants of health are the primary drivers of population health (Calogero et al., 2019). Finally, in contrast to the WNA, which prescribes weight-control practices for fat people that would otherwise be indicative of an eating disorder diagnosis in thin people, the WIA promotes behaviors that have been shown to improve health outcomes in people of all sizes (Calogero et al., 2019; Hunger et al., 2020).

Accordingly, our approach with this work is meant to inspire an empowerment-based perspective that encourages educators and professionals to teach and embrace terms historically used to shame and marginalize certain populations for their representations of diversity. Terminology, like fat, is utilized as a process of re-appropriation and normalization, as fat is the preferred term within the fat acceptance movement (Meadows & Daníelsdóttir, 2016). It is essential for the counseling field to begin modeling and teaching these tenants of weight inclusivity.

The limited research examining the intersection of counseling and the WIA primarily focuses on its absence in multicultural counseling literature (Kasardo, 2019; Rothblum & Gartrell, 2019; Veillette et al., 2018). Thus, this study aimed to examine counselor educators' training, values, and implementation of size and fat phobia-related content in their CACREP-accredited counseling courses to affirm the importance of sizeism and fat phobia training and advocate for its integration into the field and curriculum. Similar movements have been achieved with the intentional integration of sexual health and wellness (ACA, 2014; ALGBTIC, 2010; CACREP, 2015); we are hopeful the same can be done for size diversity.

Method

This quantitative study aimed to examine counselor educators' training, values, and implementation of size and fat phobia-related content in their CACREP-accredited counseling courses. As such, a cross-sectional survey design with random convenience sampling was utilized.

Procedures

This study was reviewed by the [omitted for blind review] Institutional Review Board (IRB) and was declared exempt (IRB#: 1731342-1). Researchers complied with all federal, state, and local laws, and institutional policies and procedures applicable to this research. After IRB approval, prospective participants were invited to participate in the study in several ways. First, the research team identified a list of CACREP-accredited counselor education programs and gathered prospective participants' contact information from the associated programs' websites. Subsequent emails with recruitment materials were sent to those instructors. The research team also posted recruitment materials on counselor education and supervision listservs and encouraged prospective participants to share the recruitment materials with their colleagues.

Eligibility criteria included counselor educators aged 18 years or older who taught in CACREP-accredited clinical mental health counseling programs in the U.S. If prospective participants met the requirements of the study and chose to proceed to participate in the study, they were instructed to select the link in the recruitment email that automatically redirected them to a Qualtrics survey. The Qualtrics survey began with an informed consent document. If the prospective participants provided informed consent to participate in the study, they advanced to the questionnaire composed of 34 questions used to gather data regarding each participant's demographic information, training, values, and implementation of size and fat phobia-related content in their courses. The sample size of this study (n=88) is sufficiently large to draw

meaningful conclusions, as it can detect at least a 1% difference in proportions with a power of at least 0.80 using a 2-sided test and a 5% type I error.

Measures

Demographic Information

The nine-item demographic questionnaire included gender, sexual orientation, age, race/ethnicity, geological location, level of education, employment status, university type, and number of years teaching in counselor preparation programs.

Training Information and Course Mapping

This non-validated five-item questionnaire gathered information regarding participant training in sizeism and fat phobia and their implementation of such in the courses they teach. These questions were developed by the research team to understand the training background and implementation of such in their courses. Example questions include: *Have you ever attended a workshop…with learning objectives that included size, sizeism, and/or fat phobia as components of intersectionality?*, *What CMHC courses have you taught in the last 3 years?, Within the last 3 years, which of these courses do you introduce and or cover size and sizeism as a component of intersectionality?.*

Weight Related Opinion Questions and Fat Phobia Scale

This section included a six-item validated questionnaire that gathered information about participants' weight-related opinions. Sample statements include: *Weight is a valid proxy for health* and *Weight and disease are causally related*. Each statement is rated on a 4-point Likert-type scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*).

This section also included the validated Fat Phobia Scale. The Fat Phobia Scale is a 14-item assessment used to measure fat phobia (Bacon et al., 2001). The scale lists 14 pairs of

adjectives that are often used to describe fat people. Participants were asked to view the adjectives and place a marker closest to the adjective that best describes their feelings and beliefs. Sample adjectives include *Lazy and Industrious, Attractive and Unattractive, Fast and Slow, Weak and Strong, Insecure and Secure*. The adjectives are listed parallel to one another with a 5-item numbered Likert scale between each. A higher score indicates more fat phobia, while a lower score indicates less fat phobia. The Fat Phobia Scale demonstrates excellent psychometric properties, is reliable (Cronbach's alpha=0.87), and exhibits construct validity (Bacon et al., 2001).

Analysis

Descriptive statistics were utilized to describe the study sample and survey findings. Analyses were performed using STATA version 14.2. Kruskal-Wallis and Pearson's $\chi 2$ were utilized to assess continuous and categorical variables, respectively. Bivariate analysis using Ordinary Least Squares regression was used to determine the associations between fat phobia composite scores and select participant experience and age while controlling for gender. Variance inflation factors (VIFs) were assessed to gauge the presence of multicollinearity and outliers. We selected to control for gender, given prior evidence suggesting a relationship between gender and fat phobia. Age was operationalized as a continuous variable. Due to sample distribution, we operationalized the six opinion-based questions as *disagree* and *agree*. All tests of significance were 2-sided; parameter estimates (regression coefficients) and p-values were reported. The level of statistical significance was set at p-value < 0.05.

Results

Participants (n=88) in this study were instructors teaching in Clinical Mental Health Counseling CACREP-accredited programs in the United States. The majority of participants were female (68.54%), heterosexual or straight (76.92%), Caucasian or White (76.34%), and living and

teaching in the South region of the United States (55.65%). The mean age of participants was 49 years old, with a standard deviation of 12.15 years. About 90% of participants held a PhD, EdD, or PsyD in Counseling, Counselor Education, or a related field. Over one-third (36.36%) of participants were Assistant Professors, while 20% were Associate Professors, 26% were Full Professors, and less than 10% were Adjunct Professors. About 60% were early career (10 or fewer years teaching). Overall, the majority of participants were teaching at either a public (32.37%) or private (37.41%) higher education institution. Complete demographic statistics are presented in Table 1.

Table 1

Participant (n=88) Demographic Characteristics

Demographic Characteristics	**N**	**%**
Gender		
Man	27	30.34
Woman	61	68.54
Nonbinary	1	1.12
Sexual orientation		
Heterosexual or straight	70	76.92
Other	21	23.08
Asexual	1	4.76
Bisexual	9	42.86
Bicurious	1	4.76
Gay	1	4.76
Lesbian	4	19.05
Pansexual	1	4.76
Queer	2	9.52
Something not listed	2	9.52
Race/Ethnicity		
Caucasian or White	71	76.34
African American or Black	9	9.68
Asian	5	5.38
Other	8	8.60
Latinx or Hispanic	1	12.50
Native American	2	25.00
Native Hawaiian or Pacific Islander	1	12.50

Biracial or Multiracial	1	12.50
Prefer not to answer	1	12.50
Something not listed	1	12.50
Bi-ethnic	1	12.50
Region		
Northeast	11	12.50
Midwest	17	19.32
South	49	55.68
West	11	12.50
Current level of education		
MS, MA, M.Ed in Counseling, or related field	4	4.55
Currently completing PhD, EdD, PsyD in Counseling, or related field	4	4.55
PhD, EdD, PsyD in Counseling, Counselor Education, or related field	80	90.91
Current status as a Counselor Educator		
Currently completing PhD, EdD, PsyD	4	4.55
Postdoctoral student	0	0.00
Adjunct Professor	8	9.09
Visiting Professor	3	3.41
Assistant Professor	32	36.36
Associate Professor	18	20.45
Full Professor	23	26.14
University currently teaching CMHC courses		
Public	45	32.37
Private	42	37.41
Online	13	9.35
Faith-based	18	15.83
Other	3	2.16
Years teaching in CMHC programs		
Early Career 10 or less years	52	59.09
Mid-Career 11-20 years	17	19.32
Late Career 21+ years	19	21.59

Table 2 highlights the results of the course mapping questions.

Table 2

CMHC Courses Taught and Those Covering Size

	What CMHC courses have you taught in the last 3 years?	Within the last 3 years, which of these courses do you introduce and or cover size and sizeism (size discrimination) as a component of intersectionality?	Percentage of courses taught that cover size and sizeism
	N	N	%
Skills	49	12	24.49
Theory	34	5	14.71
Ethics	31	8	25.81
Group	29	6	20.69
Multicultural Counseling or Diverse Populations	43	31	72.09
Research	29	3	10.34
Assessment	22	1	4.55
Human Growth and Development	25	5	20.00
Diagnostics	27	6	22.22
Career	24	4	16.67
Addictions	24	5	20.83
Sexual Issues	14	8	57.14
Electives	30	3	10.00
Other	42	12	28.57

Results indicated that 72.09% of participants introduce and/or cover size and sizeism in Multicultural Counseling or Diverse Populations courses, 57.15% in Sexual Issues courses, and 28.57% in other courses such as Crisis and Trauma courses. Less than 5% of participants introduce and/or cover size and sizeism in Assessment courses, and only 10% introduce and/or cover size and sizeism in program elective courses. When asked about their own training, 93% of participants indicated that they never took a college course with learning objectives that included size, sizeism, and/or fat phobia as components of intersectionality. Moreover, 94% reported never attending a workshop, webinar, or continuing education unit with learning objectives that included size, sizeism, and/or fat phobia as components of intersectionality.

Table 3 highlights the results from the six weight-related opinion-based questions.

Table 3

Participants' (n=88) Opinions of Weight-Related Statements

In your opinion:	**Disagree, n (%)**	**Agree, n (%)**
In the courses you teach, it is important for you to include size and sizeism (size discrimination) as a component of intersectionality.	19 (21.59)	69 (78.41)
Weight is a valid proxy for health.	43 (48.86)	45 (51.14)
Weight and disease are causally related.	30 (34.09)	58 (65.91)
Body weight is controllable and should be controlled for better health.	50 (57.47)	37 (42.53)
Weight loss is maintainable for the majority of the population.	61 (69.32)	27 (30.68)
Weight loss is a practical and positive treatment goal for clients.	44 (50.57)	43 (49.43)

About 78% of participants agreed that it is important to include size and sizeism as a component of intersectionality. Slightly over half agreed that weight is a valid proxy for health and 65% agreed that weight and disease are causally related. About 57% disagreed that body weight is controllable and should be controlled for better health. The majority disagreed that weight loss is maintainable for the majority of the population. Finally, half of the participants agreed, and the other half disagreed that weight loss is a practical and positive treatment goal for clients.

Results from the Fat Phobia Scale are presented in Table 4.

Table 4

Fat Phobia Scale

Listed below are pairs of adjectives sometimes used to describe obese or fat people. For each adjective pair, please check the mark closest to the adjective that you feel best describes your feelings and beliefs from 1-5	**1**	**2**	**3**	**4**	**5**
	n	**n**	**n**	**n**	**n**
lazy - industrious	0	12	52	12	12
no will power - has will power	0	11	49	17	11
attractive - unattractive	10	9	37	26	6
good self-control - poor self-control	5	8	51	20	4
fast - slow	1	5	42	33	7
have endurance - having no endurance	6	9	44	24	5
active - inactive	5	9	46	22	6
weak - strong	0	8	53	21	7
self-indulgent - self-sacrificing	2	17	58	9	2
dislikes food - likes food	0	1	44	35	8
undereats - overeats	0	2	44	32	10
insecure - secure	9	25	45	7	2
low self-esteem - high self-esteem	5	32	44	5	2
Fat Phobia Score, mean (SD)	3.15 (0.55)				

The total fat phobia composite score was 3.15, with a maximum score of 5 and a standard deviation of 0.55. Recall that a higher score indicates more fat phobia, while a lower score indicates less fat phobia. Multivariate analysis (Table 5) revealed that late-career participants reported a lower fat phobia composite score (less fatphobic) than early-career participants while controlling gender. Furthermore, for every 1-year increase in age, fat phobia composite scores decreased by 0.01 points.

Table 5

Ordinary Least Squares Regression of Fat Phobia: Career Length & Gender

	Coefficient (SE)	P-Value
Model 1		
Gender (Reference: Male)	0.01 (0.13)	0.92
Career (Reference: Early Career)		
Mid-Career	-0.23 (0.15)	0.14
Late Career	-0.43 (0.14)	0.00
Model 2		
Gender (Reference: Male)	-0.06 (0.13)	0.65
Age	-0.01 (0.00)	0.03

Discussion

The primary purpose of this study was to explore counselor educators' training, values, and implementation of size and fat phobia-related content in their CACREP-accredited counseling courses. Our goal is to advocate for the inclusion of size, sizeism, and fat phobia as a component of diversity and intersectionality to be taught throughout the counseling curriculum. One way to achieve this goal is to adopt and promote a WIA in the counseling field. While many participants reported including size and sizeism in a few of their courses (e.g., Diverse Populations (72.09%) and Sexual Issues in Counseling (57.15%)), participants also reported agreement with the shame-based tenants of harmful WNA. If counselor educators inadvertently teach their students about size, sizeism, and fat phobia while harboring negative attitudes and weight-normative beliefs, they may promote stereotypes and weight discrimination.

Additionally, the total fat phobia composite score was 3.15, indicating moderate fatphobic beliefs of participants. These results indicate that educators may be aware of sizeism and its effect on clients; however, they still observe increased weight through a negative lens. Furthermore, results indicate that 45% of participants agree that weight is a valid proxy for health, 58% agree that weight and disease are causally related, and 49% agree that weight loss is a practical and positive treatment goal. These results suggest that educators are operating under a WNA. A weight

inclusive lens would promote the idea that (a) individuals have the right to be any body size without fear of discrimination, (b) that weight and disease are not causal, and (c) that the promotion of weight loss as a goal is harmful and can increase internalized weight stigma (Calogero et al., 2019).

The findings of this study are congruent with current literary findings related to existing negative weight stigma in healthcare professions (Hunger et al., 2020). Current literature indicates that healthcare providers operate under a WNA, resulting in adverse health outcomes due to weight bias (Nutter et al., 2020). Without adopting a WIA, counselor educators and clinicians could unintentionally harbor harmful weight bias and stigma when working with clients, potentially causing mental and physical harm (Nutter et al., 2020; Prunty et al., 2022). Ideally, counselor educators and clinicians will adopt a weight inclusive lens, view size as a natural body diversity, and promote wellbeing independent of weight.

Although many educators in this sample agreed with weight normative beliefs, there is hope that a weight inclusive reality is achievable, as 61% of participants disagreed that weight loss is maintainable for most of the population, and 50% disagreed that body weight is controllable and should be controlled. Ultimately, the WIA needs to be adopted by and implemented in the counseling field. Counselor educators, clinicians, and counselors-in-training must dismantle sizeism and fat phobia and honor size as a component of intersectionality in the classroom and clinical practice.

Implications

To move toward a weight inclusive future, counselor educators can begin to adopt weight inclusive vocabulary in their curriculum and courses to help promote awareness. They can also include resources in their coursework to help supplement the lack of such in counseling textbooks; this includes recommending supplemental reading materials on size diversity, sizeism, and fat

phobia. Specifically, counselor educators are encouraged to visit reputable resources to inform their clinical and teaching practices. Resources include websites, podcasts, and continuing education from sources such as: (a) Health at Every Size, (b) Weight Inclusive Nutrition and Dietetics, (c) Intuitive Eating, (d) Body Kindness, (e) Be Nourished, and (f) Academy of Nutrition and Dietetics. In the classroom, counselor educators can also (a) teach students key terms, common misconceptions, and truths around size; (b) highlight inclusive literature; (c) have students take the Fat Phobia Scale and facilitate honest conversations around biases; (d) invite guest speakers or have students interview a Health at Every Size Nutritionist; and (e) have classroom projects that encourage students to look into the systemic issues around sizeism and fat phobia, and how they can advocate for their size diverse clients.

Additionally, counselor educators and practitioners using WIA can serve as advocates to validate clients' firsthand experiences concerning body diversity. Educators and clinicians can also educate clients and colleagues on size discrimination and how to include weight inclusive language and ideas in their lives and practice. Finally, educators and clinicians need to stay abreast of the developing research surrounding body diversity and weight inclusive language and practices; this includes continuing education regarding inclusive practices.

Advocacy for Weight Inclusivity in Counselor Education

Currently, CACREP (2016) defines multicultural as a "term denoting the diversity of racial, ethnic, and cultural heritage; socioeconomic status; age; gender; sexual orientation; and religious and spiritual beliefs, as well as physical, emotional, and mental abilities." This definition does not include size or weight bias. The WIA (Tylka et al., 2014) encourages practitioners to (a) see body diversity as natural, human diversity; (b) promote health and wellness; (c) view morality as independent of weight; and (d) to utilize interventions that do no harm (i.e., encourage sustainable,

maintainable, and client-centered tools that sustain health and wellness for people across the weight spectrum) (Calogero et al., 2019). Integrating size as a component of diversity can easily translate into CACREP standards to improve understanding, conceptualizing, diagnosing, and caring for size-diverse clients using a WIA.

Without CACREP standards, counselor educators are responsible for choosing to include weight and size as a diversity component; even if included, counselor educators have the freedom to teach through a weight normative, fatphobic approach. This research highlights the need for minimum competencies in knowledge, attitudes, and skills related to size through the WIA. Without a requirement, educators could mislead counselors-in-training to practice through a harmful WNA which is why we advocate for including size, taught through a weight inclusive lens, as a dimension of diversity in standards that govern the counseling field.

Limitations

While the present study contributes to the limited literature on sizeism and fat phobia in counselor preparation programs, some limitations exist. First, the data was collected from volunteer participants, and self-selection may bias the findings. Despite a concerted effort to recruit a diverse sample, most participants in this sample identified as White, cisgender, straight, and women. While this aligns with trends in the counseling field, these participant characteristics may limit the extent to which the findings can be generalized to the broader population of counselor educators. Additionally, recruitment was limited to counselor educators who taught in CACREP-accredited CMHC programs. Thus, the results may not represent those teaching in related- or non-accredited programs. Finally, the survey used to collect data was a combination of validated and non-validated questions intended to assess beliefs related to WNA, WIA, and Fat Phobia. Finally, the order of the questions within the survey might have primed educators for response bias.

Recommendations for Future Research

Based on the limitations of this study, recommendations for future research include expanding and replicating this study in other settings with a more diverse sample. It is recommended that future researchers explore non-CACREP-accredited programs as well as school and rehabilitation counseling programs. Researchers should also expand this work and explore these components in other health-related training programs, such as nursing programs, nutrition, dietetics, exercise science, social work, etc. Exploring and expanding upon this work can lead to a shift in our society, training programs, and helping practices that embrace inclusive practices and dismantle those rooted in outdated stereotypes and discrimination. Future research may also utilize qualitative methodologies to gain a deeper understanding of how sizeism and fat phobia impact the counseling field and perhaps explore the specific impact of weight inclusive counseling versus weight normative counseling on clients. Finally, the results indicated that early career educators who have been teaching for fewer than ten years reported increased fatphobic beliefs. Future researchers may target and explore this intersection to future understand this finding.

Conclusion

A lack of diversity training still exists regarding size and weight normative interventions in CACREP-accredited clinical mental health counseling programs (Kasardo, 2019; Rothblum & Gartrell, 2019; Veillette et al., 2018). While findings from this quantitative, cross-sectional study indicated that some educators do include size and sizeism in a few of their counseling courses, participants also reported agreement with the shame-based tenants of harmful WNA. Additionally, many participants reported a lack of their own training in the subject, with a majority reporting that they never took a college course, webinar, or workshop with learning objectives related to size, sizeism, or fat phobia as components of intersectionality. With the lack of training, coupled

with the detrimental impact of WNA, it is necessary that counselor educators understand, advocate for, and include learning objectives related to WIA in their curriculum to avoid promoting stereotypes and weight discrimination. This study adds to the existing literature as it contributes substantive advocacy initiatives and provides practical implications for educators and clinicians.

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