"Doctor-Prescribed and Mother-Encouraged":

Interpersonal Interactions and Body Image Concerns in Higher-Weight Clients with Eating Disorders

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Abstract

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Restrictive Eating Disorders (EDs) have the highest mortality rate of any psychiatric illness. Among restrictive EDs, individuals can present across the weight spectrum, however those with low body weight have traditionally been the focus of ED research. Though a major issue in ED treatment, there has only been small amount of research done to understand the impact of problematic weight-biases and stigma on the treatment and recovery of this illness. This thesis is a qualitative thematic analysis of the ED illness narratives. It examines the impact of interpersonal interactions (between family members, peers, and medical providers) on participants' experiences of body image concerns and disordered eating for higher weight women with restrictive EDs. This analysis describes participant-perceived impacts of interpersonal relationships on body image and their own ED narratives. *Methods:* Drawing from a larger ongoing longitudinal, observational, mixed-methods study of women and non-binary persons with atypical anorexia, this study utilized a purposive sub-sample (n=21) of semi-

structured qualitative baseline interviews to describe participant perceived impacts of interpersonal relationships on body image and eating disorder illness narratives. *Results:* The analysis found several emerging themes relating to the impact of interpersonal interactions on body image and eating disorder illness narratives in the following categories: 1) Family Interactions, 2) Peer Interactions, 3) Medical Provider Interactions, and 4) Positive Interactions. Emerging themes included: 1) *problematizing bodies, internalized fat phobia; 2) normalizing dieting, pathologizing body, disbelieving ED/missed ED symptoms/unacknowledged, encouraging ED behaviors; and 3) teasing, bullying, isolation, and norming of societal expectations*. As one of the disciplines most frequently involved in treating eating disorders, these findings suggest that social workers need to address how they interact with higher weight clients—particularly clients with EDs, including being critical of traditional social work interventions, educating members of their interdisciplinary team about the importance of intersectional identities of ED patients, focusing on prevention efforts with families and peers (targeting body shame and dieting), and advocating against weight stigma toward a more weight inclusive models of treatment.

Key words: Eating Disorders, Body Image, Weight Bias, Stigma, Social Work

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Introduction

Restrictive eating Disorders (EDs) have been shown to have some of the highest rates of mortality among psychological disorders (Mugoya, Hooper, Brynn & Cumi, 2018; Stice, Marti & Rohde, 2013). Causes of death for patients with restrictive EDs include complications associated with the physical toll that these disorders have on the individual due to the caloric restriction, in addition to high rates of suicide (Sawyer, Whitelaw, Le Grange, Yeo & Hughes, 2016; Mugoya, Hooper, Brynn & Cumi, 2018; Stice, Marti & Rohde, 2013; Davenport, Rushford, Soon & McDermott, 2015). However, because of limitations with diagnostic criteria for restrictive EDs, higher weight individuals with restrictive EDs experience substantial barriers to the treatment that is needed to enhance their health and well-being. Further, interpersonal interactions with family members, peers, and healthcare providers function as a conduit for social stigma related to body size and weight. Since the field of "social work considers individual experiences *and* contextualizes these experiences within systems and structures, social workers must consider the implications of bodies that are perceived as deviant on the basis of size" (Friedman, 2012, p.53).

Studies have acknowledged the exclusion of individuals, who do not meet the required weight criteria, from research on the impacts of these serious disorders (Sawyer, Whitelaw, Le Grange, Yeo & Hughes, 2016; Mugoya, Hooper, Brynn & Cumi, 2018; Stice, Marti & Rohde, 2013; Davenport, Rushford, Soon & McDermott, 2015). However, research that provides insights into the *lived experiences* of higher-weight individuals with restrictive EDs is lacking.

Exploring these lived experiences of individuals could provide meaningful insight into clinical work with this important patient population.

Issues in Eating Disorder Diagnosis

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), EDs diagnosed in adults are categorized into the following categories: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge-Eating Disorder (BED), Other Specified Feeding or Eating Disorder (OSFED), and Unspecified Feeding or Eating Disorder (UFED) (American Psychiatric Association, 2013). AN is characterized by severe psychological and behavioral disruption resulting in a low body weight; BN is characterized by psychological disturbance in addition to binge and purge cycles; BED is characterized by psychological disturbance accompanied by binge cycles; OSFED contains various other forms of EDs which do not fit these specific categories; and UFED is typically used as a preliminary diagnosis in emergency room settings prior to full psychiatric assessment. Specifically, OSFED includes various types of "subthreshold disorders" such as purging disorder (wherein individuals purge but do not engage in regular bingeing), BN of low frequency or duration, BED of low frequency duration, night eating syndrome, and Atypical Anorexia Nervosa (AAN). AAN is a diagnosis reserved for folks who meet all of the criteria for AN, except despite significant weight loss, the individual's weight is within or above the "normal" range (American Psychiatric Association, 2013, p. 353). A guideline suggested by the DSM-5 to determine body weight within or above "normal" is a Body Mass Index (BMI) ≥18.5 (American Psychiatric Association, 2013, p. 340). Despite having a separate diagnostic category, research has found that people with AN at higher weights (classified as AAN), demonstrate equivalent levels of caloric restriction to those with AN at lower weights who are classified with typical AN (Coniglio et al., 2017). Given that AAN is a

new term, the literature on the diagnosis is limited (Moskowitz, & Weiselberg, 2017).

Diagnosing patients with EDs based on the criteria provided in the DSM-5 can be especially difficult and complex at times, as the DSM-5 contains thresholds which limit or exclude individuals based on criteria which could be impacted by the presence of other disorders or illnesses (Sawyer, Whitelaw, Le Grange, Yeo & Hughes, 2016; Mugoya, Hooper, Brynn & Cumi, 2018). According to Sawyer, Whitelaw, Le Grange, Yeo and Hughes (2016), research into the complications of EDs found that "there is growing evidence that adolescents with restrictive eating disorders who have lost significant weight, but are not underweight, may be just as physically compromised as those who are underweight" (p. 2). Therefore, there is a significant portion of individuals at high risk of suffering from health problems (such as those with AAN), but not receiving a typical diagnosis because they do not meet the criteria for being underweight. Because individuals with AAN appear to have similar levels of impairment (Sawyer, et al., 2016), it is questionable whether the DSM-5 may promote an overreliance on BMI as an appropriate measure on which to base diagnoses.

Understanding the Body Mass Index (BMI)

For many decades, the preferred method of defining one's "weight status," which is often applied clinically as an indicator of health, has been the BMI. BMI is calculated by dividing a person's weight in kilograms by the square of the of the person's height in meters. For adults 20 years old and older, BMI is interpreted using standard weight status categories, which are the same for men and women of all body types and ages (Centers for Disease Control and Prevention, 2017).

BMI	Weight Status
Below 18.5	Underweight

18.5 – 24.9	Normal or Healthy Weight
25.0 – 29.9	Overweight
30.0 and Above	Obese

One noteworthy flaw in the use of the BMI as an overall health indicator is that it fails to distinguish between weight from a person's bone, muscle, or fat. Therefore, the Centers for Disease Control and Prevention indicates that BMI can be used as a *rudimentary* screening tool to assess relative risk of health issues based on population health data, but is not an appropriate diagnostic tool to assess *individual risk*, including the body fatness or health of an individual (2017). Similarly, BMI does not correlate well with metabolic health measures (e.g. blood pressure, triglyceride, cholesterol, and blood glucose levels), such that individuals in the normal BMI category have been found to frequently have poor metabolic health indicators, and those in the overweight and obese categories often have been frequently found to have healthy metabolic health indicators (Tomiyama, 2016). Such findings suggest that using BMI as a proxy for individual health markers is rudimentary *at best,* and potentially stigmatizing and harmful at worst. This research calls into question the soundness of relying on BMI for diagnostic purposes, particularly when BMI is a major consideration in whether or not a diagnosis is given (e.g. such as in the case of AAN vs. AN).

Positioning BMI and EDs

BMI is often a significant factor in how one is diagnosed with an ED. As stated above, low BMI is required for the psychological diagnosis of typical AN, which is the only disorder in the DSM-5 that requires a threshold BMI. Because of this BMI requirement, those who are higher-weight and still experiencing symptoms of AN might be undiagnosed, and therefore not appropriately treated, despite similar levels of behavioral, cognitive, and physical impairments

(Sawyer, Whitelaw, Le Grange, Yeo & Hughes, 2016). Additionally, when ED treatment is received by higher weight individuals, some researchers have suggested that emphasis on BMI, as required by the DSM-5 for AN (American Psychiatric Association, 2013, p. 338-339), results in inequalities in that treatment (Harrop, 2019). The frequent exclusion of higher-weight individuals is associated with many problems, including delay of diagnosis and care, longer periods of symptoms, and increased distress related to eating and body image (Sawyer, Whitelaw, Le Grange, Yeo & Hughes, 2016).

In order to address the treatment needs of higher-weight individuals who present with similar behavioral, cognitive, and physical symptoms as those associated with AN, the DSM-5 included AAN for individuals who meet all of the criteria for AN except a BMI less than 18.5. Despite the prevalence of AAN (Hay et al., 2017; Isomaa et al., 2010; Stice et al., 2013), this diagnosis remains under-researched compared to typical AN, with literature largely focusing on the experiences of those who are underweight. In addition to being excluded from full-threshold diagnosis, some treatment, and some research, higher-weight individuals with restrictive EDs also face the additional challenges of weight bias as they seek to recover into bodies which may be pathologized by society and the medical community due to stigma related to larger body size and higher weight (Harrop, 2019).

As providers, social workers need to be aware of how we reflect the common stigmatizing narrative in the broader society—what bodies are acceptable and worthy—and the impact this has on our clients. Though there may be less research on eating disorders as they relate directly to social work practice, social workers make up a large proportion of clinicians who treat EDs. For instance, one study about the implementation of evidence-based practices in eating disorder treatment, found that of eating disorder specialists surveyed 22.9% were social

workers (Von Ranson, Wallace, & Stevenson, 2013). Furthermore, the competency of many community clinicians in their treatment of individuals with EDs appears uncertain, with most clinicians who treat EDs reporting having received only some specific training in the treatment of EDs, in which the intensity of training received often appeared to be minimal (Von Ranson et al., 2013). As mental health professionals, competency in the specific illnesses we are treating is an ethical obligation, and is particularly important in the treatment of EDs, given the complexity and vulnerability of the population, including the high risk of comorbid medical complications, and potential for mortality (Arcelus, Mitchell, Wales, & Nielsen, 2011; Williams & Haverkamp, 2010; Wolff & Treasure, 2008; as cited in Von Ranson et al., 2013).

Impacts of Weight Stigma

Sadly, due to societal stigma against those in larger bodies, BMI thresholds make it extremely difficult for high-BMI individuals to receive proper diagnosis and therefore proper treatment—even though psychological symptoms (including drive for thinness) are similar (Davenport et al., 2015). When considering stigma, it is also important to consider the words we use and the potential implications for stigma contained within those words. Individuals with a BMI of 30 or greater are labeled as "obese" according to the Centers for Disease Control and Prevention (2017). This label may create additional barrier to care in the form of stigma, fostering stereotypes and negative expectations on the part of healthcare providers. Weight stigma refers to public and private encounters of being stigmatized by others because of your weight, which is experienced in practically every domain of daily living, including healthcare (Meadows & Calogero, 2018). Those with higher-weight bodies experience this stigma in enacted ways (external stigma), the experience of unfair treatment by others (e.g. microaggressions, marginalization, overt discrimination, violence), in addition to internalized

(felt stigma or self-stigmatization) processes (e.g. internalized weight stigma, threats to the social self, social identity threat) (Dickerson, Gruenewald, & Kemeny, 2004; Hunger, Major, Blodorn, & Miller, 2015; Major, Mendes, & Dovidio, 2013; Major & O'Brien, 2005; Rebecca M. Puhl & Heuer, 2009; as cited in Harrop, Hutcheson, Harner & Franz, under review). In addition to impacting interpersonal experiences and healthcare experiences, weight stigma can also directly impact eating disorder symptoms such as body dissatisfaction, a leading risk factor in the development of eating disorders (National Eating Disorders Association, 2019).

EDs, Body Image, and Interpersonal Interactions: Family Factors

While there is no single cause of EDs, research suggests that one of the strongest environmental contributors to the development of EDs is the sociocultural idealization of thinness (Culbert, K., Racine, S., & Klump, K., 2015), with body dissatisfaction strongest contributors to the development of AN specifically (Stice, 2002). The National Eating Disorder Association defines body image as "one's thoughts, perceptions, and attitudes about their physical appearance" (2018, pp. 1). Although a subjective evaluation, body image is an individual and intrapersonal judgment based on internalized values and goals, which reflects and is shaped by experiences with others in the social world (Jones, C. D., 2011).

Some theories of disordered eating place emphasis on the role of interpersonal relationships on development of concept of self, body, and eating behaviors (Wilfley, Pike, & Striegel-Moore, 1997; as cited in Shomaker, & Furman, 2009). Since families provide the primary relationship in development and play a formative role in shaping attitudes and values in their children about body image (Jones, 2011, p. 111), and the development of health and unhealthy self-perceptions and coping strategies (Arroyo & Segrin, 2013), it is necessary to consider family relationships and the interactions through which they are experienced on the

impact of ED development. Research has linked a weight-centric family environment and appearance-focused family culture (including parental commentary about weight/size) with increased disordered eating and body image dissatisfaction in daughters (Kluck, 2010), drawing attention to family interactions as a key factor related to disordered eating attitudes (Arroyo & Segrin, 2013).

As in other experiences of weight stigma, family interactions around body image are often gendered. More specifically, parental criticism of their daughter's body may communicate that her body is unattractive and encouragement to diet, exercise, control her weight/size could indirectly communicate that the daughter's present physical appearance is unacceptable and gives a daughter specific directives she should act to change her body (Kluck, 2010). When parents put great value on appearance, stress the importance of being thin, and encourage their children to lose weight, they are likely to initiate dieting and hold negative views about their appearance (Jones, 2011). This is important because, youth who diet, internalize cultural thin ideals, and experience increased body dissatisfaction, are at increased risk of EDs (Stice, 2002). So, taken together, this research suggests that if families place high value on appearance, thinness, and weight-loss, these familial factors could be associated with increased ED risk for children.

EDs, Body Image, and Interpersonal Interactions: Peer Factors

Beyond family relationships, the values and expectations about appearance that children and adolescents learn from their families are brought into peer groups, further perpetuating an "appearance culture" that is governed by norms and expectations that are modeled and reinforced by peer interactions (Jones, 2011, p. 112). As a powerful means for transmitting what is acceptable and unacceptable behaviors, peer influence occurs through both direct means, such as

positive or negative verbal feedback and comments (i.e., teasing, direct reinforcement, direct teaching), and through modeling (vicarious reinforcement, pressure to be popular), creating the greatest risk for the development of eating problems in those who experience pressure from peers to be thin (Lieberman, Gauvin, Bukowski, & White, 2001).

Peer attributions and appearance-focused conversations with friends affect body dissatisfaction and dieting through internalization and social comparison (Matera, Nerini, & Stefanile, 2013). Peers directly communicate their criticisms of appearance through teasing, a potent way of reinforcing appearance standards and critique deviations of the norms (Jones, 2011, p. 115). For example, one study found that teasing by peers has a direct effect on girl's body disaffection levels (Matera, Nerini, & Stefanile, 2013), with teasing about weight being a significant predictor of dieting (Lieberman, Gauvin, Bukowski, & White, 2001). Sadly, the study failed to assess impacts of teasing in boys and other genders, thus limiting the conclusions that can be drawn about other populations.

EDs, Body Image, and Interpersonal Interactions: Healthcare Provider Factors

In considering interpersonal interactions that impact ED development and trajectories, it is also important to consider the roles of healthcare provider interactions (Harrop, et al., under review). Particularly for higher-weight populations, healthcare provider interactions have been found to be marked by experiences of stigma (Phelan, et al., 2015). Healthcare providers have been found to have strong negative attitudes towards higher weight patients, leading to negatively stereotyping larger patients, and influencing provider judgments, patient-perceptions, interpersonal behaviors, decision-making, and ultimately quality of care (Phelan et al., 2015). One study that interviewed higher-weight women in Australia found that once patients felt they "were seen as a large woman[men]," their size then became the prevailing and dominant part of

their health identity, leading to their presenting health issues being overlooked in favor of focusing on weight; in addition to those presenting issues being attributed to weight (Williams, 2018, p.71). Healthcare providers may also over-attribute symptoms and problems to the patients' weight, and fail to refer patients for diagnostic testing or to consider treatment options beyond advising weight loss (Phelan et al., 2015). Although current research suggests that in this context patients' needs are not met or they are over-looked or disregarded as unimportant, there has been little investigation into how larger bodied and higher weight women understand their interactions with healthcare providers (Williams, 2018).

Purpose of Study and Research Questions

While the available research suggests that family and peer relationships and interactions are significant to the development of problematic body image and ED behaviors, and interactions between higher-weight patients and medical providers result can in inadequate treatment based on inadequate diagnostic tools and weight stigma, very little is known about how higher-weight women *with AAN specifically* perceive the impacts from these interactions and relationships on their self-concept of body image and ED behaviors and cognitions.

Situated within the limited body of research on how interpersonal interactions with family members, peers, and healthcare providers influence body image concerns and subsequent ED journeys for higher-weight individuals with restrictive EDs, the overarching aim of this study is to describe how patients report interactions with family members, peers, and healthcare providers contribute to the development of body image concerns and ED behaviors. By describing interpretations of interpersonal interactions as they relate to body image and ED behaviors, this research will inform the future development of appropriate treatment of, and care for, this underserved population. More specifically, this study was informed by the following

research question: How do participants report interpersonal interactions with family/partners, peers, and medical providers as impacting their body image concerns and ED illness narratives?

Methods

Study Design and Procedures

Data for this study was drawn from the baseline interviews of the Women's Illness Narratives Through ED and Remission (W.I.N.T.E.R.) Study conducted by Erin Harrop, MSW (PI)[1].

The W.I.N.T.E.R Study participants (n=38) include adult, English-speaking, US-residing women and non-binary-assigned-female-at-birth individuals, with a history of or current experience of a restrictive ED while at a "normal" (24.9<BMI>18.5) or higher-weight (BMI≥25.0) (Harrop et al., under review). This study focuses specifically on the experiences of higher-weight women; therefore only W.I.N.T.E.R. Study participants whose current BMI is within the "obese" range (BMI≥30.0) were included in analyses (*N*=21). As weight stigma is an important consideration when studying body image, sampling was limited to those participants who would be considered most stigmatized by their weight status.

Recruitment and Sample

Parent Study

Preliminary sampling or gathering of potential participants was facilitated through two Northwest-based eating disorder treatment. The centers allowed for the posting of flyers, as well as the possibility of provider referral for participants in specific cases. In addition to recruiting from these treatment centers, local eating disorder treatment professionals were sent

[1] The W.I.N.T.E.R. Study is supported by the National Center for Advancing Translational Sciences of the National Institutes of Health, under Award Number TL1 TR002318, and a Health at Every Size Expansion grant through the Association of Size Diversity and Health.

informational flyers to post at their practices and were also invited to individually refer potential participants. Snowball sampling was also used, and enrolled participants were invited to refer acquaintances who may qualify to the study. Additionally, flyers were distributed through Facebook groups related to eating disorders and other groups aimed at over-recruiting more marginalized populations. Word-of-mouth recruitment also occurred when potential participants learned of the study through other participants and news media about the study content and contacted the PI directly. Recruitment for the W.I.N.T.E.R. Study is ongoing. Recruitment and data collection is conducted solely by the PI, Erin Harrop. Currently, 39 adult women (*n*=35) and non-binary-assigned-female-at-birth individuals (*n*=4) in the United States, with a history of AAN have been enrolled in the W.I.N.T.E.R. Study (Harrop et al., under review).

Current Study

This study utilized a purposive sub-sample of 21 participants in the W.I.N.T.E.R. which were available at the outset of this study in November 2018. Using Criterion sampling, this study includes a subsample of participants that meet a predetermined criterion of a BMI≥30.0 (*n*=21) and whose interviews were conducted and transcribed by November 1, 2018 (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015).

Screening, Eligibility, and Inclusion/Exclusion Criterion

Parent Study

The selection of specific candidates for the W.I.N.T.E. R. study utilized criterion sampling, by only selecting potential participants (candidates) based on predetermined criteria This predetermined criterion included: being female-identified (trans and cis inclusive) or non-binary-individuals-assigned-female-at-birth, at least 18 years of age, residing in the US, fluent in English, and having had (previously or currently) an experience of significant caloric restriction

with all psychological and behavioral disruption of AN while at a BMI above 18.5, and qualifying for a diagnosis of either AAN, UFED (with restriction as a primary symptom), or OSFED (with restriction as a primary symptom), or AAN based on the current DSM-5 criteria. Verification of diagnostic status was determined by use of the clinician-led diagnostic interview, the Eating Disorder Assessment for DSM-5 (EDA-5) (Sysko et al., 2015)

All potential participants were screened by the PI of the parent study (a licensed social worker and mental health evaluator) using the EDA-5, and a brief mental status examination. Exclusion criteria included: acute suicidality, acute psychosis, and/or being currently enrolled in either residential care, inpatient care, or current hospitalization (Harrop et al., under review).

Screening procedures were as follows: After initial contact with the PI, potential participants were scheduled for a 20-minute screening interview with the PI which consisted of verbal consent for screening procedures, demographic variable collection, the EDA-5 clinician-led screener, and brief mental status evaluation, including screening for acute suicidality and psychosis. Ineligible participants were provided with referrals for care as needed. Eligible participants were scheduled for their first base-line appointment or added to a waitlist during periods of high recruitment.

Ethics Considerations and Confidentiality

Parent Study

All study protocol and procedures for the W.I.N.T.E.R. Study were approved by the University of Washington (UW) Institutional Review Board (IRB) and followed the standards set by the U.S. Federal Policy for the Protection of Human Subjects. All research participants completed an informed consent process. All original data in the W.I.N.T.E.R. Study was collected and managed using Research Electronic Data Capture (REDCap) tools; a secure, web-

based application which is compliant with the Health Insurance Portability and Accountability Act regulation (Harris, Taylor, Thielke, Payne, Gonzalez, & Conde, 2009).

Current Study

For this current study, I, and my thesis committee, were approved by the UW IRB to work with data from the W.I.N.T.E.R. Study. I also took the Human Subjects Training by the UW IRB and have also been trained on HIPPA prior to beginning this study. Additionally, all participants of the W.I.N.T.E.R. Study were informed of my use of their data, reminded that their data is confidential (de-identified), and encouraged to reach out to the PI of the W.I.N.T.E.R. Study if they had any questions or concerns.

Data Analysis

Semi-structured qualitative interviews were audio-recorded, transcribed, and validated by the PI and their research assistants. Transcribed interviews were examined to identify and categorize recurrent themes and emerging concepts related to the stated research question. Braun & Clarke (2006) provide clear principles and practical steps involved in thematic analysis, providing researchers with a well-defined explanation of what it is and how it is carried out through a six-phase guide.

Phase one: "Familiarizing yourself with your data, is focused on reading and re-reading the data, noting down initial ideas" (Braun & Clarke, 2006, p. 87). For the first phase, I immersed myself in the data in two ways. First, I became a research assistant for the W.I.N.T.E.R. Study in March 2018; allowing me to become familiar with the parent study and the data. I then immersed myself by listening to the 21 baseline interviews being utilized in this study, and assisted the PI prepare the transcripts for analysis. I then reread the transcripts making notes about my first impressions and discussing my observations with my thesis committee in

preparation for phase two.

Phase two: "Generating initial codes: coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code" (Braun & Clarke, 2006, p. 87). I began the initial coding by hand, highlighting excerpts and assigning a code that was created using the reoccurring concepts and broad patterns I saw in phase one of my analysis. I coded transcripts 1-3, and then discussed my initial findings with my thesis committee. Based on this initial coding, additional coding and analysis was then conducted using Dedoose version 8.0.35, a web-based data management application. I then reread all of the transcripts again, this time paying closer attention and taking notes of any broad patterns or reoccurring concepts relevant to body image that I began to see, becoming my initial set of codes found in appendix 1.

Phase three: "Searching for themes, collating codes into potential themes, gathering all data relevant to each potential theme" (Braun & Clarke, 2006, p. 87). Codes (a small section of the text) were analyzed and then sorted into identifying themes (a higher-level of labeling, used to identify a major element in the data). In this phase, I began to engage in conceptual detangling of the different codes; reordering codes in relation to identified themes.

Phase four: "Reviewing themes, checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2)" (Braun & Clarke, 2006, p. 87). In this phase, I began to label the themes, deciding which are the most relevant to my research question, and analyzing them to see how each theme relates to one another, represents a portion of patterned meaning from the data, and provide an accurate understanding of the overall picture of the participant's experiences and perceptions; working to identify the underlying concepts and meaning. Moving iteratively between my initial codes and themes, and relevant literature, I repeated steps 2-4 with

revised codes and themes to identify new themes and thematic patterns.

Phase five: "Defining and naming themes, ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definition and names for each theme" (Braun & Clarke, 2006, p. 87). Once codes were categorized into cohesive identified themes, I continued the analytic process by reviewing transcripts to verify consistency between identified themes and codes. In this phase, I used the coded excerpts from the transcripts to describe the connection between the codes and themes, as well as to construct an analytic narrative reflecting previous research on familial, peer, and medical provider relationships and interaction, and how this fits with the participant's perceptions of the impact on their body image and ED illness narrative.

Phase six: "Producing the report: the final opportunity for analysis. Selection of vivid, completing extract examples, final analysis of selected extracts, relating back of the analysis to the research questions and literature, producing a scholarly report of the analysis" (Braun & Clarke, 2006, p. 87). The themes and their connections are reflected in the results of my study below. With the understanding developed through phases 1-5, I then continued with the analytic process, with a specific focus on applying my knowledge to a deeper interpretation of the participant's own perceptions. Driven by my research question and analytic framework, in this stage of analysis I refined this thematic analysis in the interest of applying findings to how social workers have an impact on their clients through the interactions they have with them, the types of interventions and treatments we use with our clients, and how we advocate for our clients.

Rigor and Trustworthiness

To be accepted as trustworthy, qualitative researchers must demonstrate that data analysis has been conducted in a precise, consistent, and exhaustive manner through recording,

systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible (Nowell, Norris, White, & Moules, 2017). To conduct a rigorous and trustworthy thematic analysis, I worked to check my own personal assumptions and biases by initiating analysis with open coding, allowing for codes within the data to emerge, and by conferring with my committee about codes and their relation to the research literature and my research question.

Methods for enhancing trustworthiness occurred in three primary ways: prolonged engagement with data; memoing; and discussions with my thesis committee.

Prolonged engagement with data: I made sure to be immersed in the data through-out the research process, this began when I became a research assistant for the W.I.N.T.E.R. Study and continued through consistent engagement with coding. *Documenting thoughts about potential codes/themes, theoretical framework, and reflective thoughts:* a journal was kept to track any theoretical and reflective thoughts I had throughout my research, as well as on commonalities I saw throughout the data and on any emerging codes/themes. *Audit trailing*: codes were audited using a data dictionary, as well as through discussion with my thesis committee. *Having themes and subthemes examined by committee*: themes and subthemes that emerged from the data examined by my thesis committee through assessment of codes against the data dictionary, and each other. *Testing for referential adequacy by returning to raw data:* I tested the validity of the data by taking my preliminary findings and applying them to a portion of the raw data that has not yet been analyzed.

Reflexivity

A key component throughout the analysis is reflexivity. This critical reflection of the research, both as process and as practice, on my role as a researcher, and on my relation to

knowledge, is imperative to showcasing my various positioning and how this might shape the collection and analysis of data (Braun & Clarke, 2013). Examining the "perspective" I bring into my research is a necessary step to producing good qualitative research. As a researcher, I bring my own histories, values, assumptions, perspectives, politics, and mannerisms into the research; which is to be thought about and considered in how they may be shaping my data (Braun & Clark, 2013). A Health at Every Size (HAES), body positive, fat acceptance, and critical-feminist-theory driven position has guided my engagement with the data and my analysis. Looking at the research from this perspective is valuable because of the social justice values it holds of being strengths-based, inclusive, and valuing of all individual's backgrounds and experiences; and brings forth social problems, trends, and issues that have been overlooked or misidentified by historically dominant perspectives. Reflexivity was practiced throughout my research using the trustworthiness criteria mentioned above. Additionally, I documented my thoughts and feelings about the participant's narratives throughout the research process.

Results

The analysis identified several themes related to the impact of interpersonal interactions on body image and ED illness narratives, which have been categorized into positive and negative interactions, and divided into three sections: 1) Family Interactions, 2) Peer Interactions, and 3) Medical Provider Interactions. Jones (2011) suggests the importance of looking at family and peer interactions when looking at how children and adolescents develop body image and disordered eating concerns. The third category of medical provider interactions was added, because medical providers were one of the most frequently referenced group of people referenced by participants in the interviews, when speaking about formational moments in their

ED journeys. Overall, when participants described the development of their ED and their illness journeys, their interactions around body image lean towards negative ones.

Family Interactions

Participants described two main themes within interactions with their families: *Problematizing of Bodies*, and *Internalized Fat-Phobia using Normalizing Dieting* as a way in individuals take on a "good fatty" persona to manage this. A summary of excerpts representing the problematizing bodies and internalized fat phobia/normalizing diet themes are listed in Table 1.

Problematizing bodies

Participants reported that family members would often make direct, negative comments about their bodies. For example, Bette[2] recalls her mother telling her "Oh, you've got my thighs and I have such bad thighs." Similarly, Amanda received comments from her grandmother needing "to do something about that" regarding the cellulite dimples on her legs. Interactions with family members regularly centered around the participant's weight, sending messages that because of their size "no one's going to want you unless you lose weight." Often these messages progressed to recommendations to "diet" to get a boyfriend. Sometimes family involvement progressed to combined family efforts to diet or reduce weight.

Even when in recovery from their EDs when weight gain might be expected, participants continued to received messages around weight gain. For example, Bette describes her stepmom's concerns around her ED treatment, stating "I just don't understand what they're doing with you, why they're forcing you to eat all this food" and suggesting to Bette that she could eventually "exercise more and be thinner" at a later point in her treatment journey. Participants also

2 Pseudonyms used

described becoming aware of how family members viewed their bodies, and in turn, their weight, which fostered greater negative feelings about eating or body image for participants themselves.

Internalized Fat-Phobia, Normalizing Dieting

Many participants recalled interactions where family members set parameters around dieting behaviors, such as monitoring or restricting food and promoting exercise. Riley recalls during childhood having to engage in exercise. Each time a commercial came on the T.V., Riley's mom told her she "had to get up and run up and down the stairs." Participants experiences around imposed food constraints varied in intensity, from Arati being "restricted" and not "have these things" (e.g. such as ice cream bars or sugar on her strawberries), to Jen being placed on "Weight Watchers and other diets" by her mother as an adolescent. Household diet culture came up often throughout participant's illness narratives. Not only were disordered eating behaviors modeled to participants throughout their lives, but they often received suggestions on how to eat in order to be thin from various family members, making this a salient interaction for participants.

In addition to more direct communication, participants also received subsidiary messages around fatness. For example, Josephine remembers her mother placing ceramic Buddha's all throughout the house as a reminder that "it wasn't good to be fat."

Medical Provider Interactions

Interactions with medical providers showcased externalized fat-phobia and pathologization of weight. Participants described three main themes within their provider interactions: *Pathologizing of the participant's bodies; Disbelief of the ED, missed ED symptoms, and unacknowledgment of Illness;* and *Encouragement of ED behaviors*. A summary

of pathologizing body and disbelieving ED/missed ED symptoms/unacknowledged reported by participants can be found in Table 2.

Pathologizing Body

Numerous participants received messages from various types of medical providers that their weight was too high. For example, Amanda was chastised and lectured by her provider about her weight. On her first meeting with her gynecologist, she was told, "Where you gonna be in 20 years? Where you gonna be in 10 years if you keep gaining weight like this?", implying a direct association between her weight and future health.

As with family interactions, participants received negative messages about their weight during recovery. In interactions with their ED treatment teams, participants perceived that excess weight was a central focus. Riley illustrates this point by recalling that she was told by her treatment team that "you already weigh enough—you don't need to gain any weight. We just need to get you back to eating."

Providers also often overlooked histories of participant's EDs, instead focusing on their size and weight, and immediately suggesting weight loss. Even when seeking care of something completely unrelated to weight, provider interactions emphasized the need for weight loss and assumed over-eating or poor eating habits when patients presented at higher weights. Riley recalls going to the emergency room for a panic attack and being told that "if you just stopped eating fried food" she would not be in this situation.

Disbelieving ED/Missed ED symptoms/unacknowledged

One of the most frequently discussed themes was providers failing to believe participants' statements about EDs, missing ED symptoms, and not acknowledging EDs. Nearly every participant described how perceptions of their weight and size was a barrier to diagnosis

and treatment of their ED. Even when showing significant evidence of accepted warning signs of EDs, such as the loss of a significant amount of weight, ruptured lining of the esophagus, elevated bilirubin levels, vomiting blood, and amenorrhea, participants typically did not describe feeling that medical providers showed any real concern for their potential EDs. When participants expressed unease over their ED behaviors and inquired about potential treatment, they were often meet with disbelief by providers. For example, Tori recollects her medical providers having a "strange reaction" to her concern of having an ED and responding with "Uh-huh. So, let's talk about your blood pressure" and then completely changing the subject.

Similarly, when Bette expressed to her provider concerns over her eating habits, she was meet with "You're in the healthy range" [of BMI], and was never asked about what her eating habits were. Because participants were not underweight providers generally did not acknowledge the signs and symptoms of EDs that participants did present with. Amanda attributes her body size as the reason her ED was not recognized, accrediting this to a lack of training in EDs. The all too common discourse was that because participants had an above normal BMI, weight was the problem that needed to be fixed (and therefore reduced); *even if* the participant was being seen for a specific ailment, unrelated to weight, or presented with warning signs of disordered eating.

Encouraging ED Behaviors

Participants report encouragement of disordered eating behaviors by several of their medical providers throughout the span of their illness narratives. Several participants, even as children, were instructed to engage in diets and caloric restriction. Margot discussed how her first ED [in childhood] was "doctor-prescribed and mother-encouraged." Even during the onset of Margot's ED, when her doctor was aware of her constant working out and eating less than

1,600 calories per day, her doctor continued to encourage her disordered behaviors because her of her BMI which was deemed "too high."

This type of interaction was commonly described by participants and did not stop after participants were diagnosed with EDs and began treatment. Throughout their ED recoveries, many participants were encouraged to engage in food restriction and compulsive exercising. Riley, was persistently told to exercise and diet by medical professionals because of the size of her body, even after disclosing she was in ED recovery. She also recalled a "falling out" with her nutritionist who to expressed concern over not wanting her to "gain too much weight" in ED recovery as she began to pay more attention to her internal body cues of hunger and fullness, and attempted to eat more than her basic caloric minimums each day.

Peer Interactions:

Interactions with peers were not mentioned as frequently as those with family and medical providers, which may indicate that interactions with peers do not hold as much influence within ED illness journeys. A summary of excerpts related to teasing, bullying, isolation and norming of societal expectations reported by participants can be found in Table 3.

Teasing, Bullying, Isolation

Bullying during childhood was a significant experience for some participants. Several recalled "getting picked on" and being called the "fat kid" or "fatso," "being made fun of," and getting "teased" by their peers due to their body size. For Rosalie, attending high school as a "fat kid" led to being "terrorized," "bullied," called names, and physically assaulted. These occurrences led to Candy noticing her size and beginning to "associate it with negative things," thus illustrating how interactions with peers at times fostered body dissatisfaction within participants themselves.

Norming of Societal Expectations

The perpetuation and norming of societal expectations around body image by peers was seen throughout the span of participant's illness narratives—both before and after ED diagnosis. In childhood, dialogue with friends that revealed individuals' weight sometimes elicited intense negative reactions from peers, such as "Oh, my God" as peers did not expect participants to weigh as much as they did. Such interactions sometimes fostered unhelpful comparisons between participants and their peers, in which participants came to view their bodies as problematic, due to being larger than their peers. For example, Bette recalled during her childhood, having many disordered eating behaviors and cognitions communicated as "normative" to her by her peers, as part of what teenagers typically do.

Furthermore, the pursuit of the thin-ideal was perpetrated through both friends and co-workers by means of diet talk, such as "it's bikini season, and, so, I need to get into my bikini body." Pressure to be accepted by friends took a toll on participant's self-concept and ED behaviors. For example, Gretchen experienced a sudden need to make herself "shrink again," after being told what is expected of her as the Maid of Honor at her friend's wedding.

Positive Interactions:

While the clear majority of the participant experiences were negative, it is important to note that there were also some significant positive interactions. When participants experienced interactions where providers finally acknowledge their symptoms, naming that they had an ED and seeing them as more than just their size, this had a profound impact on their recovery and self-worth. A summary of positive interactions reported by participants can be found in Table 4.

Positive interactions often took place around participants feeling seen, listened to, and validated as ED patients with legitimate concerns. Although not appearing as saliently or

frequently as other interactions throughout the ED illness narratives, participants reported positive interpersonal interactions made significant impacts on the participant receiving or continuing to engage with ED treatment. A notable subtheme of positive interactions arose when participant's EDs were finally being recognized. Jen felt it was "really helpful to be recognized as someone with a restrictive ED who is overweight, because "the assumption is always bulimia… If they get a good look at you, they never believe you [that you have anorexia]." Additionally, some participants recalled experiences with providers who acknowledged that the problem does not lie within the participants or their bodies, but instead implicating the larger social context, stating that "It's society." This acknowledgement provided reassuring support, leading towards the path to recovery. Furthermore, participants expressed appreciation for providers who utilized perspectives that were not solely focused on weight or weight reduction, such as a Health at Every Size approaches. These approaches were received as especially helpful, compassionate, supportive, and encouraging to participants.

Discussion

This study examined how participants perceived the impact of interpersonal relationships with family, peers, and medical providers on their body image and ED illness narrative; providing unique insight into the socio-cultural experiences of this group.

Family Interactions

Participant interactions with family found two main themes: the problematizing of bodies, and internalized fat-phobia using normalizing dieting as a way for individuals take on a "good fatty" persona to manage their self-stigma. Families often criticized bodies that did not meet the thin-ideal, either through direct disapproval of the participant's body or by more indirect means of communicating that fat bodies are undesirable. Both pressure to be thin and

criticism about appearance uniquely contribute to the prediction of disordered eating over time (Shomaker, & Furman, 2009).

Participant's also experienced restricted access to "unhealthy foods," and families also engaged in diet practices together. This diet-culture families enact, is a byproduct of their internalized fat-phobia. Participants discussed how they internalized these messages about body image from childhood and built their self-concept based upon the messages they received.

Medical Provider Interactions

Interactions with medical providers demonstrated themes of *pathologizing of the participant's body*; *disbelieving ED, missed ED symptoms, and unacknowledged of illness*; and *encouraging ED behaviors*. Although participants frequently presented with tale-tale symptoms of malnutrition (e.g. weight loss, vomiting blood, ruptured lining of the esophagus, evaluated bilirubin levels, and amenorrhea), providers overlooked these symptoms and instead focused on the participant's weight and BMI. Providers often disbelieved participants when they expressed concerns of having an ED, and routinely recommended and encouraged eating behaviors would be considered as eating disorders or otherwise dysfunctional behaviors in people with "normal" or lower weights (Friedman, 2012).

These experiences greatly impacted participant's medical dealings through avoidance of care, minimization or denial of their own ED symptoms, and adding to their negative body image and feelings of worth; exhibiting that the effects of stigma are both immediate and long-term (Phelan et al., 2015). The findings in this study reflect prior research, which has revealed experiences of provider weight-bias and provider praise of ED behaviors as barriers in healthcare provider interactions (Harrop, 2019).

Peer Interactions and Positive Interactions

Peer interactions revealed themes of *teasing, bullying, isolation*, and *norming of societal expectations.* Although not a reoccurring theme throughout the data, participants who experienced various forms of bullying during childhood gave insight into how these interactions reaffirmed negative feeling and beliefs participants had around body image. Additionally, normalization of societal expectations around body image and diet culture by peers (e.g. body ideals, acceptable weight, and restrictive eating practices) were seen in both childhood and adulthood. Those who experience pressure from peers to be thin, seem to be at the greatest risk for the development of eating problems (Lieberman, Gauvin, Bukowski, & White, 2001).

Clinical Implications

The lived experiences of these participants highlight how interpersonal relationships impact one's self-concept of body image and ED behaviors and cognitions. As one of the disciplines most frequently involved in treating eating disorders, these findings suggest that social workers need to address how they interact with higher weight clients—particularly clients with EDs, including being critical of traditional social work interventions, educating members of their interdisciplinary team about the importance of intersectional identities of ED patients, focusing on prevention efforts with families and peers (targeting body shame and dieting), and advocating against weight stigma toward a more weight inclusive models of treatment.

When social workers interact with fat patients (with or without EDs), it is essential that we are aware of how societal stigma around fatness could be influencing the clinical interaction; we must consider our biases, and do personal work to move toward understanding our privilege (if we are thin) and dismantling sizeism (for all). As both practitioners and activists, we must acknowledge and become educated about the needs of fat service users and the specifics of working in communities with a range of responses to body diversity (Friedman, 2012).

For social workers interacting with fat patients and their families (specifically in pediatrics, when so many patients developed their EDs), be aware of the temptation to pathologize the child's body; advise medical partners about the dangers of prescribing diets in children and the potential risks associated with developing disordered eating. Social workers interacting with ED patients in mental health settings, need to be aware of the potential need to facilitate critical consciousness around fat oppression and body image issues, especially from a liberatory/HAES perspective; helping patients get a more critical, insightful view into the pressures of society and being resilient towards such harmful messages. Consciousness-raising is necessary as one component of size acceptance, however to focus exclusively on the individual—whether individual clients or individual practitioners—doesn't begin to address the need for structural change (Friedman, 2012). As social workers, we must also engage at the policy level, working toward size inclusive policies in healthcare, mental healthcare, and society.

Strengths of the Current Study

This study had many strengths. First, to my knowledge, this is the first study to explore how qualitative participant reports of interactions with family, peers, and medical providers impacted their self-concept of body image and ED illness narratives. Second, this study involved a lengthy data immersion, involving reading and coding in a time span over one year. Third, data analysis involved a systematic coding guide which was revised, with each iteration of coding, and all changes were discussed with the research team. Fourth, data coding was reviewed and discussed by all members of the research team, to provide additional perspectives, idea generation, and accountability. Fifth, qualitative data software (Dedoose) was utilized to better organized a large amount of data with complex themes. Sixth, I engaged in regular self-reflective

practices (as discussed in Methods) in order to reflect upon how my own identities and life experiences were shaping my experience and perspective on the data. Finally, this sample reflects a rich, diverse sample of women and non-binary perspectives, with participant ages spanning the life-course, a large diversity of body sizes represented.

Limitations of the Currents Study

This study has several important limitations. First, this study utilized a subsample of participants with a history of ANN that did not exclude participants who had experienced other EDs in their lifetime (Harrop et al., under review). Thus, the findings in this study are not limited or unique to individuals with ANN. Instead, this study describes the experiences of how interactions with family, peers, and medical providers impacted their body image and illness narrative, who have experienced disordered eating, which may have taken several diagnostic forms throughout their lifetimes. Second, this data was not double coded; though my coding was reviewed by members of my thesis committee, I was the sole coder. Third, this study was retrospective, asking participants to look back on their lives and tell their illness and remission narratives as related to their EDs. As such, many participants were looking back over decades of life, and so memories from earlier points may not be as clear as later memories; however, this strategy of hearing participant's narratives does shed light on what stories have emerges as most important in participant's own understandings of their life stories.

Conclusion

In sum, participants reported both intelligibly similar and contrasting interactions experiences related to their ED illness journey. These interactions spanned multiple narratives, representing an assortment of generations, localities, socioeconomic groups, cultures and lifestyles. While each participant has their own personal narrative, it is evident that both positive

and negative interactions with Family, Peers, and Medical Providers play a critical role in the recovery for those with an ED. Therefore, these factors must be prioritized and further studied to ensure we as Social Workers properly serve and empower those who are looking to us for care.

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Table 1. Interactions with family

Theme 1: Problematizing Bodies	**Theme 2: Internalized Fat Phobia/Normalizing dieting**
1: And then my mom also would comment a lot on my body. So, I remember being like pretty little, like 9 maybe, and she always said things about my body, like, "Oh, you've got my thighs and I have such bad thighs, and you have my this and have such bad this."	13: So from a very, very early age, I think there were definite food issues that I exhibited and then also food issues that I was starting to pick up from my mother. I don't remember a time that she was not either on a diet, talking about being on a diet, or about to go on a diet.
3: I remember my grandma driving me back from a tennis match. I was in shorts sitting on the passenger side and I had cellulite dimples on my legs and she pokes on my legs. "Oh, you need to do something about that."	17: They [family] were worried about my weight, and, like, as a family, we tried going on a couple of different diets. Like, we tried Atkins for a little bit, and, like, then it was like, oh, well, we're just going to watch what we're eating.
6: When I was a kid, like the reason why I was told to diet were because I didn't have a boyfriend and I didn't have friends and I felt lonely. And so, my mom would say, go on a diet, let's go on a diet let's kick this, let's get skinny and that inferred that then you would have all these things.	7: As much as my momma loves me and my sister, she has fought with her weight her entire life. And I have watched her. Every diet, every single diet plan. Weight Watchers, Jenny Craig, all that stuff. I have watched. I have been told not to eat that, or I was gonna get fatter. I have been told to limit ever since I was – I can remember.
18: I got lectures from my brother. "You're so pretty. You -- but you're not going to date anybody. No one's going to want you unless you lose weight." My mother would say the same thing. "Who's going to want you?"	9: And that pretty much started my weight cycling and just some of the things. It definitely was a center focus. My mom used to decorate cakes professionally. So, my siblings always used to get these amazing birthday cakes, but I did not because I didn't need the junk. So, I would see them get these amazing cakes for their birthday, and I was just told, "We don't need that. We don't need the junk right now."
2: But just at that point, I started gaining weight, I think, just normally. Then my mom started getting really pretty obsessed about my size. So then I started feeling bad about eating.	5: When I was losing weight at the end of college – a couple years after college – I got a lot of praise. A lot of people told me I was doing a good job. My dad told me I was doing a good job.
10: It was probably like, preschool – or the year before preschool, so I must – probably like, four, I'm guessing – four. I know that my grandma, and my mom didn't like – she didn't like my sister and my bodies	4: So, my mom she really kind of pushed dieting after a certain age… I know third grade, fourth grade. She told the school that I couldn't get seconds, but I had gained a lot of weight

Table 2. Interactions with Providers

Theme 1: Pathologizing body	**Theme 2: Disbelieving ED/Missed ED symptoms/unacknowledged**	**Theme 3: Encouraging ED behaviors**
1: She[doctor] took the opportunity to tell me I was overweight. I was like, "I know. I just had a baby. I'm going to get down to a lower weight." I learned at that point that if I got down below 160, I would get really sick. I told her, "You're looking at a BMI that I don't feel is reflective of my frame and I'm telling you I can't get below 160 unless I use diet pills and some really terrible practices to my body."	1: Yeah. So, if I ever said, "Sometimes I don't eat what other people eat." My doctor didn't ask what I eat, but it was like, "You're in the healthy range." I was running three miles every night and doing all these other activities. It seemed fine.	6: So, for two years I took Fen Phen and the doctor, who was also overweight was distributing Fen Phen and shakes, kind of like an Opti Fast type of thing along with the Fen Phen.
3: She's like, "192?" … It was the worst moment in – one of the many worst moments is that time I went to the gynecologist and she was like, "Where you gonna be in 20 years? Where you gonna be in 10 years if you keep gaining weight like this?"	1: I feel like if I had a smaller body right from the start, I would have gotten help when I was 15, for sure, when everybody started noticing I was losing a lot of weight and at 16 when I was vomiting blood. I would have gotten help when I kept going to all the doctors and I kept asking them like what can I do? Here's what I'm eating.	9: And I would say my first eating disorder was doctor-prescribed and mother-encouraged.
	3: "Your bilirubin is really high which is indicative someone's starving themselves. Are you starving yourself?" I was like, "No, not at all!" totally denied it. So, that's the only time I've ever heard anything was from healthcare providers	9: 'Oh, good job. You only ate 800 calories today.'" That's ridiculous. Or when I was at my lowest weight and belonged to three gyms and was obsessively tracking my food for a good two years, my doctor told me, "Oh, you're so close. You only need to

		lose like ten more pounds." Okay.
	3: So, at my classified overweight size, I'm healthy and at my normal weight size, I was severely unhealthy. So, I think that's how my body size attributed to my eating disorder because it wasn't what they teach in med school – or at least what society accepts.	
	5: Then I got to point where I had really terrible pain in my chest and had to go to the ER. I basically had ruptured the lining of my esophagus, so I stopped purging as much after that but didn't have any type of treatment or anything.	
	5: For many years, I had no idea that I had an eating disorder because of my body size. I was average if not larger than my peers, so I really didn't think I was sick. Nobody around me thought I was sick, not even my doctors. Even though I had no period and I had a lot of depression, anxiety, I was purging, and cutting myself, nobody thought there could be an eating disorder.	
	7: [medical provider] She had a strange reaction because she was like – I was like, "I think I have an eating disorder." She was like, "Uh-huh. So, let's talk about your blood pressure."	

Table 3. Interactions with Peers

Theme 1: Teasing, bullying, isolation	Theme 2: Norming of societal expectations
4: I do remember at one point I just didn't even know I was fat, but I went to the swimming pool one day in a yellow crab bikini that I was so proud of and kids were calling me fatso	1: my friends would go out to like Dairy Queen or something and I ate a diet of things you could get at the condiment counter, like ice and Equal, and then they would eat fries and it would be like, "Oh, it tastes the same if I just like put my finger in ketchup and just eat ketchup." So, I had a lot of things that I just felt like it was normative and everybody sort of communicated that it was normative to me.
4: That's when I started like – because I was a fat kid so I had a chest – I started kind of feeling more adultified because I would kind of get teased for that, but I mean in a way that felt very uncomfortably sexual.	4: She basically told me that this is what she expects from me for her wedding because I'm her Maid of Honor and I need to do this stuff… and also I all of a sudden feel like I have to make myself shrink again
9: And I am so beyond grateful. I only have one person who, I think, she had an eating disorder of her own, and, so, it was triggering to her that I was going through treatment. But, so, when I told her, she's like, "No, you don't. You don't have an eating disorder. Nope. No, you don't." I said, "No. Yeah, I do." "Nope, you don't." Okay.	5: Yeah, I have a cousin who I'm pretty close with and she's been on her own weight loss journey the last couple years kind of at the same time I've been in recovery. She's been extremely successful and loss a significant amount of weight – more than I ever did. We've had a couple conversations where I've asserted that I don't believe in dieting anymore, and I'm really working on actually eating enough instead of limiting what I eat. Her question was, "Well, aren't you worried about the weight gain – the health issues that you're gonna have?"
	7: Even when my skinny friends would talk about their eating disorders, I'd be like, uh, yeah. In my head, I'd be like, I totally get that. Totally understand where you're at. And I'd be like, I couldn't do that. Because they wouldn't believe me. There's no way. How could they believe me, a big girl, that I had an eating disorder?
	7: As much as my momma loves me and my sister, she has fought with her weight her entire life. And I have watched her. Every diet, every single diet plan. Weight Watchers, Jenny Craig, all that stuff. I have watched. I

	have been told not to eat that, or I was gonna get fatter. I have been told to limit ever since I was – I can remember.
	9: And it does – it takes the power out of an event because I had co-workers like, "Oh, well, you know, it's bikini season, and, so, I need to get into my bikini body."

Table 4. Positive Interactions

Theme 1: Positive Interactions

9: And my other really good friend also has been asking questions and has checked in with me a couple of times about like, "I wanna say this. Is that okay to say this to –"
19: I started slipping a few months ago, and one of my really good friends was like, "I'm watching you slip, and I'm really worried about you. And I want you here, and I want you here for a long time, and the only way that that's going to happen is if you eat.
9: When I moved into this house, my best friend came up to help me close out my other house, and it was – she helped me go through my whole closet – so, it was three or four years ago and just when I had started eating disorder therapy. I had 12 sizes in my closet – 12 sizes – because I was hanging on to those lower ones because I was gonna get back there. And, so, she was like, "Okay. You've gotta try it on. If it doesn't fit or –" So, we ended up having a clothing give-away party just because I was like, "Oh, no. I can't." I need to know it goes to a good home. But that was one of the turning points, too, about acceptance
3. Oh, yes. I started seeing a therapist because I was like, "Oh, I'm gaining all this weight again. Something's wrong with me. I need to get in charge of my – I need to see a therapist on how to not eat," basically was what my issue was, but when I started seeing her, she was great. That's when everything changed. That's when I had this reopening of realization like, "Oh, everything I've been doing is actually not good." So, the conversation with her was – it just happened naturally over a year of therapy until I finally read the HAES book. She had been wanting me to read it. Life changing – truly – crying to her because when I would walk home from the bus stop, I would pass Trophy Cupcakes. All I wanted was a cupcake. Some days, I would buy 12 of them and eat them all at once and I'm crying about that. She's like, "If you walk by and you want a cupcake, go in and have one." Just the simplicity of it blew my fucking mind. I was like, "What? You can? Someone's giving me permission to do that? That's insane!" and it helped. A couple times I did go in and had one cupcake by myself and it was okay. It took the power away from it. So, that's when things really started to change
9: My therapist recognized, "Nope. It's not you. It's society." And put me on a path that I'm very grateful to finally have gotten on.

APPENDIX 1. Initial Codes

Code Name (A-Z)
Being Seen
Body Image
Body Relationship
Body Size
Changing Body
Diet Culture/Disordered Eating
Externalized fat phobia/weightism
Internalized fat phobia/weightism
Medical Care
Not Being Seen
Trauma
Treatment Barrier
Treatment Facilitator
Value/Worth