

Patient Perspectives on Nutrition Providers' Phenotypes and Attitudes About Weight
During Treatment for Atypical Anorexia Nervosa

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Abstract

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Introduction: To date, research on the experience of patients with higher weight who have restrictive eating disorders (EDs) is lacking. The patient's narrative provides meaning, context, and an understanding of the patient's experience of illness.

Methods: The Women's Illness Narratives Through Eating Disorder and Remission (WINTER) longitudinal, mixed methods study explores treatment-related weight bias experiences in adult patients, ages 22-74 with BMI range from 25.6 kg/m² - 61.1 kg/m² who have past or present diagnosis of Atypical Anorexia Nervosa. The present study is a partial sample (N=20) from the WINTER study, which included three semi-structured interviews. Participants were asked to discuss: 1) their positive and negative experiences with healthcare providers and in ED treatment settings, 2) how these positive and negative experiences impacted their journey going forward, 3)

how the visible identities of ED and healthcare providers impacted their experiences, and 4) how health professionals can improve their current practices. Dedoose software was used to analyze baseline and 6-month interviews for salient themes related specifically to nutrition providers. Nutrition providers were defined as any provider who prescribed a meal plan, offered nutrition advice, or discussed nutrition concepts as part of treatment, regardless of whether this provider was a known Registered Dietitian.

Results: Three main themes were identified. Two of these themes described ideologically opposed treatment approaches. One type of treatment centered weight and used it as a driving determinant of care, and a second type of treatment that was weight-inclusive, incorporated Health At Every Size® (HAES®) and Intuitive Eating principles, and acknowledged the harm of weight bias. The third and final theme identified participants' ideas for improved future support.

Conclusion: Patient perspectives identified the need for greater awareness regarding the specific challenges individuals with restrictive eating disorders at high weights face. Further, these perspectives revealed the need to increase weight-inclusive nutrition treatment approaches (e.g. HAES ®) that target ED behaviors and cognitions and promote body acceptance at all sizes, and the importance of including diverse bodies in the ED treatment profession.

INTRODUCTION

Eating disorders (EDs) encompass a range of psychological conditions that can affect people of all genders, ages, races, religions, ethnicities, sexual orientations, body shapes, and weights.

Other Specified Feeding or Eating Disorders (OSFED) are a category of EDs that cause significant distress or impairment but do not meet the full criteria for any other disorders in the feeding and EDs diagnostic class.¹ Atypical Anorexia Nervosa (AAN) is a subtype of OSFED characterized by the criteria for Anorexia Nervosa (AN), except that despite significant weight loss, the individual's weight is within or above the normal Body Mass Index (BMI) range.¹ While individuals with AAN do not meet the diagnostic criteria for full syndrome AN, individuals who present with AAN can experience a severity of symptoms, acute complications, and caloric restriction equal to those with AN.² Further, in one study, the number of adolescents who required inpatient treatment for complications related to AAN increased fivefold over a 6-year period between 2005 and 2010, highlighting the importance of screening for restrictive EDs at all weights.² Evidence from the Mayo Clinic suggests that adolescents with a history of higher weight, including those who qualify as overweight or obese according to current BMI criteria, may represent at least 36% of patients seeking treatment for restrictive EDs, thus demonstrating how these debilitating disorders impact individuals across the weight spectrum.³

Given the demonstrated prevalence of restrictive EDs in individuals of higher weights, it is of great concern that patients with AAN experience similar psychological and physical morbidity, and more severe distress related to eating and body image, when compared to individuals with AN.⁴ While research has not yet explored why individuals with AAN experienced greater distress related to eating and body image, it could conceivably be related to weight bias, a

phenomenon characterized by negative attitudes and discrimination toward an individual based on their overweight or obese BMI status.⁵ Weight bias can take on varied forms and is experienced by individuals in numerous settings including educational institutions, the workplace, and in healthcare.⁵ For example, research suggests that physicians perceive patients with obese BMI status as less compliant and self-disciplined than patients with normal BMI status, and physician interest in providing healthcare interventions decreases as BMI increases.⁶

While it is well-established that weight bias exists among physicians and negatively impacts the health outcomes of individuals of overweight or obese BMI status who seek treatment, the prevalence and impact of weight biases among nutrition providers is apparent, though less understood.^{6,7,8} A 2015 systematic review of weight stigma among Registered Dietitians (RD) and nutritional sciences and dietetics students suggests that weight bias does exist among nutrition and dietetics students, and practicing RDs.⁹ In a study that assessed the attitudes about treatment and perceived patient outcomes among healthcare providers specializing in ED treatment, external weight bias was observed among study participants, though RDs only accounted for 14% of the study sample.¹⁰ In regard to inpatient ED care, one case study describes a patient with AAN's perception of weight bias in the form of a restrictive meal plan prescribed by a nutrition provider, during residential care for AAN, which typically involves nutritional rehabilitation.¹¹

In an effort to reduce weight bias in healthcare, weight-inclusive treatment approaches, such as Health At Every Size® (HAES®), have been demonstrated in some wellness interventions, but are not widespread or standardized for use across healthcare settings.¹² Given these efforts, it

seems reasonable to explore the impact of explicit weight-centered advice or treatment approaches in ED care, and how those may relate to patients' experiences of weight bias.

Provider phenotype may also play a role in the AAN patient's perceived experiences of weight bias. Evidence suggests that provider figure or body type is important to ED patients and that patients prefer a provider whose shape is similar to their own.¹³ Provider body type or weight is also thought to influence patient provider selection, patient trust, and patient adherence to medical advice.¹⁴ However, data regarding the general phenotypes of ED providers and how patient perspectives of nutrition provider phenotype may affect the treatment experiences of individuals treated for AAN is unknown.

Considering these knowledge gaps, it would be useful to examine the AAN patient's perception and experience of these phenomena during treatment. The primary aim of this study is to discover how individuals with a history of (or current) AAN have experienced weight bias from nutrition providers during their illness, treatment, or recovery by describing their perceptions of the attitudes, treatment approaches, and phenotypes of the nutrition providers who treated them. The primary outcome of this study is to better understand the nutrition provider's role in the treatment of persons with AAN, and to identify any gaps in knowledge regarding provider phenotype and attitudes about weight that may be used to inform future development of healthcare services for this population.

METHODS

Study Design

Data for this study are drawn from the Women’s Illness Narratives Through Eating Disorder and Remission (WINTER) Study. The WINTER Study is a longitudinal, observational study that utilized mixed-methods to explore the experiences of women and non-binary assigned female at birth (NB-AFAB) individuals who had a history (or current diagnosis) of AAN. Participants were enrolled in the study for one year and completed one in-depth semi-structured interview at baseline, 6-months, and 12-months for a total of three interviews. The baseline interview assessed the development and progression of participants’ illnesses, the 6-month interview assessed participants’ help seeking and interactions with medical providers in treatment settings, and the 12-month interview assessed participants’ perspectives on recovery and relapse. In addition to the in-depth interviews, participants completed quantitative surveys every 2-months, and completed one exit survey at the 12-month timepoint, which included open-ended questions that assessed participants’ experiences and perceptions of their nutrition providers.

Study Setting and Participant Recruitment

Adult women and NB-AFAB adults were primarily recruited from ED treatment center(s) that incorporate HAES® treatment modalities and tend to serve individuals with a range of BMI status, located in or near Seattle, Washington and Portland, Oregon. US-residents who were not located in the Seattle area were permitted to participate if they could attend video or phone interviews. Participants were recruited through flyers posted at treatment centers, provider referral, and social media groups. A snowball sampling method was used to increase sample size, which led some interested potential participants to contact the Principal Investigator (PI) directly after hearing about the study through other participants or through media reports of the study. Monetary incentives in the form of online gift cards were offered to participants for each

qualitative interview (\$15 per interview) and survey (\$10 per survey) completed. The current study utilized a partial sample of the 20 individuals (N=20) who had completed baseline, 6-month, and 12-month interviews at the time of this study's completion.

Participant Screening and Eligibility

Prospective participants were screened via telephone or in-person to meet eligibility criteria. To be eligible, women and NB-AFAB persons had to be 18 years of age or older, live in the US, speak English, and have experienced AAN at a BMI > 18.5. Mental health status, ED pathology and diagnoses were assessed through clinical interviews by the PI, who is a mental health evaluator and is a Licensed Social Work Associate & Independent Clinical practitioner in Washington State. The Eating Disorder Assessment for DSM-5 was used to verify the presence of AAN at BMI > 18.5.¹⁵ Participants who, at any point in their lifetime, met criteria for AAN or any OSFED for which restriction was a primary symptom, were eligible for inclusion; ultimately, all participants met criteria for AAN. Participants were permitted to have experienced multiple lifetime ED diagnoses, including diagnoses that crossed from subthreshold to threshold ED presentations, as this is common among persons with EDs.^{16,17,18} Individuals who resided in residential or inpatient hospital settings, or who endorsed acute suicidality or acute psychosis in the two weeks prior to the screening were ineligible.

Data Collection

Qualitative interviews were conducted by the PI in person when possible, and via the online video conference platform, Zoom, when in-person interviews were not possible. Interviews were audiotaped and transcribed using a modified verbatim format in which filler words and false

starts were omitted. Following transcription, interviews were validated and de-identified by the PI and research assistants, with the PI conducting a final review of all transcripts. Participants were allowed to review their de-identified transcripts for transcriber or speaker errors and make desired revisions accordingly. Two out of the twenty participants in this study provided revisions to their transcripts. Quantitative and short answer survey data was collected and managed using REDCap (Research Electronic Data Capture) tools hosted at University of Washington. REDCap is a secure, web-based application designed to support data capture for research studies.¹⁹ REDCap is compliant with the Health Insurance Portability and Accountability Act regulations.

Data Sources

The present study utilized data from the baseline and 6-month interviews, which addressed participant experiences with ED providers during ED treatment and in primary care, including nutrition providers and dietitians. Data from Participant 7's interviews were not analyzed because Participant 7 reported never having seen a nutrition provider or dietitian. Six-month interviews typically took 2-3 hours to complete. During the baseline interview, participants were asked to describe the progression of their ED, including: 1) what having an ED means to participants 2) how others have responded to participants' EDs 3) the events that led up to ED treatment 4) how participants felt their weight and body size impacted their ED journey, and 5) a discussion regarding their ED journey in the present and going forward in relation to recovery and remission. During the 6-month interview, participants were asked to discuss: 1) their positive and negative experiences with healthcare providers and in ED treatment settings, 2) how these positive and negative experiences impacted their journey going forward, and 3) how the visible identities of ED and healthcare providers impacted their experiences.

Ethics Considerations and Confidentiality

All study protocols and procedures were approved by the University of Washington Institutional Review Board and conformed to recognized standards set by the US Federal Policy for the Protection of Human Subjects. All research participants completed an informed consent process, which included a consent quiz to assess for understanding. A waiver of signed informed consent was in place for participants who were interviewed online; all others completed signed informed consent documents. First author (MB) has full access to all original data and takes responsibility for the integrity of the data and accuracy of the data analysis. Additionally, all participants chose (or were assigned) a pseudonym and participant number to be used in publication and dissemination of findings.

Data Analysis

All baseline and 6-month interviews were coded in Dedoose software by research assistants (including this author and the PI) for content that referenced nutrition providers.²⁰ Providers were considered nutrition providers if participants referred to them as "nutritionists" or "dietitians", or if they were known community ED nutrition providers by name. When a participant mentioned an experience with an "ED provider" or other "provider" who prescribed a meal plan, offered nutrition advice, or discussed nutrition concepts as part of treatment, this provider was considered a nutrition provider even when not specifically described as such. Incidental or tangential mentions of nutrition content were not analyzed. Nutrition content was considered tangential if it included nutrition or nutrition provider key words such as "nutrition," "treatment team," or "providers" if it was unclear whether the participant discussed ED providers

specifically, or if these key words were solely used to describe a setting or location during a non-nutrition provider related experience.

After initial screening for nutrition provider-related content, interview data was coded for data related to experiences of weight-biased and weight-inclusive nutrition care, nutrition provider attitudes about weight, phenotypes of ED providers, and participant ideas for improving future support. In generating initial codes, the present author utilized Dedoose software to highlight interesting features of the data, while handwriting descriptive comments for each highlighted phrase or text segment. Singular thoughts and ideas were categorized by free coding phrases and text segments.

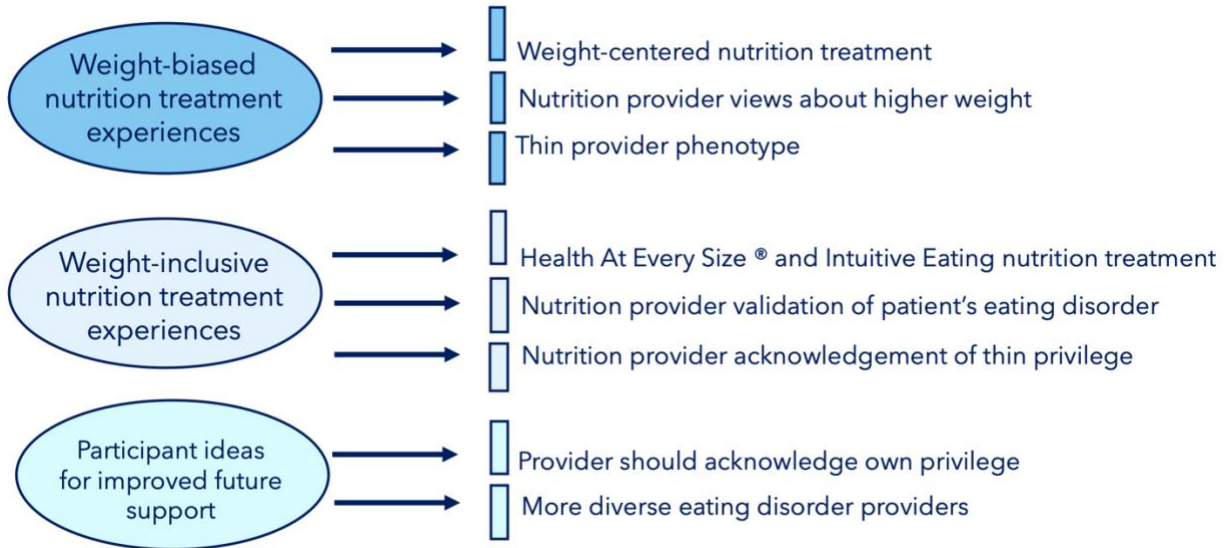
Following initial coding, the lead author (MB) of the present study engaged in data analysis as described by Braun and Clarke (2006).²¹ This process involved developing thematic concepts by generating initial codes, looking for themes, reviewing these themes, and defining and naming these themes. ²¹ After initial coding, codes were organized into an initial coding tree, and an ongoing process of reviewing, revising, and re-organizing key ideas and codes occurred between the present author and the present author's mentor (faculty member MA). Before interpretive analysis was completed, data codes were reviewed by the PI, who validated that codes generated were in alignment with the data. Following code validation, a final coding tree was assembled.

Additionally, to increase rigor, all transcripts were coded by a graduate research assistant.

Finally, themes and sub-themes pertaining to the research questions were finalized by creating a

mind-map, linking relevant codes from the coding list to one another. A simplified version of this thematic map is represented in Figure 1.

Figure 1. Thematic map



RESULTS

Study Participants

The study sample consisted of 20 women and NB-AFAB adults between age 22 and 74 (mean age = 37.6 SD = 13.3). Eighty-five percent of participants had experience with weight-inclusive, HAES® treatment approaches. Participants represented a wide range of body size, racial and ethnic, and sexual orientation identities. Participant BMI ranged from 25.6 kg/m² to 61.1 kg/m² (mean BMI = 41.2 kg/m², SD = 11.5). Of the 20 participants, 14 identified as white or Caucasian, one identified as Latina, one identified as Alaskan Native, and four participants identified as multi-racial ethnic minorities, including one participant who identified as Black

Kenyan and white, one participant who identified as Caucasian and Hispanic, one participant who identified as Caucasian and Persian, and one participant who identified as white, Latinx and Mexican. About one-third of participants experienced economic hardship during childhood, with seven participants reporting that their families received public assistance as children.

Participants represented an array of gender and sexual minorities. Seventeen participants were cis-female, two participants were NB-AFAB, and one participant was trans-female. Sexual orientations represented in the sample included six straight or heterosexual participants, one straight-leaning participant, three bisexual participants, two lesbian participants, two queer participants, and six multisexual participants including one heterosexual to asexual participant, one sexually fluid participant, one bisexual to pansexual participant, one pansexual participant, one asexual and homoflexible participant, and one asexual participant.

Themes

Three main themes emerged among participants' treatment experiences: 1) weight-biased nutrition treatment experiences, 2) weight-inclusive nutrition treatment experiences, and 3) ideas for improved future support. These themes, and their distinct subthemes, are summarized in Table 1 and discussed in detail below.

Table 1. Summary of key themes

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Theme	1. Weight-biased nutrition treatment	2. Weight-inclusive nutrition treatment	3. Future support
Key Ideas	<ul style="list-style-type: none"> • Participants experienced nutrition treatment plans that were determined by their weight • Participants felt they were not taken seriously by nutrition providers because of their higher weight • Participants felt it was difficult to exclusively receive treatment from ED providers who were thin 	<ul style="list-style-type: none"> • Participants experienced Health At Every Size (HAES) and Intuitive Eating nutrition treatment modalities • Participants felt validated by nutrition providers who offered HAES approaches • Participants felt supported when nutrition providers acknowledged thin privilege, including their own 	<ul style="list-style-type: none"> • Participants indicated that it would be helpful if ED providers acknowledged their own privilege (including but not limited to thin privilege) • Participants hoped that in the future there would be more body diversity among ED providers

Theme 1. Weight-biased nutrition treatment experiences

Participants reported that, from their perspective, being in a larger body negatively impacted their care. When asked about how they felt their body size affected their experiences of ED treatment, participants described how being at a higher weight led to three distinct experiences of weight bias: 1) receiving weight-centered nutrition treatment, 2) experiencing biased attitudes about higher weight from their nutrition providers, and 3) exclusively receiving care from providers with thin phenotypes.

Theme 1a. Weight-centered nutrition treatment

Participants reported that often their care pathway seemed to be determined largely by their weight. Some providers neglected to acknowledge the significance or types and frequencies of disordered eating and compensatory behaviors among participants in larger bodies. For example, participants who engaged in high levels of restriction and other dangerous ED behaviors (e.g.

purging, diet pills, laxative abuse, compulsive exercise) frequently reported that they were not referred to higher levels of care (or received no care at all). Participant 1 reported:

“...[I saw] a nurse who did nutrition and I told her... I was going long periods of time without eating...then barely eating...and then she suggested that I eat throughout the day and more, but that was it. I didn’t get referred to another provider or anything like that.”

– Participant 1

Participant 13 shared with her medical providers that she regularly did not “eat that much for breakfast” or “eat anything for lunch.” Regardless of disclosing this level of restriction, she noted it was not “clicking” with her providers that her behaviors “may be an eating disorder.” When she finally disclosed the severity of her behaviors in detail, her medical team promised a referral for more specialized care during the appointment, but never followed through at her follow-up visits. As a result, Participant 13 was not diagnosed with AAN until she was screened for this study by the PI during a clinical diagnostic interview.

Additional participants felt that even while they were being treated for their EDs, the severity of their EDs were not taken seriously. Recalling her experience at an ED treatment facility, Participant 8 noted:

“When I told my dietitian that [I was going to start using laxatives], she was like, okay, whatever.I felt like, if I was 90 pounds, she probably would’ve [taken] me more seriously.” - Participant 8

Participant 1 recalled her struggle with restriction, compulsive exercise, and dangerous dieting practices from high school, through college, and into adulthood. She described how she felt previous providers dismissed the severity of her disordered eating behaviors:

“... Sometimes [dietitians] told me, ‘You’re not eating enough.’ ...I work[ed] out two, three hours a day, and [ate] a...chicken skewer, brown rice, peanut sauce, and vegetables... That would be my entire day’s meal.” – Participant 1

She went on to share that it was not until she turned 37 that a provider set aside her high weight, showed significant concern for her eating behaviors, and referred her to a specialized ED outpatient program.

Participant 6 also noted feeling as if her nutrition providers were not concerned about her ED behaviors because of her higher weight:

“My one nutritionist is the only one I really discussed [my restrictive eating behaviors and use of diet pills] with and she just said, ‘It was very unhealthy.’”- Participant 6

In sum, many participants reported that because of their weight, they were not taken seriously or that their ED was misunderstood, at different points during their care pathway. Overall, participants viewed their treatment course as largely dictated by their weight, with less emphasis put on their disordered eating behaviors and cognitions.

Theme 1b. Nutrition provider views about higher weight

Participants described instances where they felt nutrition providers disapproved of their higher weight by deliberately deterring weight gain during nutritional rehabilitation, or offering weight loss plans as a means to treat their ED. Some participants received “maximum weights” during treatment, were told not to expect weight gain at all, or told that their bodies would likely lose weight as a result of the refeeding process. Participant 8 described her experience being given a maximum weight upon entering treatment for her restrictive ED:

“They did all these body tests, with calipers, and stuff, and this weight range. 10-pound weight range...I needed to be between 161 and 171 pounds. Which –

Interviewer: And, you entered treatment at around 160?

Abby: Yeah. Well, I was around 161, I think, so I was around the weight range.

Interviewer: So, they didn’t account for any refeeding weight gain?

Abby: No” - Participant 8

Participant 19 recalled how a peer’s prescribed meal plan (total daily calories) was reduced due to her weight status:

“... My friend[’s... plan of exchanges was dropped down really low because of weight gain, and I was like... ‘why, why are you doing that?’” – Participant 19

In regard to her own treatment, Participant 19 shared her team's perspective on her weight at the beginning of her treatment course:

"...my treatment team's position was... 'You don't need to gain any weight. We just need to get you back to eating'..." – Participant 19

Reflecting back to when she was further along in treatment, she added that her nutrition provider viewed her weight gain as problematic and attempted to interrupt it:

"...I [started] actually trying to hit caloric minimums during the day. And, lo and behold, I started gaining weight... and my nutritionist was like, 'Well, we need to start discussing your caloric intake, because you are gaining weight... we don't want you to gain too much, and we're concerned.' And I felt so betrayed and so upset." – Participant 19

In another situation, Participant 10 shared about the weight loss advice she was prescribed in high school while seeking treatment for her restrictive eating, compulsive exercise, and purging behaviors. After disclosing to her provider that she “sometimes...throw[s] up food,” her provider recommended a “diet, and an exercise regimen” to help her stop purging. Rather than using strategies that targeted Participant 10's restrictive behaviors, her provider simply addressed the purging by encouraging her to lose weight in a more socially acceptable manner.

Ultimately, participants felt that they faced weight-biased attitudes while seeking help for their restrictive EDs, even at times during refeeding protocols; specifically, nutrition providers

thought participants' higher weight was unacceptable, worrisome, and required weight loss interventions, further complicating their treatment.

Theme 1c. Thin provider phenotype

When asked about how the visible characteristics of ED treatment providers affected their experience of treatment, nearly half of participants mentioned being treated exclusively by thin providers. Participants used words such as “thin,” “very slender,” “tiny,” and “skinny” to describe their providers' phenotypes. Participant 3 shared:

“All three of my ED therapists... are conventionally thin, attractive...white women, and every [employee] I see that works at [the treatment center] is a very thin, conventionally attractive white, woman.” - Participant 3

Some participants overtly stated that the ubiquity of thin ED providers was evidence of systemic weight bias in their treatment settings. Participant 3 reported that the “fault” of being thin does not necessarily fall on the thin provider who cares for her. Instead she suggested that a larger-bodied individual may have tried to pursue ED provider training but “didn’t get into school because she was fat.” She further speculated that the overabundance of thin providers could be attributed to the cultural belief that being in a larger body is inherently less desirable than being thin, which she felt has created “fatphobic discrimination.” Participant 13 also speculated that treatment centers that only hire thin women may institutionally hold a weight biased attitude, even if they use weight-inclusive practices such as HAES®. She stated:

“When I look at a provider’s website and it’s all really thin women... it’s hard for me to trust that the [weight] bias isn’t there.... [or] that [the] organization believes in a HAES® model... [if] they’re not employing people at every size...” - Participant 13

For many participants, receiving care only from thin ED providers was difficult because they idealized this body type, and viewed their own bodies as more marginalized than those of their providers. Several participants further described the sheer number of thin ED providers as a symbol of unintended institutional weight bias that added difficulty to their journey toward recovery. Specifically, many participants mentioned that receiving treatment exclusively from thin providers created false hope for recovering into a smaller body (or recovering at all), and reinforced their ED thoughts.

Theme 2. Weight-inclusive nutrition treatment experiences

Despite experiences with weight bias, many participants also had weight-inclusive nutrition experiences. When asked to describe their most positive experiences with healthcare providers during ED treatment, participants identified three distinct types of experiences related to weight inclusive nutrition treatment: 1) HAES® and Intuitive Eating treatment approaches, 2) provider validation of participants’ EDs and higher weight, and 3) thin providers’ acknowledgement of their own thin privilege.

2a. Health At Every Size® and Intuitive Eating nutrition approaches

When recounting positive experiences with nutrition providers, many participants described weight inclusive nutrition elements of their treatment. Several participants specifically discussed

HAES® and Intuitive Eating (IE) treatment modalities, and reported that these approaches were helpful in leading them further toward recovery. Participant 15 stated:

“...Treatment providers [who] incorporated IE and HAES® [are] what led me to...full recovery.” - Participant 15

Participant 9 shared that she found it helpful when ED nutrition care endorsed weight loss as harmful for larger bodied individuals. She asserted that weight-inclusive nutrition care should universally be utilized across ED treatment facilities to maximize positive experiences for all individuals who seek recovery:

“...All ED treatment [centers should practice] HAES®... because it’s harmful, [to] prescribe [on] one end of the weight spectrum what you’re trying to cure [on] the other end of the weight spectrum...” - Participant 9

Many participants highlighted the helpfulness of HAES® and IE nutrition approaches, a pronounced distinction from previous negative experiences with weight-centered nutrition treatment modalities. Nearly all participants who experienced HAES® and IE reported positive experiences.

Theme 2b. Nutrition provider validation of patient’s eating disorder

Several participants shared that it was important for them to hear nutrition providers validate their ED and take their eating concerns and disordered behaviors seriously. Many reported

previous experiences of nutrition providers who failed to recognize their ED or invalidated their ED experiences at higher weights. They contrasted this with the experience of finally being taken seriously by nutrition providers who practiced from a weight-inclusive approach such as HAES®. Participants 6 and 8 shared their experiences of validation:

“...When [my nutrition provider] said I was ‘dieting like an anorexic,’ [she] validated that the... pain that I was going through... the suffering I [endured] to achieve [weight loss] was definitely not normal.” - Participant 6

“...When I was my sickest...[my dietitian] was urging me to go to treatment...which was really validating... everyone else in my life...was telling me how amazing [I looked].” - Participant 8

Participant 2 also noted that her nutrition provider was the first person who did not factor her size into the discussion, and who recommended a higher level of care:

“[My nutritionist said] ‘I think you...should [enroll in] an outpatient program where they take control back over your food.’ That totally freaked me out...But she was...the first [provider I had a discussion with where] my...size was not a factor...” - Participant 2

In sum, most participants found that providers who validated their EDs, and took them seriously, regardless of their weight, played an integral role in their ED treatment. Many noted that

nutrition providers who practiced within a weight-inclusive paradigm were often the first provider to recognize and treat their ED, regardless of their weight.

Theme 2c. Nutrition provider acknowledgement of thin privilege

A few participants recalled that nutrition providers' acknowledgments of thin privilege, including their own, was an important part of their journey toward recovery. Participant 9 noted that until her nutritional therapist, no provider had "ever admitted thin privilege," acknowledged that fatphobia existed, or "been sympathetic" about her experiences with fatphobia and how that impacted her experience with her ED. Participant 14 expressed a similar sentiment, noting that on one occasion, she spoke with her dietitian about "her own privilege" and asked her how it felt to embody the thin "ideal" that patients like her aspired to. While this was a challenging conversation to have, Participant 14 found that having this discussion with her nutrition provider was helpful in addressing her concerns about her provider's own potential weight bias.

While these conversations were difficult to have because most participants viewed themselves in more marginalized bodies than their providers, participants reported that these discussions were influential in their recovery processes. Only a small minority of participants reported having these conversations with providers, suggesting that conversations regarding provider thin privilege may be rare events in this sample. However, for the few participants who had these conversations, their providers' acknowledgement of both their own thin privilege as well as societal discrimination towards higher weight individuals, helped facilitate the participants' healing.

Theme 3. Participant ideas for improved future support

Experiences of both weight bias and weight inclusion featured prominently in the data, and profoundly affected participants' ability to heal from their EDs. In an effort to understand how practitioners can improve their practices, we asked participants how healthcare providers could be more supportive of their recovery. In general, participant suggestions for improved future support were connected to their own experiences with health professionals, particularly as they related to weight bias and weight-inclusive experiences. Participants offered many specific ideas to improve future support, but two distinct subthemes emerged. First, participants indicated that providers should acknowledge their own privilege. Second, participants expressed a strong desire for more diverse ED care providers.

Theme 3a. Provider should acknowledge own privilege

As depicted in subtheme 1C, participants described that being treated exclusively by thin providers suggested a systemic form of weight bias. Additionally, subtheme 2C demonstrates that participants found it helpful when thin providers acknowledged their own thin privilege. According to Participant 13, providers could be more supportive by “being aware” that staff in thin bodies do not visually “reflect” a HAES® treatment model, even if those staff have participated in HAES® trainings and “adopt it as [their] working model,” personally and professionally.

Similarly, Participant 1 noted that because weight bias had been so difficult for her, it would be helpful if providers could have “better awareness of where they’re coming from and what their

privilege is.” In other words, in addition to utilizing a HAES® treatment approach, staff who also live with thin privilege could further support clients in larger bodies by acknowledging their thin privilege, and acknowledging how systemic weight bias may impact patients and providers differently. Accordingly, this theme suggests that providers who acknowledge their own privilege may be a particularly impactful step in healing from AAN, yet this element may often be missing from treatment.

Theme 3b. More diverse eating disorder providers

Several participants hoped for more diverse ED providers in the future. Most participants described a desire for larger-bodied providers. For example, Participant 15 stated:

“...I wish there were more body types... in eating disorder treatment facilities.” -

Participant 15

Participant 3 discussed the difficulty she faced being surrounded by “totally skinny people” working in ED facilities who are “walking triggers.” She also noted that in addition to more providers in large bodies, more racially and ethnically diverse providers would be helpful. She asserted:

“...I would love to have more fat women of color [as providers]...” - Participant 3

Participant 6 shared a desire for more providers that represent her own identities. Specifically, she hoped to see more providers in the future who have “walked in [her] shoes a little bit.” She shared further:

“I want to see... [a provider] my age or older... [who] walks around in a bigger body.” -

Participant 6

Similarly, Participant 20, who is a person of color, desired providers that share her own gender and racial identities:

“I generally find that I like having practitioners who are women of color.” - Participant

20

In sum, participants felt that having providers who embody phenotypes that represent a diverse array of sizes (particularly larger bodies), races/ethnicities, and ages would offer them further support during treatment for their ED.

DISCUSSION

Participants reported two main ideologically opposed treatment approaches. One type of treatment centered weight and used it as a driving determinant of care, and a second type of treatment that was weight-inclusive, which incorporated HAES® and IE principles and acknowledged the harm of weight bias. The differences between these two health paradigms have been discussed by multiple authors, who have argued that weight-inclusive paradigms for

health are more ethical and effective when contrasted with weight-normative paradigms.¹²

Findings from this study both affirm the use of HAES® and IE approaches in nutrition care, and also showcase the pervasiveness of some harmful practices in the ED field and healthcare.

Weight-Inclusive Nutrition Approaches in Eating Disorder Treatment

Participants spoke of experiences with HAES® and IE treatment approaches often. Preliminary research has evaluated the efficacy of HAES® interventions to improve psychological, behavioral, and psychosocial measures of health in adult women with higher BMI as compared to weight management approaches, and have largely demonstrated positive results.^{12, 22, 23, 24} IE is a well-documented weight-inclusive flexible eating approach that centers honoring the body's natural hunger and fullness cues, and improves disordered eating and body image concerns.^{25, 26, 27} In a 2017 pilot study conducted by Richards et. al, IE skills among patients with restrictive EDs was associated with positive treatment outcomes.²⁸

In line with this research, participants perceived providers who practiced HAES® and utilized IE principles as integral to their journeys toward recovery. In fact, many participants identified HAES®-based providers as turning points in their ED journeys. Participants spoke positively of HAES® providers who validated the severity of their ED after years of disordered eating without previous providers expressing concern. This acknowledgment allowed participants to finally be “seen” by their providers. Many participants even attributed their recovery from AAN to the HAES® and IE treatment modalities. Additionally, one specific component of HAES® that participants found meaningful was when a provider acknowledged their own thin privilege, further suggesting that participants may find it valuable when providers identify the systemic

harm of weight stigma in society. The act of acknowledging one's own privilege is a responsible way that providers might consider using to both address and leverage privilege to decrease social inequities that promote health disparities.²⁹ In the context of AAN treatment, naming one's thin privilege is one significant way that providers validate patients' lived experiences of weight stigma and disordered eating while recognizing that they cannot fully comprehend the lived experience of weight discrimination.

Weight Bias in Eating Disorder Nutrition Treatment

In concurrence with positive, weight-inclusive experiences, participants faced weight bias during treatment. Some participants were given a maximum weight during nutritional rehabilitation, or were encouraged to lose weight if their weight gain during treatment was deemed "too much" by nutrition providers or their treatment team. Providing restrictive meal plans to patients with AAN to prevent "too much" weight gain also aligns with a previously published experience during treatment for AAN. Specifically, upon admittance to an inpatient program, one author recounts being prescribed a restrictive caloric meal plan that mimicked the author's ED.¹¹ These findings are consistent with the dominant and dangerous discourse about weight, which iterates that being at a higher weight is a greater risk to one's health than weight loss interventions that are largely ineffective and potentially harmful.³⁰

Participants felt that some nutrition providers thought that their weight was a greater indicator of the type or severity of a patient's ED, rather than their ED behaviors or cognitions. Researchers have noted that weight restoration in AAN is a "clinical conundrum," due to the competing natures of medical complications associated with lower weight and undernutrition (such as

bradycardia and electrolyte abnormalities), and cardiometabolic disease risk associated with higher weight and weight gain.³¹

The National Institute for Health and Care Excellence guidelines for the treatment of OSFED with subtype AAN recommend following the treatment guidelines for typical AN.³² Currently, the standard of practice for weight restoration during nutritional rehabilitation for typical AN includes reaching a healthy body weight for age, and emphasizes that weight gain is key for supporting physiological and psychological changes that will improve quality of life. By public health standards, a healthy weight is defined as a weight within the “normal” BMI category (18.5 kg/m² - 24.9 kg/m²),^{22a} which may lead to provider perception that weight restoration in those with AAN who are at a high weight is not necessary or should be avoided if the patient has stable vital signs.³³ This study’s findings demonstrate that, while well intended, participants experienced weight-centered treatment approaches as unfavorable, and felt that they led to provider minimization of dangerous ED behaviors such as purging, caloric restriction, compulsive exercise, and laxative use. Participants spoke frequently about their belief that this minimization of behaviors often prolonged their ED. Addressing some of these weight-centered practices by focusing on the reduction of ED behaviors rather than weight may facilitate faster referral and treatment of individuals with AAN.

Participant accounts of weight bias in the form of not being taken seriously by their providers are consistent with previous findings that ED providers perceive a patient’s weight to largely determine the severity of their ED. For example, in a 2018 study assessing provider perception of the severity of a fictitious patient’s anorexic cognitions and eating behaviors, if the patient was

randomly assigned a higher BMI, providers failed to appropriately diagnose AAN.³⁴ This is troubling, as the differentiating feature of AAN from AN is weight, and individuals with AAN can experience medical complications and behavioral and psychological disturbances as serious as those with AN.² Thus, in accordance with what is known, this study's findings imply that underlying weight bias may influence providers to falsely assume that AAN patients are at lower risk of medical complications from their ED behaviors. Minimization hinders evidence-based treatment practices, threatens the patient-provider relationship, and could increase the likelihood that a patient discontinues care.

In addition to intimate experiences of weight bias, participants also noted systemic weight bias in their treatment settings. With no exceptions, participants stated that most or all of participants' ED providers presented as thin, white females. While this trend is likely not an intentional practice, it highlights institutional or structural factors that likely favor thin bodied providers, whether this occurs at the educational level (who is attracted to, admitted to or succeeds dietetic programs) or employment level (who is hired or remains employed at ED treatment facilities). To our knowledge, previous research has not objectively assessed ED provider body types. The finding that participants' had shared experiences receiving care predominantly from thin providers may be problematic as it implies the most common provider body type is one that resembles the thin ideal. Since a hallmark of EDs is overvaluation of the thin ideal, overrepresentation of thin phenotypes in ED treatment could negatively impact individuals' journeys toward recovery by continuing to normalize and center thin bodies, at the expense of excluding (or ignoring) larger ones.

Improved Future Support

Participants reported that one additional and important aspect to positive and weight-inclusive experiences included providers' acknowledgement of their own privilege. As previously discussed, participants perceived this specific act of care as one form of validation of their ED by others. While some participants noted that providers put this message into practice, its emergence as a distinct subtheme for improved future support indicates that it is not yet a widespread practice.

In response to their innumerable experiences with providers that embodied the thin, white phenotype, participants shared a hope for more diverse providers. Further, this finding indicates that many people affected with eating disorders who are not thin, white cisgender women, may have difficulty finding providers who reflect their own identities and can identify with their cultural experiences. This is an important consideration as providers strive for culturally-humble care to reduce negative experiences in healthcare.³⁵ Additionally, these findings highlight the importance of the therapeutic relationship during ED treatment and recovery. They align with one study's findings that a therapist's body type can impact the therapeutic relationship by influencing an anorexic patient's beliefs about a provider's ability to help them, and their willingness to engage in treatment.³⁶ With this in mind, recruiting, training, and hiring ED providers of all shapes, sizes, ethnicities, genders, and sexual orientations could promote stronger therapeutic relationships, could improve patient-provider communication, and could improve care for patients in larger bodies or other marginalized (or multiply marginalized) identities.

Strengths and Limitations

The existence of both weight-inclusive and weight-centered nutrition treatment approaches highlights the complicated nature of treating AAN and other EDs. This study provides specific insight into the potential helpful nature of weight-inclusive nutrition approaches for the treatment of AAN, as participants who experienced weight-inclusive nutrition care universally preferred it to weight-centered approaches. The study includes novel findings that relate to the experiences of personal and systemic weight stigma in care, highlighting the ways weight stigma may be experienced by these individuals during treatment.

In addition to offering new insight into a novel area of research, a key strength in this study was the rigorous analysis process. Data was utilized from both baseline and 6-month interviews, which captured a greater quantity of data, as well as greater depth of data related to rapport built between participants and the interviewer. Additionally, several qualitative analysis practices were implemented to increase validity of the data. Transcripts were validated by both the PI and each participant, a qualitative software was used to assist with coding, and two members of the research team evaluated qualitative codes to verify and dissolve discrepancies.

Despite these notable strengths, the present study has limitations which constrain applicability of these results to the general population of individuals with AAN. In order to access higher weight patients with AAN, participants were recruited from treatment centers with higher AAN populations, which tended to be HAES®-informed, in addition to other methods of recruitment (online, clinician referrals). As such, the participants recruited from HAES®-based treatment centers were likely to be familiar with HAES® and IE approaches. Additionally, this writer did not interview participants, and a second researcher coded data but an IRR test was not run. Last,

neither nutrition provider credentials (e.g. Registered Dietitian licensure) nor provider perceptions of weight bias were confirmed or investigated in this study. Future research should extend to a wider range of treatment centers, confirm nutrition provider credentials, and collect nutrition provider perceptions in parallel to patient perceptions to better understand weight bias in ED treatment. Future research may also consider directly assessing the impact of HAES® and IE approaches on longitudinal outcomes for patients with AAN. Last, future endeavors should further investigate how being treated exclusively by thin providers specifically impacts AAN patient experiences to better understand how ED patient-provider rapport is facilitated among patients in more marginalized bodies.

CONCLUSION

The compelling experiences of participants in this study provide insight into the successes and challenges that individuals in larger bodies face during treatment for AAN. The weight-inclusive themes identified highlight that individuals living with AAN perceived HAES® and IE as helpful nutrition treatment approaches. The weight bias themes identified showcase the potentially harmful nature of weight-centered nutrition treatment approaches in the treatment of AAN, and the negative impact a predominantly thin, white, female ED provider workforce might have on individuals with AAN. Our study revealed that participants felt increasing efforts to acknowledge thin privilege, systemic weight stigma, as well as to diversify the ED field may improve treatment for AAN in the future.

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