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FINDING BODY APPRECIATION THROUGH THE WEIGHT-NEUTRAL FRAMEWORK

A Dissertation

Presented to the Faculty of
Antioch University New England

In partial Fulfillment of the degree of
DOCTOR OF PSYCHOLOGY

by

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August 2023

FINDING BODY APPRECIATION THROUGH THE WEIGHT-NEUTRAL FRAMEWORK

This dissertation, by Hannah J. Goehner, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of
Antioch University New England
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

FINDING BODY APPRECIATION THROUGH THE WEIGHT-NEUTRAL FRAMEWORK

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Body dissatisfaction is a critical risk factor for well-being; however, it can be considered normative in women. Body dissatisfaction is exceptionally high for women in larger bodies (Murnen, 2011). Due to body dissatisfaction's prevalence and risk, mental health providers must assist higher-weight women in developing body appreciation. This qualitative study aims to comprehend how weight-neutral treatments promote body appreciation among higher-weight women. Utilizing a feminist and positive psychology framework, the study explored how higher-weight women developed body appreciation, how weight-neutral treatment promoted this development, and what outside factors assisted their progression. Comparison analysis between the weight-neutral and weight-focused samples was completed to compare body appreciation trajectories and treatment factors. Nine higher-weight women participated in semi-structured interviews. Six women were in the weight-neutral treatment sample. With use of Interpretive Phenomenological Analysis, 11 global themes were extracted from the weight-neutral group's experience. Themes captured body image development, weight bias effects on well-being, treatment experiences, treatment and outside factors that promoted body appreciation, and the impact of developing body appreciation. Nine themes emerged out of the weight-focused data. Implications for clinical practice and training, as well as future research, are discussed. This

dissertation is available in open access at AURA (<https://aura.antioch.edu>) and OhioLINK ETD Center (<https://etd.ohiolink.edu>).

Keywords: body appreciation, weight-neutral, Health at Every Size, higher-weight women, body image treatment

Dedication

To those who came before me and started this work. Thank you for building and paving the path so everyone can experience body peace, acceptance, and liberation.

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CHAPTER I: INTRODUCTION

Body dissatisfaction for women is so prevalent that it can almost be considered normative, and this is particularly true for women with larger or fat bodies (Murnen, 2011). Due to the thin ideal and women's societal value associated with their appearance, many women in larger bodies internalize that their value is less when their body is not thin (Brown, 1989; Harrison, 2019; McKinley, 2011; Murnen, 2011). This inability to see their value outside of their weight and body size often causes body dissatisfaction. However, unlike women in smaller bodies, women in larger bodies' beliefs about their worth are reinforced by weight stigma and discrimination. This makes it challenging to see beyond their body as one of their primary characteristics of worth and deepens their body dissatisfaction. No matter their size, all women deserve to experience adaptive positive body image, which is linked to better overall well-being.

Due to society's values around weight and body size, many people believe that individuals with larger bodies should feel uncomfortable or dissatisfied with their bodies to assist them with weight loss (Latner & Wilson, 2011). However, evidence suggests that having a negative body image does not facilitate weight control; on the contrary, it often increases the development of unhealthy behaviors and leads to more weight gain (Latner & Wilson, 2011; Murnen, 2011). Still, most body image treatments for those with larger bodies focus on dieting and losing weight, also known as weight-focused treatments, as the primary way to develop a positive body image. While some of the literature has found weight-focused treatments to improve body image and satisfaction, they also note that only about 5–10% of individuals maintain weight loss, and sometimes others gain more weight than their baseline (Harrison, 2019; Martin Ginis et al., 2012). Bariatric surgery is another common form of weight-focused

treatment; however, about 20% to 35% of patients do not lose as much weight as expected after surgery, and many others experience physical discomfort (Pyykö et al., 2021). Patients encounter other adverse side effects from these types of treatments: unexpected pain, loss of energy, continued “obesity,” negative relationship changes due to weight loss, and decreased satisfaction in their sex life (Lindberg et al., 2020; Perdue & Neil, 2020).

Also, many people in larger bodies have dieted “on and off” throughout their lives, also known as weight cycling, which puts them at risk for developing disordered eating, eating disorders, and other physical and psychological risks (Bacon, 2010¹; Bacon & Aphramor, 2011; Harrison, 2019; Tylka et al., 2014). Due to the risks of weight cycling and the difficulty of maintaining long-term weight loss, “weight-neutral” or non-weight loss treatments are becoming more common. These types of treatments have been shown to decrease body dissatisfaction and improve health for “obese” and “overweight” individuals through building healthier lifestyles and better self-outlook without the emphasis on weight (Bacon, 2010; Bacon & Aphramor, 2011; Mesinger et al., 2016). While many studies have found that weight-neutral treatments have decreased women’s body dissatisfaction or negative body image, they have not studied how women in larger bodies develop positive body image (Bacon, 2010; Bacon & Aphramor, 2011; Mesinger et al., 2016; Wilson et al., 2020).

There is discourse around the weight-neutral approach, particularly that it will lead to poor physical health and higher mortality and morbidity rates among higher-weight individuals (Pokrajac-Bulian, 2018; Sainsbury & Hay, 2014). This is the primary argument against

¹ Dr. Lindo Bacon has repeated incidents of inducing harm to Black, Indigenous, and other People of Color and fat communities. The fat community has asked them to be accountable for their actions and change their approach, but they have failed to do so (Association for Size Diversity and Health [ASDAH], 2022).

weight-neutral approaches. Yet this has not been found to be true. When higher-weight people adopt a weight-neutral approach, they experience similar health benefits of losing weight, such as decreased insulin levels and blood pressure (Bacon et al., 2005; Bacon & Aphramor, 2011; Schaefer & Magnuson, 2014). Regarding mortality and morbidity, data do not consistently suggest that weight is the key factor for decreasing chronic disease prevention and mortality. Data suggest that people who are in the “overweight” or moderately “obese” Body Mass Index (BMI) categories live at least as long as people who are considered within the “normal” category and, often longer when they are in the overweight category (Bacon & Aphramor, 2011; Flegal & Graubard et al., 2005; Flegal & Ioannidis, 2018; Flegal & Kit et al., 2013; Mesinger et al., 2016; Tylka et al., 2014). Also, it is well known that “obesity” is associated with an increased risk for many diseases; however, causation is less well-established. Weight-loss studies rarely acknowledge other confounding variables like fitness activity, nutrient intake, weight cycling, or socioeconomic status when considering connections between weight and diseases (Bacon & Aphramor 2011; Bombak et al., 2019; Tylka et al., 2014). When studies do control for these factors, the risk of disease is significantly reduced or diminished (Bacon & Aphramor, 2011).

Positive psychology argues that removing negative or maladaptive characteristics without teaching positive and adaptive characteristics creates intermediate mental health characterized by a lack of pathology and the absence of vitality (Tylka, 2011; Tylka & Piran, 2019; Tylka & Wood-Barcalow, 2015b). Much of the research and treatment of body image often focuses on understanding the pathology of body dissatisfaction but does not consider how to promote positive body image. Without this understanding, it may be challenging to assist clients in fully accepting and appreciating their bodies, preventing them from fully thriving (Tylka, 2011). Not knowing how to promote positive body image may also impact treatment. Clinicians may be

poorly equipped to promote health and well-being and may not effectively prevent or treat body image disturbances in their clients. Considering only the pathology of body dissatisfaction, clinicians may reduce symptoms of negative body image but promote the mindset, “I do not hate my body; I tolerate it,” which is also known as neutral body image. Developing the skills to promote a positive body image would likely lead to more effective treatment with more significant gains and lasting results (Tylka & Wood-Barcalow, 2015b). Numerous studies have shown that encompassing positive body image increases one’s psychological and physical well-being; however, people in larger bodies have not been the primary focus of this research (Tylka, 2011; Tylka & Piran, 2019). The psychological community needs to learn how to assist with developing a positive body image in women in larger bodies who experience the pressure to fulfill the societal constructs of the woman’s body, while also facing weight stigma and discrimination.

Definition of Terms

“Overweight” and “obesity” are widely used to reference people with elevated body weight. Recently, concerns have been voiced about using these labels due to their stigmatizing and medicalized nature, which implies that one healthy weight range exists. In this paper, the terms “overweight” and “obesity” will be presented with quotation marks and will be solely used to reference extant research that used these labels for ease and understanding (Harrison, 2019; Romano, 2018). There is also a movement in the fat community to reclaim the word “fat” and promote it as a neutral body descriptor (Kinavey & Cool, 2019; Rothblum & Gartrell, 2019). Thus, the word fat may also be used within this study. However, not everyone in a larger body prefers to identify with that description due to its stigma. Due to these considerations, the phrasing of *people in larger bodies* or *higher-weight people* will be used (Harrison, 2019).

Conceptual Framework

Feminist Perspective

Within the current study, a feminist and positive psychology framework will conceptualize this study's understanding of the problem. In current Western society, the dominant culture states that there is an ideal body type. That ideal body type tends to be thin, athletic, White, cis, and able-bodied, similar to a White, cisman. If an individual does not have this body type, they are devalued and seen as unhealthy. This view results in weight bias, mainly aimed at women (Brown, 1989, Harrison, 2019; McKinley, 2011; Murnen, 2011; Pearl & Puhl, 2016). In the dominant society, women are valued by their looks which creates the context that women are objects and valued for their appearance, unlike men, who are valued for their mind and strength. Since women are praised for their appearance, they learn to view their bodies through an outside perspective to be accepted. Women learn that to be accepted or considered beautiful, they must be thin (McKinley, 2011; Tylka, 2019). Challenging this perspective is difficult because many women internalize this cultural standard and have been taught that it is attainable for all women. As a result, many women feel shame and anxiety when they are not able to meet this standard and feel that they have failed, even though they spend large amounts of effort, time, and money trying to reach the ideal (Harrison, 2019; McKinley, 2011; Tylka, 2019). In the feminist perspective, women's discontent with their body image is not pathological but "a systematic social phenomenon that oppresses women and causes their distress" (McKinley, 2011, p. 54).

Positive Psychology Perspective

Positive psychology encourages researchers and practitioners to consider the importance of human strengths, psychological well-being, and physical health within their work. Humanistic

and counseling psychology are close relatives of positive psychology. These three disciplines share several principles: promote well-being through the necessary ingredient of conditional acceptance; utilize a strength-based therapeutic approach; appreciate cultural and body-related diversity; prevent illness through health promotion; and consider how one flourishes (Tylka & Wood-Barcalow, 2015b). Regarding body image, a positive psychology approach does not address what causes and maintains negative body image, but creates an understanding of how an individual can appreciate, respect, celebrate, and honor their body.

Purpose Statement

The purpose of this qualitative study is to describe the experience of women in larger bodies who sought treatment for negative body image with a provider who utilizes a weight-neutral framework to develop body appreciation. These women's experiences have assisted in ascertaining how health providers and mental health providers can promote body appreciation for people with larger bodies. The research has shown that numerous aspects of the weight-neutral framework have assisted women in larger bodies to develop body appreciation and that the process is different for those who have sought out weight-focused treatments to assist with their body image.

Summary of the Methods and Research Questions

A qualitative approach was beneficial for this research because it allowed the perceptions and experiences of the participants to be used to assist researchers and clinicians in providing strength-based treatment for body image for fat women or women in larger bodies. Critical feminist theory's principles have highly influenced this study. Within a critical feminist frame, the researcher is expected to address inequalities and empower humans to look at the perspectives of power in relationships, individuals, and society, and how they impact women,

thereby creating a study that transforms the underlying orders of social life (Creswell & Poth, 2018). The current study critiques Western society's standards for assessing body sizes (i.e., BMI, clothing sizes, etc.). Furthermore, the study hopes to transform the idea that someone in a larger body can find peace in and celebrate their body by considering how systemic powers, such as diet culture, have impacted the body relationship and creating a conceptualization of what it means to have a positive body image at a higher weight.

The researcher interviewed six women who received weight-neutral treatment (e.g., psychotherapy, nutrition, coaching, etc.) and three who received weight-loss treatments (e.g., bariatric surgery, weight-loss programming, coaching, etc.). The three who received weight-focused treatments became the comparative analysis group. All the women wore pants sizes 16 or higher, which is an average waist measurement of 35 inches and above. After the interviews, the researcher identified themes that the participants experienced in their treatment and that assisted them with developing body appreciation. The researcher also noted how the participants discussed their relationship with their bodies. Interpretive Phenomenological Analysis (IPA) was used to analyze the responses.

Study's Significance

The current body image study encourages future researchers to not only look at how to lower body image pathology for higher-weight women or anyone in a larger body, but also to begin to wonder what it means to have a positive relationship with one's body at a larger size. Naturally, I hope this will help mental health clinicians assist their clients in developing positive body image no matter their size. I also hope this study will assist clinicians in preparing to provide treatment that does not discriminate against or oppress higher-weight clients. Instead,

clinicians should highlight client strengths and acknowledge their resilience within a social environment where they are already highly stigmatized due to body size.

Delimitations

The delimitations section introduces the boundaries of this study and the reason for them. Participants were between the ages of 25–45, who self-reported as receiving 3 months or more of weight-neutral treatment where body image was one of the primary foci, who scored between average and high on the Body Appreciation Scale-2, and who wore pants sizes 16 and higher. These criteria were chosen to protect women's treatment progression and decrease confounding variables that might affect or change the understanding of the phenomenon.

While collecting data, it became apparent in the interview that three women did not receive weight-neutral treatment but, instead, weight-loss treatment. These women believed they received weight-neutral treatment at a weight-loss clinic while preparing for bariatric surgery since they did not recall any moments of discussing weight or how to lose weight in those counseling sessions. Since these three women experienced body image treatment in a weight-loss center in preparation for bariatric surgery, it is assumed that the primary goal for treatment was to assess and assist these women in bariatric treatment readiness, which is considered a weight-loss treatment.

Pant Size Versus BMI

Many studies that study people in larger bodies utilize the body mass index scale (BMI) to categorize participants (Bacon et al., 2005; Bientner et al., 2019; Martin Ginis et al., 2012; Mesinger et al., 2016; Wilson et al., 2020). However, many weight-neutral treatments ask clients not to weigh themselves due to the cognitive dissonance that many experience around their weight and its influence on an individual's sense of worth (Bacon, 2010; Harrison, 2019; Tribble

& Resch, 2012). Also, the social construct around the BMI categories can be stigmatizing since many individuals who fall within the “overweight” or “obese” categories are considered by society to have a disease that they are at fault for or to “lack discipline” if they cannot fit within the “normal” category (Harrison, 2019; Kinavey & Cool, 2019; M. C. McHugh & Kasardo, 2012; Puhl & Brownwell, 2003). Since I could not weigh these individuals in person, where I could prevent participants from seeing the scale number, I utilized pant sizes to categorize these individuals.

It should be also noted that the BMI is an imperfect way to measure body fat, given that it doesn’t account for differences across race and ethnic groups, sexes, genders, and age spans (American Medical Association [AMA], 2023; Harrison, 2019). The BMI has also been connected to historical harms in its use for racist exclusion and because it is based primarily on data collected from previous generations of the White population (AMA, 2023; Strings, 2019). The researcher decided not to use it in this study for these reasons and the ones previously mentioned.

Sixty-eight percent of American women wear size 14 or larger. However, finding clothing in their size is challenging, even as the fashion industry and major department stores become more inclusive. However, once someone reaches a size 16 and up, the selection decreases significantly and is more likely to be found only online (George-Parkin, 2018; Specter, 2019). George-Parkin (2018). reported that a retail analytics firm analyzed 25 of the country’s largest multi-brand retailers, which carry more than 15,500 brands; they found that just 2.3 percent of their women’s apparel assortment is plus-size. The average size of women in the United States is 5’3” and weighs about 163 pounds, which, according to the BMI, would put most women within the higher end of the “overweight” category (George-Parkin, 2018). Many

of these women also wear a size 14 or up. It is believed that utilizing pant sizes will likely capture that they fit within the traditional BMI categories without weighing them or experiencing internalizing weight stigma due to their weight.

Age Requirements

The ages of 25–45 were chosen for this study due to generational differences regarding social media. Social media significantly influences an individual's body image development since it often portrays society's "ideal body" (Wood-Barcalow, Tylka, & Judge, 2021). Individuals between the ages of 25–45 did not grow up with social media and were not inundated with the body-based and image-focused societal messages that younger generations have had to navigate since early childhood. Those older than 45 likely did not have exposure to social media until adulthood, which would less likely influence their body relationship. Also, the weight-neutral treatments and fat community became more prominent as the internet became more accessible through web-based communities, such as the Fatosphere and social media, which may limit older generations' exposure to the research topic (National Association to Advance Fat Acceptance [NAAFA], n.d.).

Organization of the Study

The remainder of the current dissertation consists of four more chapters, followed by appendices. Chapter II presents a review of the related literature discussing how feminist and positive psychology conceptualizes body image, positive body image and its characteristics, weight bias, and the different types of body image treatments there are for people in larger bodies. Chapter III delineates the research design and methodology of the study. The determination of sample selection, interview protocol, and data analysis process will be

described. An analysis of the data and a discussion of the findings are presented in Chapter IV.

Chapter V contains the summary, conclusions, and recommendations.

CHAPTER II: LITERATURE REVIEW

The current chapter will review the literature in four major areas examined in preparation for this study. The first section will provide literature on how feminist and positive psychology conceptualize body image and the pathology that occurs from body dissatisfaction. The second section focuses on literature concerning body image and its characteristics, particularly positive body image. The third section will discuss weight bias, where and how it occurs, and how it affects the well-being of higher-weight people. The fourth section will close this chapter by reviewing body image treatments for people in larger bodies and their effectiveness.

Section One: Body Image Within the Feminist and Positive Psychology Perspective

We all live within a body and need it to be an active participant on this earth. While this statement may be redundant, many do not consider the relationship or how their relationship with their body was created. Before we continue discussing body image and the experience of those in larger bodies, it is important to examine how research is understanding how humans build and maintain a relationship with their bodies. Feminist and positive psychology will be the two perspectives used to understand this relationship. Within this section, I will discuss each theory's principles, how they conceptualize body image, and why it is beneficial to use their perspective.

Feminist Perspective and Body Image

Feminist theory exists today because there has been a history of women who have bravely spoken out about their struggle with being excluded from the dominant culture. The exclusion was primarily through not being allowed to gain knowledge within the predominant avenues and seeing their own experiences, concerns, and worth minimized and invalidated by those with power (Hesse-Biber, 2012). The feminist perspective examines the lived experiences of all women and encourages them to share their stories due to the belief that personal

transformation leads to a political one (Brown, 2010; Hesse-Biber, 2012). In the dominant culture, maleness, specifically White maleness, is often associated with privilege. Qualities attributed to women or other non-dominant groups are not equally valued, no matter the gender of those in whom these qualities are found. The dominant culture convinces society that maleness, Whiteness, ability status, and thinness equal power and health. If unable to hold these standards, it often leads to discrimination and the oppression of those who do not hold those standards (Brown, 1989; Harrison, 2019).

Feminist theory puts women's and other marginalized groups' experiences at the center of inquiry, which creates new knowledge by taking a multitude of different standpoints and negotiating these identities simultaneously (Hesse-Biber, 2012). It also challenges the dominant discourse of knowledge by urging people to "live and invite difference and to embrace creativity and knowledge building that lies within differences" (Hesse-Biber, 2012, pg. 13). The acknowledgment and appreciation of difference is the catalyst to continue fighting for meaningful social change.

Even though feminist theory encourages differences, it has not always embraced those who live in larger bodies or seen "living in a larger body" as an identity outside of the dominant culture. Researchers since the 1980s have called for feminist researchers and practitioners to consider higher-weight women's experiences due to the oppression they face from the dominant culture (Brown, 1989; Fikkan & Rothblum, 2012). It has been noted that women in larger bodies experience higher rates of deleterious effects than males in larger bodies or women in smaller bodies within numerous realms, including health, socioeconomic status (SES), and overall well-being, which will be discussed in more detail later in this section (Fikkan & Rothblum, 2012). These higher deleterious rates for higher-weight women compared to their counterparts

shows that weight discrimination is a gender issue (Brown, 1989; Fikkan & Rothblum, 2012). Feminist theory is utilized in this study because it captures the experiences and lives of women in larger bodies who have found joy, appreciation, and peace within a culture that minimizes their worth and invalidates their experience based on their size and gender. For the remainder of this discussion, I will review how society continues to oppress women with their bodies by examining how Western societal gender roles influence how one treats and sees their body and how weight and gender intersect.

Gender Role Expectations and the Body

Bodies exist within a social and cultural context constructed through the culture's practices and discourse. As a result, everyone's body conveys social meaning, and society affects how one creates a relationship with their body (Fredrickson & Roberts, 1997). Gender is one way we make meaning of the body (Murnen & Smolak, 2019).

Women's Role Expectations and the Body. In Westernized societies, females are expected to maintain physical appearance and value thinness. Women's "ideal" body type is thin and toned, with long hair and eyelashes, full lips, large breasts, a thin waist, round buttocks, and long legs. Gender expectations also ask women to be sexy, which means enhancing, emphasizing, and exposing sexualized parts of their bodies (Murnen, 2011; Murnen & Smolak, 2019). Embracing the ideal body type has been linked to high body dissatisfaction in women and the development of eating disorders and disordered eating behaviors (Murnen, 2011).

While some may argue that there has been a shift in this "ideal" body type where there is more diversity, it is still the primary image we see in media today (Bombak et al., 2019, Murnen, 2011). Body image is not only influenced by the media but also influenced by friends and family. This is particularly true with the strive for thinness. By adolescence, many girls become part of

an all-female appearance subculture where there is talk and behavior associated with maintaining their weight; it can be seen as a “bonding” experience to diet together or share dieting “secrets” (Harrison, 2019; Murnen, 2011). Thinness and maintaining appearance also compromise a social norm for women, and women are expected to spend time, energy, and money to pursue the ideal. Many women believe their life would be better if they looked like the ideal, and their belief is not wrong. Those who embody the ideal are seen to have more success in their careers and heteronormative romantic relationships (Brown 1989; Fikkan & Rothblum, 2012; Murnen, 2011).

Many of these body standards that women are supposed to strive for were created to assist women in appearing sexy. Women and adolescent girls are encouraged to accept the perspective that being a sex object legitimizes their role in society (Murnen, 2011; Murnen & Smolak, 2019). This role expectation encourages women to view their bodies as sexual objects to be approved by males to secure attention and protection, particularly in heterosexual relationships (Murnen & Smolak, 2019). These observations led feminist researchers to create objectification theory to assist in how women experience their body.

Objectification Theory. Objectification theory is a “theoretical framework that places female bodies in a sociocultural context with the aim of illuminating the lived experience and mental health risks of girls and women who encounter sexual objectification” (Fredrickson & Roberts, 1997, pg. 174). Sexual objectification is the experience of being treated as a body or a collection of body parts that is valued predominantly for its use or consumption by others and prevents the individual from being seen as a whole person with unique subjectivity (Fredrickson & Roberts, 1997; Tylka & Calogero, 2019). Sexual objectification can occur in many realms, including the interpersonal and social realms (Fredrickson & Roberts, 1997; Murnen, 2011).

Sexual objectification is a form of gender oppression, and it likely influences many types of discrimination towards females, such as sexual violence to the trivialization of women's work and accomplishments (Fredrickson & Roberts, 1997).

The objectification of women has numerous consequences, and the most significant consequence is how women and girls internalize the observer's perspective. The theory suggests that the cultural milieu of objectification functions to socialize girls and women to treat themselves as objects to be looked at and evaluated. As they adopt and incorporate the socialized view into their sense of self, they reflect on how others view and treat them (Fredrickson & Roberts, 1997; Murnen & Smolak, 2019). They self-objectify by scrutinizing their appearance to what they believe others desire their body to be and determine their self-worth by evaluating themselves against those expectations (Fredrickson & Roberts, 1997; Murnen & Smolak, 2019; Tylka & Calogero, 2019). It also affects their ability to have a relationship with their body and appreciate its function, which is essential for body appreciation (Murnen & Smolak, 2019).

Women continue to internalize the observer's perspective because they unconsciously see the benefits of being an attractive woman, or "pretty privilege," where physical beauty can be translated into power. Embodying the ideal can provide numerous benefits. For example, researchers have demonstrated that a woman's social mobility is affected when she is at a higher-weight than higher-weight men (Fikkan & Rothblum, 2012; Fredrickson & Roberts, 1997). Studies have also found that when women are deemed unattractive by their coworkers, they are frequently described more negatively than unattractive male peers. Physical attractiveness for women is positively correlated to popularity, positive dating experiences, and more marriage opportunities. This was not true for men (Fredrickson & Roberts, 1997). Since a woman's social and economic prospects can be determined by their physical appearance, it

encourages women to unconsciously anticipate the repercussions of their appearance, which is a strategy for helping them determine how they will be treated in the world (Fredrickson & Roberts, 1997).

The Intersection of Weight and Gender

Weight discrimination affects all genders and is considered one of the most prominent ways people are discriminated against in the United States; however, it continues to affect women at a higher rate (Fikkan & Rothblum, 2012; M. C. McHugh & Kasardo, 2012). Fikkan and Rothblum (2012) completed a literature review across various disciplines and domains demonstrating weight bias's impact on women. Throughout the literature, they found that women in larger bodies experience higher rates of deleterious effects than men in larger bodies or women in smaller bodies regarding employment and income, education, healthcare, interpersonal relationships, and overall well-being. For example, a few studies found that women tend to experience wage decreases at much lower weights than men. Maranto and Stenoien (2000) found the negative effect of weight on salaries to be highly significant for White women in the “overweight” range and marginally significant for Black women. On the other hand, White and Black men experienced wage premiums when “overweight” or “mildly obese” and only experienced wage penalties at the very highest weight levels, being 100% above the standard weight for their height (Fikkan & Rothblum, 2012). Another example of gender difference was found in the medical field, where medical doctors were twice as likely to diagnose “obesity” in women patients than men patients (Fikkan & Rothblum, 2012). These are just a few examples of how weight discrimination disproportionately affects women, demonstrating that it is a gender issue.

Positive Psychology Perspective and Body Image

Most psychological history has searched to understand and lessen the pathology and problems that occur within the human experience. However, there has not been much focus on how to promote the “good life” or what can go right for people. The founders of positive psychology noticed this discrepancy and created a new psychological discipline that studies how to promote well-being and flourishing (Peterson, 2006b; Seligman, 2011; Tylka, 2011). Positive psychology is a strength-based discipline that emphasizes human strengths and psychological and physical well-being within its research and practice (Tylka & Wood-Barcalow, 2015b).

The basic premise of positive psychology is its argument that removing negative or maladaptive characteristics without teaching positive and adaptive characteristics creates a mental health state characterized by a lack of pathology. The discipline of positive psychology believes that simply living without pathology is insufficient since it prevents people from living a life full of vitality (Peterson, 2006b, Seligman, 2011; Tylka, 2011; Tylka & Wood-Barcalow, 2015c). The theory argues that good health should be measured by fitness and resilience, and clinicians should promote well-being, including physical, psychological, and social well-being since these concepts set the stage for longevity and resilience later in life (Peterson, 2006a; Vaillant, 2003). Positive psychology aims to provide the most objective factors possible about the phenomena of well-being and flourishing so that everyone and society can make informed decisions about “what goals to pursue in what circumstances” (Peterson, 2006b, pg. 16). The study of positive psychology is not about finding ways to always be happy or positive, but it provides an opportunity for everyone to learn how to live a “good life” or to flourish (Peterson, 2006b).

Positive Psychology and the Body

The history of research on body image has primarily looked at understanding body dissatisfaction and how it correlates to eating disorders. Through this research, they concluded that negative body image is an appearance-based construct and has been identified as a risk factor for eating disorders and should be a target for prevention and clinical interventions (Tylka, 2011; Tylka & Piran, 2019). Positive psychology would argue that this understanding of body image is only partially complete, which is why within the last 15 years, more researchers have begun to study what causes positive body image.

Within the last 15 years, researchers have found numerous ways to live within a body that vary and far extend beyond appearance-related concerns, distress, or dissatisfaction (Tylka & Piran, 2019). They have discovered a positive correlation between flourishing and having a positive body image. Williams and colleagues (2004) demonstrated this phenomenon by interviewing three distinct body image groups of women (positive, neutral, and negative) and seeing how their well-being was affected by body image. They found that women with positive body image reported higher optimism, self-esteem, social support, adaptive coping, and weight stability. These findings differed significantly from the other two groups; the positive body image group had better overall well-being (Tylka, 2011). Studies have also found that individuals with positive body image encourage others in their environment to flourish by finding partners and friends that accept their bodies, which in turn, helps them feel even more appreciated and respectful of their own bodies (Tylka, 2011). Lastly, those who study positive body image found that it is complex and is not simply the opposite of negative body image but has numerous constructs that make it multi-dimensional.

The information in these studies highlights the importance of studying positive image and how to promote it because working to understand and reduce negative body image alone would not fully promote well-being. The benefits of learning how to promote positive body image for all sizes include defining protective factors against body dissatisfaction and creating more comprehensive prevention and treatment programs for eating disorders and body image concerns. It can also assist with developing the skills to discuss sexuality experiences and psychological flexibility, which is difficult for those who experience body dissatisfaction and eating disorders (Tylka & Wood-Barcalow, 2015b). Lastly, understanding positive body image can assist society in fostering safety and inclusion of all bodies.

Section Summary

This section reviewed the literature of feminist and positive psychology and how they understand body image development. The section began with a description of the basic principles of feminist theory. Then a discussion about binary gender roles and the expectations projected onto female bodies unfolded. Objectification theory was explained regarding how people, particularly women, see and develop a relationship with their bodies. The intersection of gender and weight were considered, and an argument was made that weight discrimination is a women's issue due to the oppression that higher-weight women experience. The section concluded by discussing the basic principles of positive psychology and the importance of studying positive body image since it assists with overall well-being.

Section Two: Body Image

Body image is an intricate construct that comprises cognitive, affective, behavioral, and perceptual aspects (Cash & Smolak, 2011; Razmus, 2018; Weinberger & Luck-Sikorski, 2020). Negative body image is associated with dissatisfaction and how one sees their body negatively.

Positive body image has gained more attention in recent research and is the primary focus of this section (Razmus, 2018). Before delving deeper into positive body image, it is important to review the consequences of negative body image. Then a larger discussion of positive body image will occur, identifying how it differs from negative body image and its characteristics.

Consequences of Negative Body Image

Negative body image, sometimes referred to as body dissatisfaction, is a topic in psychology that has been highly researched. Body dissatisfaction has been found to impact one's well-being significantly. It has been associated with a poorer quality of life and psychological and physical health concerns. Psychologically, poor body image has been positively correlated with lowered self-esteem, increased risk of depression, emotional distress, habitual negative thinking, and social anxiety (Carrard et al., 2018; Paquette & Raine, 2004). It is also one of the main predictors of developing eating disorders, disordered eating, and restrained eating (Weinberger & Luck-Sikorski, 2020).

The physical health concerns that are associated with negative body image are weight cycling, unhealthy eating behaviors or weight control, binge eating, and lower levels of physical activity (Carrard et al. 2018). If these behaviors occur later in life, they can also contribute to other physical illnesses. Carrard et al. (2018) completed a study on women who were 60 years old and older and found that those who had body dissatisfaction and participated in chronic and inappropriate dieting throughout their lives were more likely to have poor physical balance, sarcopenia, osteopenia, or reduced immune functioning. As one can see, negative body image is a significant risk to one's health and can be extremely harmful if not treated.

What is Positive Body Image?

Positive body image (PBI) was historically seen as a lack of body dissatisfaction. However, as more research was completed on PBI, the results concluded that it was not on the same continuum as negative body image; rather, it is its own construct (Tylka & Wood-Barcalow, 2015b). What makes it unique from negative body image is that PBI has associations with well-being, self-care, and eating behaviors that were not accounted for solely by the lack of negative body image (Tylka & Wood-Barcalow, 2015b; Tylka & Piran, 2019). Studies also show that one can have body dissatisfaction and demonstrate positive feelings about one's body (Tiggemann & McCourt, 2013). Research has also identified that there is not a large conceptual overlap between positive and negative body image, meaning that there is construct differentiation (Tylka & Piran, 2019). As this differentiation became more apparent, researchers better understood PBI.

Through much quantitative and qualitative research with numerous and diverse groups, Wood-Barcalow, Tylka, and Augustus-Horvath (2010) identified and analyzed the themes and created the “working definition” of PBI. PBI is currently described as:

An overarching love and respect for the body that allows individuals to (a) appreciate the unique beauty of their body and the functions that it performs; (b) accept and even admire their body, including those aspects that are inconsistent with idealized images; (c) feel beautiful, comfortable, confident and happy with their body, which is often reflected as an outer radiance, or a ‘glow,’ d) emphasize their body's assets rather than dwell on their imperfections, and e) interpret incoming information in a body-protective manner whereby most positive information is internalized, and most negative information is rejected or reframed. (Wood-Barcalow, Tylka, & Augustus-Horvath, 2010, p. 112)

The definition of PBI is a small example of its complexity. To better understand this construct, the remainder of this section will discuss the characteristics of PBI.

Multidimensional

PBI is a multidimensional construct that involves more than body satisfaction and appearance evaluation. Qualitative research has shown numerous facets of PBI that contribute to its development within an individual (Tylka & Wood-Barcalow, 2015b; Webb et al., 2014). To discover these facets, Tylka and Wood-Barcalow (2015b) reviewed research on what PBI or body pride was to numerous research groups. The review of the literature included a study that interviewed college women with PBI from the United States, adolescent girls, and boys with PBI from Sweden, African American adolescent girls and their maternal caregivers, and Aboriginal adolescent girls who espoused body pride from Canada (Frisén & Holmqvist, 2010; Holmqvist & Frisé, 2012; T.-L. F. McHugh et al., 2014; Pope et al., 2014; Wood-Barcalow, Tylka, & Augustus-Horvath, 2010). From there, they created the six facets across themes generated from each study, which sustained the assertion that PBI is multifaceted (Tylka & Wood-Barcalow, 2015b).

The six facets of PBI are body acceptance and love, a broad conceptualization of beauty, adaptive appearance investment, inner positivity, filtering information in a body-protective manner, and body appreciation. Each of these facets uniquely affects one's level of PBI. Research suggests that there is variance between facets that focus on how the body feels and functions more than appearance (body appreciation, body image flexibility, and functional body orientation) and functional body satisfaction (satisfaction with what the body can do and experiences), meaning that the constructs do not overlap (Tylka & Wood-Barcalow, 2015b). Each is important for understanding an individual's PBI and how to assist with the development of PBI. However, due to the lack of research and measures on each facet, this study will

primarily utilize the facet of body appreciation to understand participants' relationships with the body.

Body Appreciation. Body appreciation is respecting and approving of one's body and praising the body for what it can do, what it represents, its unique features, and its health regardless of its shape, weight, ability, or imperfections. Body appreciation is gratitude for one's body and everything it does and represents (Avalos et al. 2005; Razmus, 2018; Tylka, 2011, 2019; Tylka & Wood-Barcalow, 2015b, 2015c; Weinberger & Luck-Sikorski, 2020). Body appreciation is one of the first facets of PBI to emerge. As one of the earliest facets, it contains several central aspects of PBI, making it one of the most comprehensive facets in capturing PBI, particularly around behaviors such as accepting, protecting, care-taking, and respecting one's body (Avalos et al., 2005; Tylka, 2019; Webb et al. 2014).

Body appreciation and its effects have been studied within numerous realms. It has been seen as a psychological protective factor (Razmus, 2018; Tylka, 2019; Tylka & Wood-Barcalow, 2015a, 2015b; Weinberger & Luck-Sikorski, 2020). Body appreciation has been associated with self-compassion, lessening body dissatisfaction, optimism, increased self-esteem, proactive coping, positive affect, life satisfaction, subjective happiness, emotional intelligence, and increased sexual functioning (Razmus, 2018; Tylka, 2019; Tylka & Wood-Barcalow, 2015a). It has been inversely related to negative affect, depressive symptomatology, maladaptive perfectionism, body dissatisfaction, and body surveillance (Razmus, 2018; Tylka, 2019).

Body appreciation is also associated with numerous physical benefits such as intuitive eating, higher engagement in physical activity, higher sexual functioning, and greater sexual liberalism among women (Razmus, 2018; Tylka, 2019; Tylka & Wood-Barcalow, 2015a, 2015b). It has also been positively correlated with individuals practicing preventive care, such as

seeing a health provider for skin screenings, wearing sun protection, seeking medical attention, and having regular teeth cleaning (Razmus, 2018). Also, body appreciation is inversely related to using weight-management techniques such as dieting or stimulants, partaking in cosmetic surgeries among women and men, internalizing social appearance ideals, and disordered eating behaviors (Razmus, 2018; Tylka, 2019; Tylka & Wood-Barcalow, 2015b). Since body appreciation is highly correlated with PBI and a large amount of research has been completed on the subject, body appreciation will be utilized to capture participants' body image experiences.

Holistic

Interconnectivity and attunement are two words that assist in understanding how the body is connected to the human experience. Internal experiences of inner positivity and protective filtering are intertwined with external behaviors, interpersonal relationships, community, media, and culture. The external experience is just one aspect of how it affects the relationship with the body. Body-related thoughts, affects, perceptions, and behaviors are interconnected; thus, body image is not segregated into one dimension (Tylka & Wood-Barcalow, 2015c). There is a reciprocal process of mutual influence and co-regulation between these internal and external systems, which involves them being attuned to each other (Cook-Cottone, 2015).

Research has also seen how internal and external sources influence PBI (Tylka & Barcalow, 2015b). One example of how internal and external sources interact to influence body image came from the T.-L. F. McHugh et al. (2014) study, where there were discussions around body pride among Canadian Aboriginal adolescent girls. The participants discussed how their Aboriginal identity provided outlets for them to show body pride, such as powwow dancing, and by engaging in these outlets, they further built their body and cultural pride. As one can see here,

the external and internal sources of body image affected how they experienced their bodies and culture, furthering their PBI.

Stable and Malleable

PBI is unique because it can be stable and malleable (Paquette & Raine, 2004; Tylka & Wood-Barcalow, 2015b). Research has shown that positive body image can increase through interventions and is maintained over time through cognitive dissonance, meditation, and challenging societal body ideals. However, it can remain the same when interventions or steps are not taken to change one's body image (Tylka & Wood-Barcalow, 2015b). It seems that body image is a static construct with multiple elements that are dynamic, fluctuating, and can be influenced by new or re-interpreting previous body experiences to change how one sees their body (Paquette & Raine, 2004). This demonstrates that one's PBI can change through multiple avenues, such as working with a mental health provider, and without changing one's body.

Protective Factor

PBI is likely a protective factor of physical health and well-being (Tylka & Wood-Barcalow, 2015c). As demonstrated throughout this paper, PBI is associated with numerous well-being, self-care, and adaptive physical health indices in a positive direction and distress and disturbance in an inverse direction. It should be noted that PBI has not been linked to disengagement in healthy activity, eating, and self-care. It has been assumed that having a holistically favorable perspective of one's body may lead to disengagement with healthy behaviors, particularly for people in larger bodies. No empirical evidence has substantiated the speculation that PBI leads to disengagement in these behaviors. In several studies, body appreciation and body image flexibility are inversely related to BMI, showing that promoting

body appreciation and other facets of PBI may increase participation in health-related behaviors (Tylka & Wood-Barcalow, 2015b).

Bodies Need to Be Accepted by Others

PBI is linked to perceiving that one's body is accepted by others, including family, friends, romantic partners, a higher power, and society. If individuals believe their bodies are acceptable, they may be less preoccupied with changing their outer appearance and pay more attention to how their body feels and functions (Paquette & Raine, 2004; Razmus, 2018).

Knowing one's body is accepted by others can happen implicitly or directly in three ways: subtle acceptance-based messages from family and friends about style or appearance, infrequent appearance-related talk, and general messages about beauty and love for the body. Something that is often practiced by much of the population is body-related compliments (i.e., "You lost weight" or "You have nice legs"). These types of compliments do not aid in body acceptance, and they can cause an increase in preoccupation with one's outer appearance (Tylka & Wood-Barcalow, 2015c).

For women, their romantic partners, other women, and health physicians appear to be some of the individuals that influence body acceptance the most. Romantic partners significantly influence how women perceive their bodies through comments or the values they hold around their bodies and health (Paquette & Raine, 2004; Razmus, 2018). Paquette and Raine (2004) found that women's relationships with other women were also a significant factor. The study participants often noted how social approval was connected to female family, friends, and acquaintances' comments about other women. These women also discussed how women often feel free to comment on each other's eating behaviors and how that can affect how they view their bodies; it can feel empowering when it is approved by other women or detrimental when it

is not (Paquette & Raine, 2004). Health physicians' comments on one's body size also influence one's body image (Paquette & Raine, 2004).

Weight stigmatization significantly affects one's ability to have a PBI. The inverse relationship between PBI and weight stigma is not likely related to having higher weights; however, having the perception that others do not accept their bodies is (Augustus-Horvath & Tylka, 2011). When an individual experiences weight stigma, it will likely lower their perception of body acceptance by others, which may serve as a barrier to body appreciation and all the protective qualities it offers (Tylka & Wood-Barcalow, 2015b).

Shaped by Social Identities

PBI is best conceptualized by the intersection of various social identities. The intersection of identities affects the expression and importance of PBI for each individual, which most research does not consider (Tylka & Wood-Barcalow, 2015c). PBI is not a unitary construct that applies to all groups within all social identities; culture, age, gender, race, and size all impact one's ability to view one's body with positivity (Carrard et al. 2018; Paquette & Raine, 2004).

It is amazing how many factors can affect PBI; most are not appearance-based like originally thought. To better understand PBI in the future, research needs to delve deeper into the six facets of PBI and its characteristics. It would also be beneficial to have more research on how PBI and its facets can be used within body image treatment for all intersections of identities.

Section Summary

The main role of this section was to define and review PBI. The chapter began by discussing the difference between negative and positive body image. Then, PBI was defined, and its characteristics were discussed. The PBI facet of body appreciation will be primarily used to measure PBI in this study because it captures the concept most effectively.

Section Three: Weight Bias

According to the Center for Disease Control and Prevention (CDC, 2022), “obesity” and “overweight” traits have increased by 40% since 2000 and continue to rise among children and adults. Even with this societal change, weight bias and discrimination are highly prevalent, are comparable to race-based prejudices, and are more common than sexism and other forms of biases (Fikkan & Rothblum, 2012; M. C. McHugh & Kasardo, 2012; Puhl, Andreyeva, & Brownell, 2008; Tomiyama, 2014). This section examines weight bias, also known as anti-fat bias or sizeism. It will also review how weight bias manifests for higher-weight individuals in everyday life and health care. This section will close by discussing the harms of weight bias.

Weight bias is the bias against individuals based on their body weight. It can manifest in the beliefs (stereotypes) or behaviors (discrimination) about people who are perceived as being of a higher weight (M. C. McHugh & Chrisler, 2019; M. C. McHugh & Kasardo, 2012). All body sizes can experience weight bias. However, because of societal preference for slender body types, higher-weight people are the typical targets of prejudice and discrimination (Kinavey & Cool, 2019; M. C. McHugh & Chrisler, 2019). Weight bias is grounded in the cultural beliefs that attractiveness equates to thinness, “obesity” is a disease, and the individual solely controls their weight, even though research indicates that weight is influenced mainly by biological and environmental factors. These beliefs lead to anti-fat attitudes, stigmatizing higher-weight people (Harrison, 2019; Kinavey & Cool, 2019; M. C. McHugh & Kasardo, 2012). Discrimination and stigmatization suffered by higher-weight people are so pervasive that the effects reduce and inhibit educational attainment, employment, and personal relationships (Budd et al., 2011). Weight stigma occurs most often in public settings, followed by insurance and health care (Hatzenbuehler et al., 2009).

Weight Bias in Everyday Life

For those who are higher-weight, weight-based stigmatization and discrimination occur regularly and in multiple avenues of their daily lives. Interpersonal relationships, education, employment, and exposure to the media are just a few places they may experience weight bias. In this section, there will be an exploration of how weight stigma may occur in each realm.

Interpersonal Relationships

Weight bias is different from other biases because it is seen as acceptable since the current cultural zeitgeist believes that demeaning remarks about one's higher weight can be justified to help people become “healthier” (Major et al., 2012; Tomiyama, 2014). Since weight bias is seen as socially acceptable, one's family, friends, and coworkers may feel they can comment on their weight, affecting how one feels in those relationships (Major et al., 2012).

For some higher-weight individuals, weight bias begins in childhood. Studies from the 1960s demonstrated that children as young as three can participate in weight bias. In these studies, young children were presented with figure drawings of children with various health conditions and disabilities; they rated the higher-weight child as the least likable (Pearl, 2018; Tomiyama et al., 2018). As children age, they may begin to act on the prejudice through bullying or discrimination. Children with larger bodies are twice as likely to be bullied than their smaller-bodied peers (Pearl, 2018; Tomiyama et al., 2018). Girls are the ones to experience this type of bullying the most (Bookwala & Boyar, 2008). These early weight-bias experiences can often lead to higher-weight children feeling isolated and affect their sense of worth and ability to learn how to build healthy peer relationships.

Caregivers can also be a source of weight bias. Caregivers with higher-weight children are often reluctant to seek professional help for their children due to fears of being blamed for

their child's weight. They are also less likely to support their higher-weight children financially, particularly daughters, in pursuing a college education and encourage them not to be as ambitious as their smaller-bodied children (Burmeister et al., 2013; Crandall, 1994; Tomiyama, 2014). Caregivers may unknowingly partake in these forms of discrimination because they believe in the common stereotypes of higher-weight people. This can further impact a child's self-esteem by internalizing those stereotypes and feeling unlovable or unworthy.

In adulthood, weight bias continues to negatively affect one's interpersonal relationships, which is notably true for women. Women in larger bodies are more likely to experience perceived mistreatment due to weight from strangers and their relationships. They also report more negative experiences related to their weight than men, including teasing, slurs and insults, harassment, adverse judgments and assumptions, and perceived discrimination. Higher-weight women also report difficulty developing romantic relationships (Bookwala & Boyar, 2008; Fikkan & Rothblum, 2012). This form of discrimination is seen in the Chen and Brown study. Chen and Brown (2012) asked college students to rate the attractiveness of prospective partners and found that men were more likely to choose sexual partners based on their weight than women. Male participants rated higher-weight women as less attractive than women missing a limb, in a wheelchair, mentally ill, or with a sexually transmitted infection (Chen & Brown, 2012). In childhood and adulthood, interpersonal relationships are supposed to make individuals feel safe, authentic, and vulnerable; yet people in larger bodies may not experience that type of security because of weight bias.

Education

Educational systems are another common place individuals in larger bodies experience weight stigmatization and discrimination. Weight-based teasing and bullying by peers and educators may partially account for the observed educational disparities among children in larger bodies (Kenney et al., 2015; Pearl, 2018). Surveys found that children who had experienced weight-based teasing had poorer academic performance. This phenomenon occurred even for the individuals that scored well on standardized tests. Girls in larger bodies are at greater risk for adverse academic consequences since they most commonly experience weight-based teasing (Pearl, 2018).

Systems of higher education are another environment in which weight-based discrimination occurs. Despite equivalent performance in high school, national surveys show that higher-weight adolescents are less likely to be accepted into elite universities or obtain a college degree. This pattern was significant for female students even after controlling for relevant covariates. Adolescent girls in larger bodies are less likely to attend college and finish fewer years of school overall (Burmeister et al., 2013). Burmeister et al. (2013) conducted a study to see if the pattern of weight discrimination continued in graduate school admissions. They found that despite similar credentials and more substantial letters of recommendation, participants in larger bodies received fewer admission offers to graduate psychology programs following an in-person interview. This pattern was slightly stronger for female applicants than for males (Burmeister et al., 2013).

Employment

A considerable amount of evidence suggests that weight bias and discrimination occur at almost all employment stages, including hiring, placement, compensation, promotion, discipline,

and discharge. A job-seeker's weight seems to influence their potential employers' assessment of their career potential, such as perceived leadership rankings and predicted success (Pearl, 2018; Roehling et al., 2009). As a result, people in larger bodies are less likely to be recommended for hiring or promotion (Pearl, 2018). This type of weight bias likely occurs for numerous reasons. First, higher-weight individuals are seen as less attractive or not projecting the "right image" the corporation attempts to perceive (Roehling et al., 2009). The beliefs in the stereotypes are another reason that employment weight discrimination may occur. Many believe that people in larger bodies are lazy, lack self-control, and are less conscientious than people in smaller bodies (Pearl, 2018; Roehling et al., 2009). Lastly, there is a perception that hiring a person in a larger body will entail direct organizing costs. Those perceived higher costs include insurance premiums, greater absenteeism, and the cost of special accommodations (Roehling et al., 2009).

Overall, higher-weight people have higher unemployment rates and spend fewer years employed. This type of discrimination increases as a person reaches a higher class of "obesity" on the BMI (Pearl, 2018). Currently, people of a higher weight are not protected from discrimination through legislation, except in Michigan and some cities (e.g., San Francisco, CA, and Binghamton, NY; Martin, 2017). These rates will likely increase without these legislations that protect this identity from discrimination.

Media

Media is likely the most ubiquitous place to find examples of weight bias. The media perpetuates weight stigma by idolizing thinness and underrepresenting and stereotyping individuals with higher body weights. Most television shows, movies, and books geared toward the majority of the population portray higher-weight characters as unattractive, unhealthy, unhappy, or unpopular (Ata & Thompson, 2010). Social media, such as Instagram and Twitter,

contain an overwhelming number of fat jokes and weight-derogatory comments, including instances of verbal aggression and cyberbullying. Additionally, television shows, advertisements, and public health campaigns focusing on weight loss and “obesity” prevention also contain weight-stigmatizing content that perpetuates diet culture’s myth that individuals are entirely responsible for their weight. News coverage is another source of weight stigma that is often not discussed. News coverage of “obesity” includes incorrect or catastrophizing information about being fat. Most images and video content in the news portray higher-weight people as unflattering and engaging in stereotypical unhealthy behaviors (Pearl, 2018).

Weight-stigmatizing media has been shown to increase anti-fat attitudes and implicit bias among the general public, which can further ingrain that sizeism is socially appropriate (Carels et al., 2013; Hinman et al., 2015).

Weight Bias in the Health Field

The healthcare field is one of the most common places where weight stigma occurs. Weight-biased attitudes have been documented across a wide range of healthcare professionals, including physicians, nurses, psychologists, dietitians, healthcare trainees, and even clinicians specializing in eating disorders and “obesity” (Budd et al., 2011; Davis-Coelho et al., 2000; Forhan & Salas, 2013; Pearl, 2018; Phelan et al., 2015; Puhl et al., 2014; Tomiyama, Ahlstrom, & Mann, 2013; Tomiyama et al., 2018). Within this portion, there will be a discussion of how weight prejudice and discrimination exist in medical and mental health settings.

Medical Settings

Healthcare professionals tend to believe the stereotypes about people in larger bodies and, as a result, tend to have less respect for the higher-weight population. Due to this lack of respect, healthcare professionals tend to spend less time with higher-weight patients, engage in

less patient-centered communication, and are more reluctant to perform certain screenings (e.g., cervical cancer screenings) or discuss health or treatment options with patients (Huizinga et al., 2009; Pearl, 2018; Phelan et al., 2015; Tomiyama et al., 2018). Misdiagnosis is also common since many doctors may over-attribute symptoms and problems to a person's size and fail to refer the patient for diagnostic testing or consider other options before advising the patient to lose weight (Phelan et al., 2015). An example of this type of misdiagnosis is a study involving medical students. When presented with virtual patients with shortness of breath, the medical students were more likely to recommend a lifestyle change of weight loss if the patient was “obese.” If the virtual patient was within the “normal” weight range, they were more likely to receive medication (Phelan et al., 2015). Misdiagnosis can lead to patients experiencing harm, such as exasperation symptoms, additional medical complications, or potential death.

Many people in larger bodies struggle with the medical community due to the lack of respect and common misdiagnosis. Patients in larger bodies feel that they are not welcomed in medical settings and feel devalued, ignored, mistreated, or that their clinicians do not want to treat them (Tomiyama et al., 2018). As a result of these feelings, people in larger bodies regularly avoid seeking preventative health care or treatment, which can lead to worse symptoms that are harder to treat (Forhan & Salas, 2013; Phelan et al., 2015). Those who have experienced weight stigmatizing situations by a medical provider may experience high-stress levels when seeking medical care. This type of stress can impair one's cognitive functioning and ability to communicate their needs or symptoms to the clinician effectively, leading to misdiagnosis or solidification of the healthcare professional beliefs about higher-weight people (Phelan et al., 2015).

Mental Health Settings

Since the 1980s, psychological research has reported the prevalence of weight bias held by clinicians (Kinavey & Cool, 2019). They found that mental health professionals with weight bias were more likely to express frustration about treating higher-weight clients, see them as “unattractive but kind,” view them as resistant, and feel pessimistic about their prognosis (Kinavey & Cool, 2019; Puhl et al. 2014). Even with this research, the mental health world has not progressed in adopting an anti-sizeism perspective, which can be seen by the American Psychological Association’s adoption of the medicalized view of “obesity” and the recent promotion of clinical practice guidelines for children who are “overweight” and “obese” (American Psychological Association [APA], 2018; M. C. McHugh & Chrisler, 2019). When prominent organizations, like the APA, promote the misconception that weight is within the individual's control and state that weight loss will improve health, it permits psychologists to continue having weight bias, thereby causing further stigmatization of higher-weight clients (M. C. McHugh & Chrisler, 2019).

Weight bias has also been shown to affect the therapeutic relationship, primarily through the diagnostic process and microaggressions. Research has shown that weight bias impacts clinical judgment, and as a result, mental health clinicians often over-pathologize or misdiagnose individuals in larger bodies (M. C. McHugh & Kasardo, 2012). In today’s society, excess body fat is seen as being harmful to health and reflects maladjusted behaviors. Therefore, many clinicians explain larger bodies through pathology, such as diagnosing a higher-weight person with depression-as it is associated with weight gain-without meeting the full criteria (Davis-Coehlo et al., 2000). Clinicians may also miss a potential diagnosis because of biases, such as an eating disorder diagnosis. When lower-weight individuals pursue weight loss, it is a

diagnosable concern; however, for individuals in a larger body, more often than not, clinicians praise weight loss efforts. Because of the larger body size, many clinicians do not inquire how one is attempting to lose weight, such as through restrictive eating and excessive exercise. Clinicians' biases may cause them to miss crucial data and misdiagnose based on their assumptions rather than reported symptoms (Harrison, 2019; Kinavey & Cool, 2019).

Weight-based microaggressions are also common in mental health settings. A commonly used weight microaggression is when the therapist attributes weight as the cause of the presenting issue and recommends weight loss as the solution. Other examples include clients being told they would develop diabetes, that they could not love themselves because they were in a larger body, and not to worry, "we will not make you fat," when recovering from an eating disorder (Schafer, 2014). Microaggressions often negatively affect the therapeutic relationship, which is one of the most powerful tools for change. These ruptures in the relationship often create setbacks in the therapeutic process (Kinavey & Cool, 2019). Also, when clients experience microaggressions about their weight, they regularly experience shame and, as a result, may be avoidant or less forthcoming or avoidant during therapy sessions (M. C. McHugh & Chrisler, 2019).

The Harms of Weight Bias

Research has shown that experiencing weight-based prejudice can lead to high blood pressure, increased psychological stress, depression, anxiety, substance misuse, low self-esteem, and behaviors associated with eating disorders (Hatzenbuehler et al., 2009; Pearl, 2018; Tomiyama et al., 2018). It can also increase one's mortality risk and increase one's risk of being "obese." Yes, being told "you are too fat" is correlated with increasing one's weight, and this relationship was independent of one's initial BMI (Hunger & Tomiyama, 2014). Beyond the

physical consequences associated with weight bias, other psychological consequences can affect one's well-being.

Internalized Weight Stigma

Internalized weight stigma is the awareness and agreement of negative stereotypes about one's group and applying those stereotypes to oneself, leading to self-devaluation or self-directed stigma (Latner et al., 2013; Pearl, 2018; Pearl & Puhl, 2016). Internalized weight stigma has numerous outcomes, such as lower self-esteem and positive affect and greater levels of psychological distress (Latner et al., 2013; Pearl & Puhl, 2016). It is also associated with poor mental health. Those who internalize their weight stigma are at risk for depression, anxiety, body dissatisfaction, and eating disorder pathology (Latner et al., 2013; Pearl, 2018). Internalized weight stigma has also been shown to impact one's physical health. It affects cardiovascular health and metabolic abnormalities, leading to poorer health, weight gain, and increased risk of internalized stigma (Latner et al., 2013).

Body Dissatisfaction

Body dissatisfaction is highly correlated with weight stigma and internalized weight stigma (Latner et al., 2013; Pearl, 2018). As stated in the previous section on body image, body dissatisfaction can negatively affect self-esteem and increase the risk of depression and anxiety, emotional distress, and disordered eating and eating disorder pathology (Carrard et al., 2018; Paquette & Raine, 2004; Weinberger & Luck-Sikorski, 2020). Those who experience weight stigma have a higher chance of experiencing body dissatisfaction, which compounds their risks for poor physical health, psychological distress, and lowered well-being.

Weight stigmatization significantly affects one's ability to have a PBI. The inverse relationship between PBI and weight stigma is not likely related to having higher weights, but it

is related to the presentation that others do not accept their bodies (Augustus-Horvath & Tylka, 2011). When an individual experiences weight stigma, it will likely lower their perception of body acceptance by others, which may be a barrier to body appreciation and the protective qualities it offers (Tylka & Wood-Barcalow, 2015b).

Section Summary

This section reviewed the literature on weight bias. The section began with a description of weight bias. Then there was a discussion on how weight bias occurs in everyday life and healthcare settings. Lastly, the section closed by reviewing the numerous detrimental outcomes of weight bias, including internalized weight stigma and body dissatisfaction.

Section Four: Body Image Treatments for Higher-Weight People

There are two broad categories of intervention for people in large bodies with body image concerns: weight-focused and body image treatments (Latner & Wilson, 2011; Pokrajac-Bulian, 2018). Weight-focused treatments primarily focus on changing one's weight through calorie deficiency, increased exercise, and creating new eating habits (Carels et al., 2013). This type of treatment usually does not have a component of body image work (Carels et al., 2013; Latner & Wilson, 2011). Body image treatments do not usually include weight loss as the target of intervention (Latner & Wilson, 2011). The two body image treatments discussed are body image based cognitive-behavioral therapy (BI-CBT) and weight-neutral interventions. This section will review weight-loss and body image paradigms, and their effectiveness in treating body image and other health-related issues.

Weight-Focused Interventions

Since the late 1990s, the United States has noticed the increase of people in larger bodies and determined that the nation is in an "obesity epidemic." For the past two decades, research

has focused on the psychological and physical harms associated with being at a higher weight. These harms include Type II diabetes, coronary heart disease, hypertension, osteoarthritis, depression, body dissatisfaction, disordered eating, and internalized weight bias (Bombak, 2014; Busch et al., 2013; Carles et al., 2013; Martin Ginis et al., 2012; Presnell et al., 2008). Weight-focused treatments, also known as weight-loss or dieting, are the most well-known type of body image treatment for being “overweight” or “obese.” This category primarily has two types: behavioral weight-loss treatment programs and bariatric surgery.

Behavioral Treatment Programs

Behavioral weight-loss treatment programs (BWLTL) have traditionally been considered the treatment of choice for mild to moderate “obesity” to improve body image and overall health. The basics of BWLTL include self-monitoring, diet, and exercise with a prescribed calorie intake, such as 500–1000 calories per day, and utilizing group treatment taught by health professionals (Carels et al., 2013). Goal setting is also a primary feature of BWLTLs. Goals focus on daily calorie intake, weekly minutes of physical exercise, and the number of days for which food is recorded in a journal. Most clients also create a weight-loss goal that often begins with losing 1 to 2 pounds per week and ultimately losing 10% of their baseline weight (Butryn et al., 2011). Many programs do not focus significantly on maladaptive relationships with food, internalized weight bias, or body image concerns (Carels et al., 2013). These programs vary in length and often result in an 8%–9% to nine percent weight loss by the end of 6 months. Most BWLTLs are completed in medical-based facilities; however, commercial products like Weight Watchers or Noom have been found to provide similar results and are more accessible (Pinto et al., 2013).

Outcomes of Behavioral Treatment Programs. Weight loss, including modest weight loss, does seem to improve body image among people with larger bodies. Chao (2015)

completed a systematic review of seven studies and meta-analyzed what weight-loss interventions improved body image among higher-weight people. Four out of the seven studies showed significant improvement in body image. The review outcomes suggest that BWLTs decrease body shape concerns and size dissatisfaction and increase body satisfaction. This is important to note due to the positive psychological effects that PBI can have (Chao, 2015). However, the improvement of body image was only salient if the individual could maintain their weight loss (Latner & Wilson, 2011; Palmeira et al., 2010; Pokrajac-Bulian, 2018; Sarwer et al., 2011; Schwartz & Brownell, 2004). As an individual regains weight-even a small amount-there is a significant worsening of body image (Latner & Wilson, 2011; Rosen, 2001; Sarwer et al., 2011; Schwartz & Brownell, 2004).

When comparing groups of women who had lost weight, were currently “overweight,” or never “overweight,” those who lost weight reported an increase in body satisfaction but reported continued body preoccupation and more dysfunctional appearance investment (e.g., my self-worth is connected to my weight; Sarwer et al., 2011; Schwartz & Brownell, 2004). Their body preoccupation and dysfunctional appearance investment were similar to their currently “overweight” peers. Body preoccupation and dysfunctional appearance investment were not found in the never “overweight” category (Latner & Wilson, 2011; Sarwer et al., 2011; Schwartz & Brownell, 2004). These findings support the idea that some body image cognitions associated with excess body weight, also known as “phantom fat,” may not entirely change or dissipate with weight loss. This means that weight-focused treatments may not consistently assist higher-weight individuals with body image concerns and that additional treatment may be necessary (Latner & Wilson, 2011; Pokrajac-Bulian, 2018; Sarwer et al., 2011).

Other psychosocial improvements associated with BWLTs and lowering one's BMI include improved depression, self-esteem, and life satisfaction (Busch et al., 2013; Palmeira et al., 2010; Presnell et al., 2008). Lowering one's BMI also reduces numerous comorbidities, such as Type II diabetes, coronary heart disease, hypertension, and sleep apnea (Bombback, 2014; Carels et al., 2013; Lindberg et al., 2021; Presnell et al., 2008).

Bariatric Surgery

Bariatric surgery is a surgical procedure that assists in weight loss by changing the digestive system by decreasing stomach capacity, causing malabsorption of nutrients, or some of both. Bariatric surgery is an umbrella term for different types of surgery, such as gastric bypass, sleeve gastrectomy, gastric band, and duodenal switch (Griffin, 2022). This type of surgery is considered an effective treatment method for “severe obesity” (Perdue & Neil, 2020; Pyykö et al., 2021). Compared to BWLTs, bariatric surgery results in better weight maintenance, more significant improvement in or complete remission of “obesity-related” comorbidities, and significant improvement in patients’ quality of life and psychological health (Pyykö et al., 2021).

Bariatric surgery requires a post-operational protocol that includes dietary restrictions, exercise, and renegotiating one's relationship with food (Perdue & Neil, 2020). It should be considered a major procedure. Its common side effects and risks include acid reflux, anesthesia-related risks, chronic nausea and vomiting, dilation of the esophagus, inability to eat certain foods, infection, obstruction of the stomach, or weight gain or failure to lose weight. Long-term risks are dumping syndrome (i.e., a condition where food from the stomach is “dumped” into the large intestine without proper digestion), low blood sugar, malnutrition, vomiting, ulcers, bowel obstructions, and hernias. To lower the risks and side effects, patients are encouraged to lower their BMI, increase exercise, and quit smoking (Griffin, 2022).

Many individuals that partake in bariatric surgery see improvements in body image, self-esteem, depressive symptoms, and health-related quality of life within the first year after surgery. Although, these psychosocial benefits appear to be limited to the first few postoperative years and may regress when patients regain weight (Pyykö et al., 2021; Sarwer et al., 2011). Other positive consequences of the surgery are increased variety and fashionable clothing, improvements in some relationships, and greater satisfaction in their sex lives.

Within the bariatric sphere, successful weight loss is considered a total weight loss of greater or equal to 20% or excess weight loss of over 50% (Grover et al., 2019). However, a subgroup of patients reaches sub-optimal results or experience a lower quality of life. Insufficient weight loss or regain can occur as early as six months post-surgery, with 20%–35% of patients reaching suboptimal weight loss five years after surgery (Pyykö et al., 2021). Patients encounter other adverse side effects: unexpected pain and discomfort, loss of energy, continued “obesity,” negative changes in relationships due to weight loss, and decreased satisfaction in their sex life (Lindberg et al., 2020; Perdue & Neil, 2020).

Body Image Risks with Bariatric Surgery. Bariatric surgery has been shown to improve body image but may also be a risk factor for an individual. Excess skin is often a body image concern for numerous bariatric patients, leading to some participating in reconstruction surgery to return the body to “normal” and address some physical discomfort and pain. These reconstruction surgeries for excess skin are not regularly accessible due to the lack of insurance in the United States (Sarwer et al., 2011). Another difficulty for those who experience bariatric surgery is that they still see themselves as a “fat person” or experience a distorted body image. The feeling of being in a larger body is stored in their memory, and they may have difficulty seeing past the person they were before. For those who experience this phenomenon, body image

concerns may be more cognitively based than associated with their size (Lindberg et al., 2020; Perdue & Neil, 2020).

The Risks of Weight-Focused Treatments

There are general risks of weight-focused treatments. The two that will primarily be discussed are short-term weight loss and cycling. These risks can negatively affect physical and mental health.

Short-Term Weight Loss. There is a widely accepted view that is supported by several studies, indicating that weight loss can be achieved through treatments but often, weight is gradually regained in a large percentage of people (Bacon, 2010; Bacon & Aphramor, 2011; Butryn et al., 2011; French & Jeffery, 1994; Harrison, 2019; Mesinger et al., 2016; Montesi et al., 2016). Regularly in weight-focused treatments, weight loss peaks at about six months, and then weight regain often begins (Butryn et al., 2011). This is likely because adherence to treatment declines after its intensive stages. To maintain a stable weight-loss long-term, a patient would have to maintain (a) high levels of physical activity (about 1 hour per day); (b) a lower-calorie, low-fat diet (500–1000 calories per day); (c) regular breakfasts; (d) weight monitoring; and (e) maintain a consistent eating pattern across weekdays and weekends (Montesi et al., 2016). Some may also need to use medication and maintain long-term contact with weight-focused providers to maintain weight loss (Butryn et al., 2011).

According to a National Institute of Health (NIH) panel, people who partake in weight-focused programs generally regain as much as two-thirds of the weight they lost within 1 year and all in 5 years (Harrison, 2019; Technology Assessment Conference Panel, 1992). A recent review finds that one-third to two-thirds of dieters regain more weight than their baseline (Mann et al., 2007). Numerous other studies demonstrate that weight-focused treatments,

including surgical-based treatments, often do not lead to long-term sustained weight loss (Christou et al., 2006; Sjöström et al., 2004; Wing & Phelan, 2005). Leading individuals to believe that long-term weight loss is possible with determination and lifestyle changes often leads to poor self-esteem. The lowered self-esteem is due to believing the weight-bias stigmas about people in larger bodies, which increases internalized weight stigma, body dissatisfaction, eating disorder pathology, and weight-cycling (Bacon & Aphramor, 2011; Bombak et al., 2019; Tylka et al., 2014).

Weight Cycling. Weight cycling is the most common result of engaging in dieting or weight-loss programs and is known to increase morbidity and mortality risks (Bacon & Aphramor, 2011; French & Jeffery, 1994; Mesinger et al., 2016; Montani et al., 2015; Tylka et al., 2014). Weight cycling occurs when an individual loses and then regains weight, and that pattern continues. Weight cycling is associated with chronic inflammation of the body, which increases one's chances of developing many obesity-associated diseases like high blood pressure, Type II diabetes, and poorer cardiovascular outcomes (Bacon & Aphramor, 2011). Other adverse consequences of weight cycling are reduced bone mass, the development of anxiety or depression, low self-esteem, body dissatisfaction, and the development of disordered eating or an eating disorder (Bacon & Aphramor, 2011; Bombak et al., 2019; Tylka et al., 2014).

Two landmark studies have demonstrated the mortality and morbidity of weight cycling: Framingham Heart Study and the EFFORT cohort study (Lissner et al., 1991; Rzehak et al., 2007). The Framingham Heart Study used a sophisticated definition of weight cycling, where they captured the frequencies and the magnitude of weight fluctuations in the participants. Throughout 32 years, researchers measured the mortality and morbidity of 5,000 individuals. The results indicated that weight cycling was strongly linked to overall mortality, morbidity, and

coronary heart diseases for both men and women (Lissner et al., 1991). The EFFORT cohort study was completed in Germany and only included men, an underrepresented group in the weight cycling literature (Tylka et al., 2014). In this study, 505 middle-aged men were grouped into the weight categories of stable nonobese, stable “obese,” weight loss, weight gain, and weight fluctuations and followed participants for 15 years. The researchers found that the weight fluctuations category was the only one associated with mortality. The stable “obese” category was not linked to a higher risk of death than the stable non-obese category (Rzehak et al., 2007). These studies demonstrate that weight cycling is harmful, even compared to those who remain stable within the “obese” category.

Weight cycling may also increase one's risk of gaining weight (Bacon & Aphramor, 2011; Harrison, 2019; Tylka et al., 2014). When Mann et al. (2007) completed a meta-analysis of long-term outcomes of calorie-restricting diets to assess whether dieting is an effective treatment for “obesity,” they found that one-third to two-thirds of the participants gained significantly more weight than they lost. The weight gain that occurs after attempting to lose weight is likely due to our bodies having a “set point” range that they are genetically programmed to maintain. Genes dictate about 70% of an individual’s difference in body weight, and one’s genes create a weight setpoint where one can comfortably function (Bacon, 2010; Harrison, 2019). Harrison (2019) describes this process as an internal “thermostat,” and the setpoint range is where the body is most comfortable and able to function efficiently. The thermostat is located in the hypothalamus (Harrison, 2019). When one begins restricting calories, the hypothalamus signals off because it interprets the restriction as a famine. As the body continues to believe it is experiencing a famine, it may eventually increase the setpoint range to protect the individual from future famines, or in this case, diets (Bacon, 2010; Bombak et al., 2019; Harrison, 2019; Tylka et al.,

2014). The hypothalamus noticing the restriction may also be causing binge eating behaviors. The body's natural response after a restriction is to eat; as a result, it goes to the other side of the dimension of restriction and binge eating behaviors to protect itself, which may lead to weight gain (Harrison, 2019).

Overall, it may be more beneficial to maintain a stable weight than to lose weight due to the harms of weight cycling (Bombak et al., 2019). Tomiyama, Ahlstrom, and Mann (2013) systematically analyzed 21 randomized controlled trials involving weight-loss interventions and at least a one-year follow-up. The researchers found inconsistent patterns between weight loss and health improvement. In reviewing the studies that primarily focused on stroke reductions, two of the five studies produced reductions in stroke for participants in the weight-loss group compared to the control group. Two research studies that analyzed diabetes prevention saw lower incidences of diabetes than those in the control group. However, of the five studies that examined coronary morbidity or mortality, none of the groups randomized to the weight-loss interventions demonstrated benefits. Overall, even when weight loss was maintained among the participants in the weight-loss groups, there were no corresponding improvements in fasting blood glucose levels, blood pressure, or blood lipids (Tomiyama, Ahlstrom, & Mann, 2013).

Body Image Treatments

The two most common body image treatments are cognitive-behavioral therapy and weight-neutral treatments. Cognitive-behavioral therapy aims to lessen maladaptive thought patterns about one's body and self. Weight-neutral treatments focus on size acceptance, developing healthier lifestyles, and better self-outlook without emphasizing weight (Bombak et al., 2019; Latner & Wilson, 2011). These two types of treatments can and are regularly

integrated. The basic principles of body image cognitive-behavioral therapy and non-dieting will be reviewed, as well as their effectiveness.

Body Image Cognitive-Behavioral Therapy

Body image cognitive-behavioral therapy (BI-CBT) is an established effective treatment for body image disturbances. BI-CBT aims to modify dysfunctional thoughts, feelings, and behaviors through interventions such as psychoeducation, self-monitoring, cognitive restructuring, desensitization, and exposure and response prevention (Jarry & Cash, 2011). BI-CBT utilizes the same aims for higher-weight people as people in smaller bodies. However, higher-weight peoples' treatment also includes discussing weight stigma and processing weight-based discrimination clients have experienced (Jarry & Cash, 2011; Pokrajac-Bulian, 2018; Rosen, 2001).

Outcomes of BI-CBT. Generally, BI-CBT has been known to improve the attitudinal and behavioral dimensions of body image. It also seemed to lessen the body image investment, meaning that BI-CBT may treat the manifestations of overinvestment. However, it does not fully treat the origins of why someone invests so much of their body into their self-worth. BI-CBT does change the patterns of investment from dysfunctional to benign (Jarry & Cash, 2011).

BI-CBT also seems to improve body image for people in larger bodies. Outcomes of BI-CBT show improvements in body image, self-esteem, and shame related to eating, which correlates to decreased bingeing (Jarry & Cash, 2011; Pokrajac- Bulian, 2018; Rosen, 2001). Compared to weight-focused treatments, BI-CBT seems to improve body image long-term. Ramierez and Rosen (2001) compared a combined weight-focused and BI-CBT intervention group to a weight-focused only group. They found that both interventions significantly improved body image and psychological variables. However, the weight loss-only group regained their

weight after a year, and their body satisfaction decreased. Those in the combined group showed improved body image, even with weight regain (Ramirez & Rosen, 2001).

Weight-Neutral Interventions

Weight-neutral interventions promote size acceptance overweight loss as a route to health and well-being and are the focus intervention of this study (Bombak et al., 2019).

Weight-neutral interventions assume that everybody can achieve health and well-being independent of weight loss by promoting healthy behaviors (Bacon & Aphramor, 2011; Tylka et al., 2014). Healthy behaviors include intuitive eating (i.e., following one's internal cues of hunger and satiety rather than relying on external cues), nutritious eating, size acceptance, enjoyable physical activity, and practicing self-care and compassion (Bacon, 2010; Bombak et al., 2019; Mesinger et al., 2016; Tylka et al., 2014).

Weight-neutral interventions are more holistic compared to weight-focused interventions. They respect natural body diversity and encourage clients to build a relationship with their body, similarly, to being mindful of the body's needs and pleasures (Bombak et al., 2019; Tylka et al., 2014). Also, not requiring an individual to reduce their BMI mitigates the stigmatization that often concurs with the recommendation of weight loss (Bombak, 2014; Mesinger et al., 2016; Tylka et al., 2014). Reducing weight-based stigma makes clients feel more comfortable in healthcare settings, which increases their ability to discuss their health concerns without fearing prejudice or discrimination (Tylka et al., 2014).

There are many different types of weight-neutral or weight-inclusive interventions. "Health at Every Size," "Health at Every Respect," and "Physical Activity at Every Size" are just a few examples of weight-inclusive programs. Health at Every Size (HAES) is the most

well-known weight-neutral program, and it will be heavily featured within this paper. The HAES model was manifested through discussions among healthcare workers, consumers, and activists who reject the use of weight, size, or BMI as an understanding of health and reject the myth that weight is a result of personal choices independent of uncontrollable or involuntary genetic and environmental factors (Tylka et al., 2014). HAES promotes self-acceptance, appreciation of size diversity, and compassionate self-care, including a well-rounded diet, engaging in joyful physical activities, managing stress, and getting adequate rest. Weight changes are not the goal of HAES; the goal is to improve overall well-being (Bacon, 2010).

Common Principles of Weight-Neutral Interventions. While there are many weight-neutral interventions, they all hold common principles as the basis of treatment. The first principle is accepting and respecting the diversity of all body shapes and sizes or being weight-inclusive (Bacon et al., 2005; Bacon & Aphramor, 2011; Bombak et al., 2019; Humphrey et al., 2015; Wilson et al., 2020). Self-acceptance appears to be the cornerstone of self-care, meaning that people with strong self-esteem are more likely to adopt positive health care. HAES research shows this pattern. When individuals can accept their bodies as they are, even when this differs from their desired shape or weight, people strengthen their ability to care for themselves and sustain improvements in health behaviors (Bacon & Aphramor, 2011).

Another principle of weight-neutral interventions is that physical activity, often called movement in this paradigm, is encouraged based on what is enjoyable and life-enhancing for the client, regardless of weight status (Bacon et al., 2005; Bacon, 2010; Bacon & Aphramor, 2011; Bombak et al., 2019; Humphrey et al., 2015; Tribole & Resch, 2012; Wilson et al., 2020). Weight-neutral treatments encourage people to build activity in their routine and assist them in finding enjoyable movement. The goal of encouraging movement is to promote well-being and

self-care. As a result of this practice, one can attain the numerous benefits of physical activity rather than meeting a set of exercise guidelines simply for weight loss or to change one's body (Bacon & Aphramor, 2011). In weight-neutral interventions, physical activity can be a way of healing body distrust that many experience. Body distrust occurs when people are taught to override embodied internal signals to pursue externally derived goals, such as what occurs when someone diets (Bacon & Aphramor, 2011; Bombak et al., 2019).

The last principle that weight-neutral interventions embody encourages clients to rely on internal regulatory processes, such as hunger and satiety, when eating. This reliance on internal regulatory processes is also known as intuitive eating (Bacon et al., 2005; Bacon, 2010; Bacon & Aphramor, 2011; Bombak et al., 2019; Harrison, 2019; Humphrey et al., 2015; Wilson et al., 2020). Intuitive eating encourages individuals to increase their awareness of their body's response to food and learn how to make food choices based on that knowledge. It also encourages people to value food for nutritional, psychological, sensual, cultural, and other reasons. Intuitive eating teaches individuals to make connections between what they eat and how they feel. To eat intuitively, one needs to pay attention to mood, energy levels, fullness, ease of bowel movements, comfort eating, appetite, satiety, hunger, and pleasure as guiding principles (Bacon & Aphramor, 2011; Harrison, 2019, Tribole & Resch, 2012). There are numerous benefits to intuitive eating. Intuitive eating has a strong inverse relationship with disordered eating, body dissatisfaction, and internalization of the thin ideal. Also, it is correlated with self-esteem, optimism, proactive coping, and overall life satisfaction. Intuitive eating can be learned, even after years of dieting, and, when adopted, individuals have seen improvements in depression, self-esteem, affect, and quality of life (Bacon & Aphramor, 2011; Bombak et al., 2019; Schaefer & Magnuson, 2014).

Outcomes of Weight-Neutral Approaches. Weight-neutral approaches are a revolutionary way to conceptualize health; because it is revolutionary, there are concerns. The first concern is that remaining in a larger body will lead to the mortality and morbidity of diseases associated with being in a larger body, particularly in the long term (Sainsbury & Hay, 2014). The second concern is that having “too good” of a body image or not seeing their body size as a concern would lead to avoidance of preventive health measures and overall poor health (Pokrajac-Bulian, 2018). Weight-neutral approaches have been shown to benefit physical and psychological health and overall well-being. Regarding the second concern, having a positive body image, regardless of size, has been linked to participating in more preventive health and health behaviors, as discussed in Section 2 (Rasmus, 2018). To further demonstrate the weight-neutral interventions’ effectiveness, a detailed discussion of their outcomes will follow. The discussion will also acknowledge any other misconceptions associated with this paradigm or being in a larger body in general. It should be noted that many of these outcome studies focused primarily on a HAES approach.

Physical Health. When higher-weight people adopt a weight-neutral approach, they experience similar physical health benefits as losing weight. Research shows that many individuals see a decrease in total cholesterol levels or LDL cholesterol levels, insulin levels, and blood pressure (Bacon et al., 2005; Bacon & Aphramor, 2011; Schaefer & Magnuson, 2014). Also, many of these individuals see a growth in their healthy habits, such as increasing their intake of fruit and vegetables, practicing intuitive eating, and increasing physical movement. All these benefits were found whether weight was lost, maintained, or gained (Bacon et al., 2005; Mesinger et al., 2016; Schaefer & Magnuson, 2014; Wilson et al., 2020).

These results demonstrate that physical health can be improved by promoting healthy behaviors. For example, insulin sensitivity and blood lipids can improve due to aerobic exercise, even for individuals who gained body fat during the intervention (Bacon & Aphramor, 2011; Bombak, 2014). It is also likely that weight-focused interventions show physical health improvements because there is a change in behaviors (Bacon & Aphramor, 2011).

When considering mortality and morbidity, the common assumption among the weight-focus paradigm is that managing weight is key to one's health and chronic disease prevention (Mesinger et al., 2016). However, the data has not consistently suggested these findings. Regarding mortality, epidemiological studies find that people who are in the "overweight" or moderately "obese" BMI categories live at least as long as people who are considered within the "normal" range and, often, longer if they are in the overweight category (Bacon & Aphramor, 2011; Flegal & Graubard et al., 2005; Flegal and Ioannidis, 2018; Flegal & Kit et al., 2013; Mesinger et al., 2016; Tylka et al., 2014). The exceptions to this finding are those individuals considered within the "obese" 2 or 3 categories of the BMI (Bacon & Aphramor, 2011; Flegal & Kit et al., 2013; Flegal and Ioannidis, 2018). These findings and other findings demonstrate the "obesity paradox."

The obesity paradox is when individuals who are deemed "obese" and with particular health conditions survive longer than their "normal" weight counterparts with similar health conditions. Other examples of this paradox are: there is a large component of "overweight" and "obese" populations who are metabolically healthy; "obese" people who have had heart attacks, coronary bypass, angioplasty, or hemodialysis live longer than thinner people with similar histories; "obese" people with Type II diabetes, hypertension, cardiovascular diseases, and chronic kidney disease have statistically been shown to have greater longevity than thinner

people with these conditions; and the trend that “obese” seniors live longer than seniors in smaller bodies (Bacon & Aphramor, 2011; Bombak et al., 2019; Flegal & Kit et al., 2013; Mesinger et al., 2016; Tomiyama et al. 2014). These are all examples of how weight management is not the only key to health.

It is also well known that “obesity” is associated with increased risk for many diseases, like Type II diabetes and hypertension; however, causation is less well-established. Weight-loss studies rarely acknowledge other confounding variables like fitness activity, nutrient intake, weight cycling, or socioeconomic status when considering connections between weight and diseases (Bacon & Aphramor, 2011; Bombak et al., 2019; Tylka et al., 2014). When studies do control these factors, the risk of disease is significantly reduced or diminished. For example, Type II diabetes is a disease that is highly associated with being in a larger body. Increasing evidence shows that poverty and marginalization are more strongly associated with Type II diabetes than known risk factors such as weight, diet, or activity habits. Similar studies and results have been found in regard to high blood pressure (Bacon & Aphramor, 2011). The causes of high mortality and morbidity need to be seen as complex subjects, and a more holistic view of these concepts needs to be developed beyond one’s body size.

Psychological Health. Weight-neutral interventions have also demonstrated improvements in psychological health, including body image. Schaefer and Magnuson (2014) completed a meta-analysis of 20 studies of weight-neutral interventions where intervention groups were compared to control groups or BWLTs. They found that the weight-neutral groups significantly improved body satisfaction and self-acceptance and decreased body image avoidance, body preoccupation, drive for thinness, and negative self-talk. They also noted that the weight-neutral participants had improvements in depression, self-esteem, affect, and quality

of life. Eating disorders or disordered eating behaviors also decreased (Schaefer & Magnuson, 2014.) This research demonstrates that weight-neutral treatments can improve body image for higher-weight people.

Many singular studies also demonstrate that weight-neutral interventions improve body image. Research for weight-inclusive interventions often measures body dissatisfaction, self-esteem, and depression before and after the therapeutic intervention is given. These studies had similar findings to Schaefer and Magnuson, such as improved body esteem, decreased eating disorder pathology, and improvements in depression and self-esteem (Bacon & Aphramor, 2011; Bientner et al., 2019; Humphrey et al., 2015; Wilson et al., 2020). Two also measured anti-fat attitudes and established that anti-fat attitudes improved with treatment (Humphrey et al., 2015; Wilson et al., 2020).

Long-Term Retention. Weight-neutral treatments' outcomes are shown to be long-term, unlike weight loss. Many participants of weight-neutral interventions could maintain the new health behaviors they created in the program and continue to see the long-term benefits without weight loss (Bacon et al., 2005; Mesinger et al., 2016). When weight-loss and weight-neutral interventions were compared, weight-loss groups were able to maintain behaviors for about 6 months to 1 year after treatment, while weight-neutral were able to maintain behaviors for years. Schaefer and Magnuson (2014) found that many participants in weight-neutral groups were able to continue practicing their new behaviors for ten years. The positive psychological and physical benefits continued throughout this timeframe (Schaefer & Magnuson, 2014).

Overall, one can see that there are many benefits to the weight-neutral approach to treating body image distress in people in larger bodies without putting these individuals at risk for other health effects. When deciding on a body image treatment, providers should consider the

benefits and negative consequences and provide accurate information about each paradigm. This will assist clients in discovering what paradigm would best fit their needs and improve body image.

Section Summary

The current section was a literature review on the most common types of body image interventions prescribed to people in larger bodies: weight-focused and body image interventions (BI-CBT and weight-neutral). Within this literature review, I reviewed the benefits and risks of each program, their outcomes, and their effectiveness in improving body image for higher-weight people. The weight-focused interventions do lead to some health benefits with weight loss, but the benefits are often short-lived due to high attrition rates, which can lead to other numerous harms that are associated with weight-cycling. Body image interventions, specifically weight-neutral programs, enhance overall health through size-acceptance, intuitive eating, and respecting one's body. The weight-neutral approaches see improvement in physical and psychological variables, and clients are able to maintain the behavioral changes long-term and continue to see improvements without weight loss.

Conclusion of Chapter II

Despite a large amount of research on positive body image and body image interventions, little research focuses on promoting positive body image for higher-weight women. Much of the research presented on positive body image was completed on women considered “normal” weight, and the research on weight-neutral interventions regularly only measured body dissatisfaction to see if body image improved (Bacon et al., 2005; Boucher et al., 2016; Martin Ginis et al. 2012, Wilson et al., 2020; Weinberger & Luck-Sikorski, 2020). Understanding how to promote body appreciation is essential because there are significant protective factors and

benefits to having a body appreciation, such as the decreased risk of depression, anxiety, and disordered eating pathology and increased practice of preventive health care behaviors (Tylka & Wood-Barcalow, 2015c; Webb et al., 2014; Weinberger & Luck-Luck-Sikorski, 2020). Knowing how to promote body appreciation among this population will assist higher-weight women in living a life full of vitality.

Promoting body appreciation is pivotal because of its numerous benefits; nevertheless, many mental health providers have difficulty providing body image treatment to this population. Due to pervasive stigma and weight bias, many have difficulty providing treatment that does not discriminate against or oppress their clients further. To build on these data, this study analyzed how women in larger bodies developed body appreciation through weight-neutral interventions. This was done through a semi-structured interview to obtain qualitative accounts of what aspects of the intervention promoted body appreciation. This information will also likely give clinicians tools to nurture positive body image among all sizes, which will expectantly prolong positive therapeutic outcomes and advance the clients' overall well-being.

CHAPTER III: METHOD

Regarding women in larger bodies, most weight-loss or weight-neutral studies primarily focus on the treatment and how it affects physical health factors and psychological distress, such as body dissatisfaction or depression (Bacon et al., 2005; Boucher et al., 2016; Martin Ginis et al. 2012; Weinberger & Luck-Sikorski, 2020; Wilson et al. 2020). Many of these studies do not discuss how these individuals develop positive body image, which is linked to overall better well-being, less psychological distress, and better physical health (Tylka & Wood-Barcalow, 2015c; Webb et al., 2014; Weinberger & Luck-Luck-Sikorski, 2020). The purpose of this study is to describe the experience of higher-weight women who sought treatment for body image distress with a provider who utilizes a weight-neutral framework to develop a positive body image. Through these interviews, I hoped to learn from these higher-weight women how this approach assisted them with developing body appreciation, contributing to their ability to flourish.

The current study focused on three questions: (a) How have women in larger bodies found body appreciation within a culture that often stigmatizes and discriminates against them? (b) How have their weight-neutral treatments promoted this development? (c) If any, what are the other factors—internally or externally—that significantly affected the progression of body appreciation? It is hoped that, by answering these questions, we can better understand how to support and treat people in larger bodies within the mental health field.

Another aspect of this study is a comparative analysis between weight-neutral and weight-focused treatment samples. While interviewing participants, three women disclosed that they were preparing for or had bariatric surgery. They believed they received weight-neutral treatment at a weight-loss clinic while preparing for bariatric surgery since there was no

discussion about how to lose weight in their counseling sessions. Due to this belief, I decided, with consultation, that it would be unethical to correct their experience and decided to learn from these women by comparing their experience to those in the weight-neutral groups through the same interview questions. Their data were excluded from the weight-neutral group, since the clinics' goal was to assist people in losing weight, assessing readiness for the bariatric process, and preparing for bariatric surgery, which is not weight-neutral treatment. Instead, these interview responses formed a second, comparative group.

The current chapter will discuss the methods by which data were collected to answer the research questions, including a discussion about the research design and procedure. Data collection and data analysis procedures will also be explained. Last, the role of the researcher and credibility will be reviewed.

Research Design

A qualitative approach was used to understand how higher-weight women develop body appreciation through weight-neutral or weight-loss treatment. A qualitative approach was beneficial for this study because it allowed the perceptions and experiences of participants who experienced the development of body appreciation to assist in providing ideas on improving body image treatment for those in larger bodies. The qualitative approach also provided an in-depth understanding of these individuals' lived experiences and highlighted how body appreciation is viewed between those in weight-neutral and weight-loss treatment. Comparison of interview responses also assisted in incorporating differing perspectives from those who had different experiences with the same phenomenon (Lindsay, 2019).

Qualitative Paradigm

The current study intends to help reform body image treatment for people in larger bodies. The reformation is to initiate a treatment where clients feel that their treatment reflects them and their needs, and represents their experience in a society that oppresses larger bodies. Due to this intention, this study applied critical feminist theory. Critical feminist theory seeks to confront the patriarchal structures and empower women to transcend the constraints placed upon them and challenge injustices in the current society (Creswell & Poth, 2018). The goal of feminist critical research is to establish collaborative and nonexploitative relationships with the participants, place the researcher within the study to avoid objectification, and conduct transformative research. Gathering this knowledge is to examine and document the dominant cultural values, and the privilege and oppression they create, and call for action and change (Creswell & Poth, 2018).

The current study critiques how the United States society places value on individuals based on their weight, namely, valuing those in thinner bodies. Society often uses arbitrary or harmful practices, including the BMI scale, to discriminate or stigmatize those in larger bodies and to reemphasize the value of thinness and its associated power. Weight-neutral treatment, the primary focus of this research, challenges that perspective by acknowledging the importance of considering the whole person and encouraging society to see and honor the value in larger bodies by seeing how one can appreciate, respect, celebrate, and care for their body at any size.

I utilized a phenomenological design, which aims to reduce individual experiences to a description of universal essence (Creswell & Poth, 2018). Interpretive Phenomenological Analysis (IPA; Smith et al., 2009) was used to design the current study and analyze the responses. IPA is the examination of how people make sense of life experiences. The unique

feature of IPA is that the participants' data create common themes rather than their experiences being placed in predetermined categories that the researcher created. IPA analysts are specifically interested in experiences with considerable significance in a person's life, such as weight-neutral treatment, called comprehensive units of life. During discussion of these comprehensive units, people tend to reflect on how these experiences affect them. IPA involves researcher engagement in these reflections and the discovery of common themes or connections between groups of people who share similar comprehensive units (Smith et al., 2009). This research aims to understand women in larger bodies' relationships with their bodies and how their weight-neutral treatment affected their development of body appreciation.

Participants

Participants for this study were recruited through weight-neutral providers and social media. I advertised the study by posting messages on Facebook and Instagram, and contacted weight-neutral providers through social media messaging, email, and numerous weight-inclusive Facebook groups, such as "Washington Fat Positive Weight Inclusive Providers" or "Weight Inclusive NJ Providers." Many of these providers requested to share the recruitment flyer within their communities through their social media platforms or by email. I also advertised the study in a body-positive affinity group within a large international technology company. Many of the participants came from the affinity group. Eligibility requirements included being a woman between the ages of 25–45, who wears a pant size of 16 or higher (35 inches or more for waist), and who had at least six sessions with a weight-neutral provider (i.e., psychologist, psychiatrist, registered dietitians, mental health counselors, body image coaching, clinical social worker, etc.) within the past 3 years. Participants also needed to consent to participate in an audio-taped interview through Zoom.

If participants were interested, they were encouraged through the recruitment materials to follow links to a digital informed consent and an online form where they could learn more about the study, complete the Body Appreciation Scale 2 (BAS-2), and fill out demographic forms to determine if they met pant size and therapy attendance requirements. Once the paperwork was completed, the researcher would determine whether participants fit the criteria and contact them to schedule an interview through a digital scheduling application.

Procedure

Before beginning the study, each participant completed an informed consent form. Once they had provided informed consent, participants filled out a demographic form that collected information regarding age, height, race/ethnicity, education, income, and several other demographic variables. Participants then completed the Body Appreciation Scale-2 (BAS-2) to measure their body appreciation.

Body Appreciation Scale-2

The Body Appreciation Scale-2 (BAS-2) assesses individuals' acceptance of, favorable opinions toward, and respect for their bodies. The scale contains 10 items (e.g., I feel love for my body) rated on a Likert scale from 1 (*Never*) to 5 (*Always*), with higher scores indicating higher body appreciation (Tylka & Wood-Barcalow, 2015a). The BAS-2 demonstrated good internal consistency, with an alpha of .97 (.97 for women, .96 for men). It also demonstrated good validity in measuring body appreciation. The BAS-2 was positively correlated with appearance evaluation and negatively correlated with body dissatisfaction for women. It was also inversely related to eating disorder symptomatology and positively associated with intuitive eating for women and men. The BAS-2 predicts eating behaviors and psychological well-being beyond the

variance accounted for measures of adaptive and maladaptive body attitudes (Tylka & Wood-Barcalow, 2015c).

The Interview

Participants were asked to complete an original, semi-structured interview created by the researcher. The interview guide is an extensive list of questions about developing body appreciation and higher-weight women's experience in weight-neutral treatment (see Appendix A). Ideas for this initial list of questions were derived from several sources, such as the literature review, consulting with the researcher's dissertation and advisory group, and requesting feedback within the size-inclusive community. Once the list was completed, 10 questions seemed to capture the phenomenon most comprehensively. The remaining questions were utilized as possible prompt questions under the primary questions. All nine participants were asked these primary questions. The prompts only appeared on the interviewer's guide copy and were used when more information was needed. To test the credibility of the interview guide, the researcher shared the interview with members of the professional community and asked their opinion about the interview guide, also known as pilot testing (Creswell & Poth, 2018).

The interview began by discussing each participant's current relationship with their body and how that had changed through treatment based on size acceptance. Then there were two questions concerning their experience in the health and mental health fields and how weight-neutral treatment or other outside factors assisted with their development of body appreciation. This also included a question about their relationship with their provider, since the treatment relationship considered a cornerstone to positive treatment outcomes (Wampold, 2019). The researcher then asked about the most challenging aspects of developing body appreciation and how it improved their overall well-being. Interviews lasted between 40 and 90

minutes. Interviews were taped and transcribed.

Data Analysis

When beginning to analyze data, I listened to the recordings and read the transcripts of the nine interviews fully and then bracketed my feelings and experiences from the collected data. Bracketing assists in lessening the impact of my perspective by signifying what my perspective on participants' experiences is, so I can attempt to reduce its influence as I analyze the responses (Smith et al., 2009). Then the interviews were listened to again. While listening and reading each participant's interview, comprehensive notes, forming an audit trail, were taken on observations, connections within and among participants' experiences, and possible emerging themes.

After reviewing the interviews, I began the coding process. Thematic network analysis was used to organize the data to discover the themes salient in a text at different levels (Attride-Stirling, 2001). It aims to facilitate the structuring and depiction of themes. Thematic network analysis offers a web-like network as an organizing principle and a representational means that moves the data from text to interpretation. Network analysis is made of basic themes (i.e., represents groups of code), organizing themes (i.e., organizes basic themes into clusters of similar issues), and global themes (i.e., summarize the main themes and reveal interpretations of the overall texts; Attride-Stirling, 2001). Due to the significant amount of data, visual networks were not created; however, the thematic network process was used to maintain the diverse levels of coding within the data. Four steps were taken for both samples to create this research's thematic network.

Coding the transcripts was the first step, where significant phrases that pertain directly to the participants' development of body appreciation or treatment experience were identified. Coding was completed through a hybrid approach of deductive and inductive coding, and the

transcripts were read several times to obtain an overall feeling. Deductive coding is a “top-down” approach where the researcher creates codes based on the research questions or theoretical framework before coding begins (Delve, n.d.). The process began with deductive coding because it assisted in developing a foundation that acknowledged the study’s research questions and provided a clear train of evidence for its credibility (Fereday & Muir-Cochrane, 2006). The initial codes for this study were developed to reflect the interview questions. For example, text coded “Appreciation” answered the interview question, “How do you appreciate your body?” However, I continued to create original codes as the coding process ensued, known as inductive coding (Delve, n.d.). Inductive coding provides a systematic way to identify and describe the core data themes relevant to the research objectives. This allowed some themes to emerge from the data rather than from the expectations or hypotheses about the data (Schafer, 2014).

Once coding was finished, coded text segments were represented by sentences describing the participants’ treatment experience and body appreciation development, thereby developing the basic themes. Participants’ responses that did not fall under a basic theme, such as a singular raw text segment, were excluded from the data. The themes were then placed into similar coherent groups to create organizing themes. Organizing themes tend to center larger shared issues among the basic themes. Organizing themes were then collated, leading to the development of global themes that encapsulated the main points of the texts.

After completing each network, I verified and refined the network by reviewing the text segments and ensuring that the global, organizing, and basic themes reflected the data. A second graduate-level researcher interested in body image and eating disorders served as an auditor, reviewing the data and thematic networks to ensure that the global themes accurately represented

the underlying basic and organizing themes and that the basic themes represented all of the underlying text segments. The auditor reviewed the data numerous times and provided feedback to the primary researcher. When discrepancies between the two perspectives arose, we would discuss and agree on the best way to represent the data. The discussion resulted in removing codes, shifting definitions of basic themes, and moving some basic themes to a different Organizing or global theme. In addition to the qualitative data, I analyzed the BAS-2 by calculating the item's means and standard deviations to describe the sample's levels of body appreciation. Descriptive statistics on demographic information were also completed to describe the sample and their treatment approaches.

Methodological rigor was attained through the application of verification strategies, which are akin to the concept of validity in quantitative research (Morse et al., 2001, as cited in Creswell & Poth, 2018). Verification was fulfilled in this study by completing literature searches, adhering to the phenomenological method, bracketing past experiences, creating field notes and an audit trail, using an adequate sample, and interviewing until saturation of the data was received. Verification was also met by using multiple methods of data collection (BAS-2 results, observations, and interviews), data analysis, negative case analysis (e.g., weight-focused comparative analysis), member checks, and audit trails. Last, an auditor reviewing the themes and codes provided another form of verification. Thus, verification was appropriately addressed, based on trustworthiness and external reviews (Morse et al., 2001).

The Role of the Researcher

In qualitative research, many acknowledge that the study cannot be separated entirely from the author or their culture, history, gender, class, and personal politics; it is all positioned within the research. I, too, share this belief, and as a result, took a reflexive stance with this

paper. Reflexivity is the process of examining both oneself as the researcher and the research relationship (Creswell & Poth, 2018).

Numerous aspects of my personal experiences are relevant to research planning and data analysis. I am a woman in a larger body who has received weight-neutral treatment to assist with my history of body image issues. My treatment played a key role in introducing me to the size-inclusive community and what it means to accept my body without changing it. I have also clinically worked with numerous women and adolescents who have struggled with body image and disordered eating. As a clinician, before this study, I had maintained a significant interest in weight stigma and how the stigmatizing social constructs affect a higher-weight woman's experience within the therapeutic relationship and in the world in general. Due to my personal and professional experiences, I am interested in the lived experience of higher-weight women and how mental health providers can provide them with the most effective body image treatment. One way of reducing bias was for me to bracket throughout the research study. I practiced bracketing and reflexivity by journaling my experience and process throughout the research, discussing with professionals with similar and different views, and utilizing reflexivity in my field notes. Although I expected to find that weight-neutral treatments were more effective at promoting positive body image, given my own experiences, I tried my best to bracket those expectations out and allow the interview responses, alone, to contribute to the findings.

CHAPTER IV: RESULTS

Demographic and Descriptive Information

Weight-Neutral Group

The six participants in the weight-neutral group ranged in age from 28–42 years old, with a mean age of 35. Most participants were White ($n = 5$), with one identifying as Latina with Mexican origins. Five participants identified as cisgender women ($n = 5$). The sixth participant's gender was femme genderqueer. Half of the participants identified as heterosexual ($n = 3$), one as bisexual, and two as queer. Regarding relationship status, one participant was single, one was in a long-term partnership, three were married, and one was separated. Participants lived in a wide geographical range within the United States ($n = 5$) and Mexico ($n = 1$). Participants in the United States lived in the Northeast (e.g., Massachusetts, New Hampshire, New York, etc.) ($n = 2$) and West (e.g., Washington, Idaho, Colorado, etc.) ($n = 3$). Most participants primarily utilize English in their homes ($n = 5$). One participant's family primarily uses Spanish.

Most participants were full-time employees ($n = 3$), two were employed part-time, and one was unemployed. Annual household income for two participants was between \$25,000 to \$50,000 a year, one had an income of \$110,000 to \$200,000, and another had one over \$200,000 a year ($n = 1$). Two participants selected “prefer not to say.” Three participants received their bachelor's degrees, and the other three highest degrees were master's level.

Participants' height ranged from 65 to 67 inches, with a mean of 65.83 inches. The pant sizes of the three participants were size 16/18. The other three participants were sizes 14/16 ($n = 1$), 24/26 ($n = 1$), and 26/28 ($n = 1$). Participants' size identities were medium-sized ($n = 1$), larger body ($n = 1$), fat ($n = 3$), and “small fat” ($n = 1$). Regarding treatment, half saw a registered dietician for their weight-neutral treatment ($n = 3$), and one saw a mental health

counselor. Two participants saw multiple providers, including a psychologist, mental health counselor, registered dietitian, and primary care physician. All six participants saw these providers individually, either through in-person sessions ($n = 2$), virtual sessions ($n = 2$), or both in-person and virtual sessions ($n = 2$). Participants saw their providers for different ranges of time. Four years ($n = 2$) and 3 years ($n = 2$) were the most common. One participant saw their provider for 1 year and another for 2 years ($n = 1$). Three participants were still seeing their providers. Two participants last saw their providers 1 year ago and 2 years ago. Most participants sought services for various reasons ($n = 4$), such as mental health concerns, relationship concerns, disordered eating behaviors, body image concerns, etc. Two participants sought treatment for disordered eating or eating disorder behaviors.

Comparison Sample: Weight-Focused

The comparison sample included three cisgender women who ranged in age from 35–43 years old, with a mean of 40. Two of the participants were White, and one was Hispanic. All participants identified as heterosexual; two were single, and one was married. The participants all lived in the Southwest (e.g., Texas, Arizona, New Mexico, etc.; $n = 1$), West ($n = 1$), and Washington DC ($n = 1$). English was the primary language used in their homes. All participants worked full-time ($n = 3$). One participant had an annual home income of \$51,000 to \$100,000, and two made \$110,000–\$200,000 annually. Regarding education, two participants received their associate degrees, and one had a master's degree.

Participants' heights ranged from 65–67 inches, with a mean of 65.67 inches. The pant sizes of the comparison sample were 20/22 ($n = 1$), 22/24 ($n = 1$), and 26/28 ($n = 1$). One participant identified as a larger-bodied person, and another identified as fat. The last individual selected “other” and wanted her size to be identified as “Size, Big Girl, and Strong.” All three

participants saw multiple providers, including psychologists, registered dietitians, psychologists, mental health counselors, Bariatric Health Team, and personal trainers. The primary place they saw these providers was at weight-loss clinics. One participant saw her providers individually, and two completed individual and group treatment. All three participated in in-person and virtual services. The length of treatment varied for each participant. The longest was over 5 years ($n = 1$), and the shortest was 3 years ($n = 1$). One participant was still seeing their provider when the interviews were conducted. The others ended treatment 1 year ago ($n = 1$) and 2 years ago ($n = 1$). Two participants sought services for numerous reasons ($n = 2$), such as eating disorders or disordered eating patterns, body image concerns, mental health concerns, relationship concerns, and wanting to develop “body health and life longevity.” One participant stated that they sought services to “lose weight” and returned to services due to “covid breakdown post-baby.”

Body Appreciation Scale-2 Results

The Body Appreciation Scale-2 (BAS-2) completed before the interviews indicated that all participants had average to high levels of body appreciation ($n = 9$). The mean score was 3.60, meaning participants showed an average level of body appreciation where they could “sometimes” accept, have favorable feelings toward, and respect their bodies. The weight-neutral sample ($n = 6$) had a mean of 3.40, with a max score of 3.7 and a low of 2.9. The comparative sample ($n = 3$) had a mean of 3.9, demonstrating slightly higher body appreciation levels than the primary sample. Their scores ranged from 3.6 to 4.44.

Qualitative Data

Weight-Neutral Sample Themes

Through analysis of six interviews, 11 global themes were extracted, with 22 organizing and 76 basic themes. The following section will be organized into global themes, exploring organizing and basic themes with raw text examples from the interviews. For more in-depth inquiries, please view Appendix B, which delineates the various levels of themes.

Global Theme 1: Body Image Develops in Childhood

The participants discussed how their childhood experiences with caregivers and family impacted their body image development and how they were reinforced by romantic partners or extended family in adulthood. This global theme had three organizing themes and eight basic themes. As children, many participants shared that they began to internalize the messages from their caregivers about how one's body should look or be treated. Caregivers modeled their discomfort with their bodies, which normalized dieting or weight stigma. One participant recalled, "I remember my parents were always dieting when I was a kid. Like, there was some like a fad diet, like there was like the cabbage soup diet ... you know like they did all of those things." Participants also shared how they observed family members discussing bodies and labeling them as "good or bad" and how they were reinforced for trying to attain a smaller body, even if it was not healthy. For example,

I hit puberty at like 11, and I gained like 40, 50 lbs. in a summer. And that was even despite eating 1,200 calories a day, like in early 2000. So, I would have been like I was eating like low-fat everything ... And so that was kind of, and I was congratulated for it ... and asked if I wanted to go on Weight Watchers.

In adulthood, these beliefs continued to be reinforced through their caregivers, romantic partners, and extended family (i.e., in-laws).

Values and how the body changed also seemed to influence body image in adulthood. Often, body changes induced grief or disappointment. A participant recently began gaining weight and shared, “[I would be] lying or untruthful if I said that there weren’t times where I still wish I was in a smaller body because it affords a lot of privilege in various ways.” However, participants also shared that their progressive or feminist values affected their body image. One participant discussed how her feminist values encouraged her to consider her relationship with her body. This participant said,

How did [my body image beliefs] bump up against my feminism and how I saw that part of myself and my like, you know, the first time I saw the term like body liberation was like a big, I was like, ‘Oh, that’s really interesting.’

Another discussed how anti-fat bias was rooted in racism and misogyny, and having progressive values assisted her in questioning her size bias.

Theme 2: Pre-treatment: Body and Food Relationship

Before treatment, many participants experienced disconnection with their food, meaning they were not eating intuitively. This global theme had one organizing and two basic themes. Regarding the food relationship, participants regularly would label or moralize their food. Here is one example of this phenomenon from a participant: “Right, I might have been very much in a like this food is ‘good or bad’ or that sort of thing. And I’m really trying to move away from that framework because I don’t find it helpful.” Others also discussed how they would restrict what they ate and try to minimize their calorie intake. One participant mentioned feeling disconnected from their body before weight-neutral treatment; otherwise, pretreatment body relationships were not discussed.

Global Theme 3: The Negative Impact of Weight Stigma

Participants shared their experiences of weight stigma and how those messages affected their overall well-being. All shared that weight stigma greatly affected their community and their internal experiences, which, in turn, caused them not to feel safe in their body. This network had two organizing and 11 basic themes. Participants shared that they experienced weight stigma in numerous areas of their life (e.g., at doctors' appointments, trying wedding dresses, and at work), and they were implicit and explicit. One basic theme that three participants mentioned was the lack of accessibility regarding space or providing accommodations for people in larger bodies. One participant shared her experience about finding space at work after the pandemic:

I'm thinking about even being at work in like team meetings ... And one of the things I dread is feeling like we only have X amount of chairs and X amount of space, and feeling like I'm going to take up this extra room.

Two participants also mentioned media influences.

"I think I had a ton of anxiety about my body and how it looked, very specifically, how it looked. It felt very I got a very adversarial relationship with my body," was one's participant's experience with her body before weight-neutral treatment. She accredited this experience to anti-fat bias and weight stigma. Experiencing weight stigma appeared to negatively affect individuals' inner experience causing shame, anxiety, and internalized fatphobia or feeling disconnected from or self-conscious about their bodies. Internalized fatphobia was discussed or observed in each interview numerous times. Participants often coped by trying to get their body dieting or changing their body, adopting "perfectionism," or feeling disconnected from their bodies. The strive for body positivity also appeared to impact three participants negatively since it doesn't allow an individual "not to feel great about their body." Another shared that it felt like a "really high bar to set."

Global Theme 4: Providers Demonstrating Weight Stigma

Participants experienced anti-fat bias or a lack of awareness about body image concerns or weight-neutral care by previous non-weight-neutral providers. Participants reported more experiences within the medical field ($n = 22$) than in the mental health field ($n = 7$). The “Providers Demonstrating Weight Stigma” global theme had two organizing and nine basic themes. Participants disclosed that their providers often “expect [them] to fail” at being healthy or assume their health based on size before completing blood labs or health assessments. Some providers would also make weight-bias statements towards them, such as blaming them for their diabetes diagnosis. One participant, a registered dietician who changed careers later in life, shared an experience with her therapist after she had a baby. The participant was concerned about how her new larger size would impact her career. The participant recalls the following experience:

And she said something to the effect of, well, you’ve got to walk the walk if you’re going to talk the talk or that kind of thing. And was and then sort of shifted the conversation towards like exercise I could do or like ways that I could change the way I’m eating or, you know, like really problem-solving to make me smaller.

The weight-bias statements or assumptions often made participants feel shame and anxiety about their health care, or felt they had to “choose between medical or mental health.” Two participants said they terminated their healthcare providers’ relationship due to assumptions and statements.

Specifically, regarding mental health care, participants mentioned that they felt that their previous mental health providers did not adequately assess body image or lacked knowledge about weight-neutral approaches or people in larger bodies in general. The following is one participant’s reflection on her previous mental health experiences, “I feel very fortunate like I

never saw anybody in the mental health field that was like anti-fat, but they just didn't know what I was talking about a lot of the time."

Theme 5: Weight-Neutral Treatment Factors

Participants often experienced change due to weight-neutral treatment. Therapeutic rapport and the provider's knowledge and size identity were significant factors for effective treatment. The network for this global theme included two organizing themes and six basic themes. The relationship with the provider was "the key" to the effectiveness of weight-neutral treatment. The participants found their providers approachable, validating, non-judgmental, and knowledgeable about weight-neutral approaches and assisting people in larger bodies. One participant was reflecting between weight-focused and weight-neutral treatment. She said this about her weight-neutral provider, "instead to have a provider who listens to you and affirms you and doesn't make you feel bad about your body, it's like kind of profound. And it shouldn't be, but it is."

Another factor that the participants found to be important was the providers' size identity. Five participants shared that having a provider in a larger or "fat" body was helpful due to having "shared experiences and language" about being in a larger body. One participant shared that she benefited from having a "straight-sized" therapist due to struggling with internalized fatphobia. Here is her reflection from the interview,

The only thing is, is that she [is] straight size. So sometimes I'm like. Would it be? ... would it be more helpful? Now at this point, to be with someone, to work with someone who is fat. And so far, no. So far, it's been like because it's still such a blah topic for me.

All the participants disclosed that they found weight-neutral treatment challenging but effective and were grateful for the experience. One participant shared that "unlearning feels painful." They also experienced feeling liberated or "normal" for the first time. They attributed

this development to the therapeutic relationship, the provider being knowledgeable about diet culture and its negative effects, and having physical spaces that were friendly to people of different sizes. Here is one participant's experience as she entered their counselor's space for the first time,

She's got all this like body positive, like beautiful fat art on her walls. And I like, I remember the first time I walked into her office, and I was just like, 'Whoa.' Like, I was like, 'Oh, yeah, this is a this is a safe space. This is a good space. Like, we can really dig into this stuff and talk about it.'

Global Theme 6: Weight-Neutral Interventions

The sixth global theme is exploring what interventions or approaches were common for participants in treatment. The data show that weight-neutral providers were holistic in their approach and interventions and encouraged non-weight-loss goals for clients. This global theme had two organizing and eight basic themes. According to the interviews, participants experienced food, intra-relational, and body-based interventions. Some food interventions discussed were challenging "food rules" that were utilized while restricting, providing education on nutrition, and how to be nutritious during a busy schedule. Completing intra-relational, or the relationship with oneself, interventions were also common, such as developing insights about their relational and cognitive patterns, inducing empowerment, and developing self-compassion and trust. Here is one example of an intra-relational intervention a participant completed with her mental health counselor:

I mean, there's probably like I don't know if there's like a specific modality, but like I remember her talking a lot about permission when like she's like, give yourself permission to do X, Y, Z. So, like homework for this week, like, I want you to go home and give yourself permission to whether that was like feel your feelings or like give yourself permission to say to express this to this person or to do this activity.

Body-based interventions encouraged participants to be curious about what their body needs (e.g., "I went from thinking really terrible self-abusive diet culture thoughts to like a lot of

assessing how do we feel right now?”), redefining movement (e.g., “It’s always from a place of caring for my body and not from a place of punishment, or you know manipulation.”) or finding clothes that fit and are comfortable.

Psychoeducation was a critical part of weight-neutral treatment. Common areas of psychoeducation were introducing weight-neutral and fat liberation philosophy and values, teaching about different ways to measure health (i.e., understanding blood labs, etc.), and encouraging a “perspective shift” by discussing the societal impact of weight bias or self-compassion. Providers also provided weight-neutral or fat-liberation resources such as podcasts, books, and TV shows, including those created by higher-weight people.

Global Theme 7: Factors that Assisted with Body Appreciation

Movement, one’s community, and learning about fat activism and perspectives through self-education were outside factors that contributed to body appreciation development. This network had two organizing themes and four basic themes. One’s community accepting a participant’s personality and body increases body appreciation. One participant shared that she is “immersed in the fat, body positive, anti-fatphobia spheres” online, and she feels that those communities “shaped how [she] thinks about both [her] body and other bodies and how we think of them and treat them, etc.” Participants with children shared that it was beneficial to think about how weight stigma could negatively impact their children. This encouraged them to model body appreciation by not talking about dieting or commenting on weight. One participant shared her fears and desire for it to be “better” for her son. She stated,

I guess. I mean, just because of phobia. Right. And like, he's going to hear all kinds of messages that perpetuate fat stigma and, like, just body shame and. He's in a thin body. Like, I don't I don't know that he's internalizing anything yet, but I can tell that, you know, he hears it from friends at school, and he's going to hear it from his friends' parents, probably at their house. And, you know, it's I'm never going to be able to shield him from hearing messages and seeing things. But I guess I just want I want better for him. I want him to grow up in a world where he knows that there's an alternative. And that alternative is you can appreciate your body regardless and that you don't have to spend your life hating your body.

Self-education was another outside factor important to the development of body appreciation. Many participants completed self-led education on fat studies, weight-neutral theories and modalities, or found size-inclusive communities. One participant shared that “a lot of my body appreciation has come from like self [education].” Participants utilized literature, social media, and podcasts.

Movement also seemed to be a significant factor in body appreciation development. Practicing pleasurable movement endorsed body appreciation. Activities varied from intensive cardio, like cycling, to gentle activities, like stretching and walking. One participant discussed how she had to change her relationship with movement “from a place of punishment or, you know, manipulation” to one that is “from a place of caring for her body.”

Global Theme 8: Factors that Challenged Body Appreciation

Diet culture is “pervasive” in society, making it challenging to develop body appreciation. Participants learned that they have internal and external risk factors that decreased the opportunity for body appreciation development. This network has two organizing themes and 11 basic themes. “Self-consciousness” or feeling “triggered” by how their body functions or looks was one internal factor that negatively impacted body appreciation. A participant shared her experience of what she feels when she takes “too much space” on public transportation. The following is her experience,

I will actually have a physical reaction ... So, a lot of assessing is part of that. Like, I'll get into that situation, notice that my heart races, whatever, and I'm having the physical manifestations, and I go, okay, okay.

Participants also disclosed that it could be “challenging” consistently “practice” challenging or filtering negative body messages, which can negatively impact body appreciation. Participants also seemed to be self-critical of their body appreciation development, which may negatively impact it. When asked about how they appreciate their body, three participants answered in the following ways: (a) “Anyway, there's a joke about winning at therapy, and this answer makes me feel like I'm losing at therapy;” (b) “How do I appreciate my body? That's such a good question. I feel like I probably don't appreciate it enough; (c) “Well, I will start by saying I could do a better job of appreciating it more.”

Participants also experienced external factors that challenged their body appreciation development. Some participants felt their body was not accepted or they were unsupported by others on their body appreciation journey. A participant shared that she desires community, but it can be challenging “really wanting to find spaces that are not like people are not talking about, like Noom or whatever. Right? Just like aren't filled with diet culture talk. And that feels tricky to find.” Another shared that it has caused conflicts in her marriage, “I married my wife, and I have a number of conversations about this. She's in a very different place in her journey around it.” Not finding comfortable clothes representative of them was another factor that impacted body appreciation. Two participants discussed the difficulty of finding clothes due to “not fitting” or lack of accessibility to certain sizes and styles.

Lack of representation or accessibility also negatively influenced participants' body relationships. Participants discussed how “representation is important.” One participant shared that it has been difficult to find a therapist representative of her size, and when she found one, it

“was a really big deal.” Another discussed the lack of weight-neutral providers and how challenging it can be to find one that accepts her insurance; the following is her experience, “I’m in a couple of local [fat positive] groups, and even their list of like HAES providers [weight-neutral] is pretty small, and none of them accept my insurance.”

According to the data, another risk factor is the threat of being diagnosed with a disease associated with people in larger bodies. One participant was recently diagnosed with diabetes, which she shared “put her into a tailspin” and “felt like a backslide.” These feelings increased after a doctor said it “was all her fault.” Another participant shared that her family has a history of diabetes and her fear that she will also receive the diagnosis. She shared, “But if I don’t do anything, then it is kind of on me, and I don’t want to look back and have regrets.”

The persuasiveness of diet culture was also a risk factor for body appreciation development. One participant shared that the most challenging part was “all the comments” when people discuss body or food choices. Another noted how sometimes it was not even clear when she was being “fat shamed” due to diet culture being so common. She described this as a “secondhand” impact. Here is her thought process in more detail:

Because one of the things I struggle with is like I was never directly fat shamed, that I remember, who knows? ... it’s been secondhand. It’s been me standing with friends while they make fun of another friend or me watching a movie, TV show, or whatever. And, and me. It’s been, it’s been. It still makes me like I just laughed at myself self-consciously because it’s still I feel still weird about the idea that all these secondhand things could cause me so much stress or trauma that I have all this shit to work through, like it’s just a movie or whatever.

Global Theme 9: Body Appreciation is Unique

Body appreciation was unique to each participant, and it can be practiced individually and socially in diverse ways. This network had one organizing and five basic themes. Some common ways participants showed their body appreciation was by listening to their “body’s

needs” and wearing clothes that fit and were comfortable. The most common type of body appreciation was functionality appreciation ($n = 5$), where participants appreciated how their bodies functioned. Functionality appreciation included movement, the ability to move without pain, and completing everyday functions easily, like digesting food. One participant shared that she appreciated her sensory skills and how they allowed her to connect with others, “I like [to] touch other people. I’m a hugger. I’m like a physically affectionate person.”

Participants’ definitions of body appreciation also differed. Here is one example of a definition from a participant:

That’s what I would say is like body appreciation is, is appreciating that we have one and that it does all these amazing things. And yes, it gets older. Right. And that’s been a thing that everyone goes through, hopefully. Right. Hopefully, we go get older. But that’s all [deleted repeated word] like I wouldn’t have I wouldn’t go. I would say it’s I would say it is that is what it is. And it doesn’t encompass like. Appreciating what it looks like. That’s not part of it to me.

Global Theme 10: Body Appreciation Developmental Process

A developmental process may occur when one is developing body appreciation. This global theme comprises three organizing and seven basic themes. Each participant discussed how developing body appreciation is “a process” and is “not linear.” One participant describes it as a road path, “It’s going to be bumpy, and there’s going to be stops and starts, and like, that’s okay.” Participants also recognized the complexity of the body relationship and how it fluctuates throughout their lifetime due to weight changes, having children, or aging. The relationship being defined as complex was seen in how they answered the first interview question, “What’s your relationship with your body?” Most replied with the word “complicated” ($n = 4$) or with an acknowledgment of the expansiveness of the question (e.g., “That’s a big question!”) ($n = 2$).

In this network, participants also shared that body appreciation development includes displaying anger or “rebellious” against diet culture (e.g., “They’re trying to sell you a version of

yourself that doesn't exist. And they're, like, profiting off of it. And it like it makes me intensely angry"). Individuals also experienced a perspective shift that expanded their world view regarding their size and body. For example, "There are so many other aspects to health besides the number on a scale." Externalizing one's relationship with their body was also common. Participants began to see their bodies as "companion[s]" with needs and "deserve kindness."

Global Theme 11: Body Appreciation is Transformational

Developing body appreciation is transformational. Body appreciation and weight-neutral treatment positively affected the participants' well-being and improved their relationship with their bodies and food. There were two organizing and seven basic themes. Developing body appreciation positively impacted participants' interpersonal relationships and how they approached eating and food. Participants also felt more empowered, as seen in their interest in activism and self-advocacy. Participants also experienced increased body acceptance and embodiment, gratitude for their bodies, and decreased appearance investment. One example of this transformation was a participant accepting her body as it was and celebrating the change,

This little moment where I praised myself and congratulated me because I don't have those problems to be the perfect one, to look the prettiest, and that's it. Because I know who I am, I know that I'm pretty, and I know how to put myself above.

The relationship with the self was also positively affected. Participants felt more worthy, increased their ability to be their "fullest self," and practiced more cognitive coping skills such as filtering negative thoughts about their bodies (e.g., "And like, what can I control right now? I can't control what people think about me or what people are going to say, but I can control how I'm if I'm taking that on"). The following is an example of one's participant's transformation in her relationship with herself and body:

But like coming from that place of that, like, I deserve this, and I can, and I deserve to be able to seek this care. I deserve to take care of myself. I deserve good things for my body because my body, like I said before, is a part of me. It's not a disembodied thing.

Weight-Focused Sample

The comparative sample comprises three women who believed they received weight-neutral treatment while preparing for bariatric surgery. Their experience will be compared to the weight-neutral group in developing body appreciation through weight-focused treatment. They were asked the same questions as the weight-neutral sample; however, different global themes emerged from the data. The comparison or weight-focused group had nine global themes with 25 organizing and 79 basic themes. The following section will be organized into global themes, exploring organizing and basic themes with raw text examples from the interviews. Please view Appendix C for more in-depth inquiries.

Global Theme 1: The Self and Interpersonal Relationships Impact Body Image

Various factors affect a person's body image, such as their relationship with food and their body and interpersonal relationships. There are two organizing and four basic themes in this network. Before treatment began, participants struggled with their food and body relationship. All three participants discussed how they utilized food to cope with emotions or as an "addiction" to numb their feelings. A participant preparing for bariatric surgery shared that food was a type of "anxiety med" and assisted with her not feeling anxious. Participants also believed their size negatively affected their life and emotional and physical health. After a divorce, one participant began to reflect on how her body was negatively impacting her life; the following was her thought process:

I would say that was I didn't realize my body truly was big until my first my first and only divorce. So, I just thought it was a thing that went around. We just used it. But with that, that divorce and everything, it really made me question, you know, like, am I attractive? Am I healthy?"

This reflection led her to weight-focused treatment.

Current or potential romantic partners' comments or desires influenced the participant's body image. One participant shared that in her recent romantic relationship, she felt accepted by her partner and disclosed, "he didn't care about my weight, which is what spurred [weight gain]." Another participant who had bariatric surgery and did not like her body at a smaller size discussed how she would care more about her appearance if a future partner wanted her to look more "desirable" due to the benefits she may gain.

But if it was like they would be more preference for me to look differently, I would probably have no problem putting myself more in that desirable stage for them because, they're going to protect me. They're not going to let other people be trying to hit on me in the first place. I don't like that.

Participants' body image was also affected by how their children viewed their bodies. A participant who struggled with body image after bariatric surgery shared how her son loves larger bodies, "I don't know how my kid feels about it ... He loves bigger people. He's like, [participant's friend] bigger. You're almost the biggest [participant's friend]. And I'm like, Yeah, I'm gonna get bigger." She shared that if he "became uncomfortable" with her size, she would return to treatment.

Global Theme 2: Interview Observations

Discussing body image and size seemed to increase anxiety among participants. Two organizing and five basic themes created this network. Participants displayed numerous defense mechanisms throughout the interview, such as rationalizing or denying their desire. A participant decided to proceed with bariatric surgery when friends and family encouraged her to, even when she had no desire to lose weight. She said, "I wouldn't even care if half the people didn't love my body." Another participant disclosed that her desire to lose weight was not due to "anything

external” and would say later in the interview, “I am uncomfortable with how I look.” All three participants disclosed their strengths to the interviewer (i.e., I’m very independent, I’m the leader of everything.) when it was unrelated to the interview questions. The following was an example of this phenomenon when she was discussing outside challenges that negatively impacted her body image:

Like I was at a major university, I was working in facilities, division of operations, and it was a shit show there. And I was a very big shark in a very small pond ... When I was 23, I’d only been working there a year and a half, and I got like I literally prepped our executive director ... And he secured us in addition to our normal budget of \$140 million, I got an extra \$7 million a year just for remodeling of certain properties ... So just to give you an idea, that was a year and a half in. So now we’re 5 years in. The entire budget. Our senior VP referred to it as [participant’s] slush fund.

After this comment, she discussed a weight-bias interaction that occurred between her and her employer.

The three participants also referenced their weight numerous times throughout the interviewing process, emphasizing its importance. Participants disclosed their weight 22 times throughout the interview. Such disclosures include: “I kept myself at like 190 to 230 lbs. until I had the baby” or “I actually dropped 45 lbs. in 6 weeks” to highlight different times in their lives. These individuals also acknowledged their size numerous times through euphemisms or descriptors ($n = 15$), such as “my fat ass” or “big girl.”

Global Theme 3: Participants’ Experience with Weight Stigma

Participants have experienced weight stigma and discrimination in numerous areas. This network included two organizing themes and five basic themes. According to the data, all three participants have experienced weight stigma at their place of employment (e.g., “where [the employer] made me go during the middle of the day and, like, jog around the block”), in interpersonal relationships (e.g., “I know I am being perceived differently”), and in larger

systems (e.g., “like not [being able to ride] on a roller coaster”). The medical field was another place where participants experienced weight stigma. Medical providers would often tell participants to lose weight and make assumptions about the cause of a diagnosis. For example, “Honestly, doctors would always say, like; obviously you need to lose weight. Obviously, you would need to lose [weight]; your back problems are probably because you’re so heavy.”

Participants were also aware of the stereotypes that were being placed on them. One participant disclosed, “There’s an assumption that there’s something wrong with us who have bigger bodies. We’re either lazy or not smart, or there’s something detrimentally wrong with us that we don’t look like everybody else. And that hurts.” Participants also shared that they have experienced others being uncomfortable around them or providing unsolicited advice about their health. A participant talked about a conversation she had with her friend about her back pain, “Like my friend the other day said, well, you know, honestly, like your back probably hurts because you’re so heavy.” She shared that her friend immediately assumed it was due to her weight rather than inquiring about other reasons. Another participant shared how her friends sometimes avoid acknowledging her size, “I was like talking about my weight and or something. Like it wasn’t a big thing. It was just like, and she’s like, ‘Well, you’re not fat.’”

Global Theme 4: Negative Impact of Weight Stigma

Weight stigma negatively impacted participants’ well-being and relationships with their bodies and others. There are three organizing and 10 basic themes. Participants experienced shame and self-critical due to how they have treated their bodies. One participant compared her body to “a deep, deep secret that everyone could see.” Another said, talking to herself, “You got to get shit together, Mom.” after she realized how her size increased after a divorce. Participants also reported feeling self-conscious in public due to their size. One participant lost about 400 lbs.

throughout her bariatric process and stated that after losing weight, she became more self-conscious about her body, “Everybody looks at me crazy like I have bones sticking out of me everywhere.” Another shared, “It was hard to have positive social interactions that I didn’t feel self-conscious about my weight,” as her body increased. Participants also shared that they were anxious about how they were being perceived as women in larger bodies, such as “I don’t want to be seen as the dumb fat girl. I don’t want to be the fat girl who’s always funny.”

Participants also compared their bodies or body relationship to others. Two participants provide examples for this theme. One participant beginning the initial stages of her bariatric process, expressed her frustration with not losing weight easily, “Women at my weight can walk around the block and start to shed pounds.” The second participant compared her body to a high school friend, “There’s this girl, [participant’s acquaintance]. She’s as big as me my whole life, if not bigger.” Isolating oneself was also common for all three participants, either to avoid weight bias or to assist them in losing or maintaining weight. One participant shared how she “can’t be doing social events” due to “the amount of energy and effort it takes to lose weight.”

According to the data, participants further perpetuated weight stigma due to them holding certain beliefs around size. For example, one participant stated that “people who are morbidly obese and have been for a long period ... [they] need to kind of either close the door on their issues or open the door and examine themselves to deal with [their] weight.” Others accepted the consequences of weight stigma saying, “I’m visually different and, so that puts me at a disadvantage.” Participants also held stereotypes about their size, such as “I’m a big girl, so I love to cook.” Another discussed the difficulty of finding a romantic partner and shared, “Yeah, very few of the people who are intellectually a match and goal-wise a match or also into overweight women.”

Global Theme 5: Bariatric Process

Participants ($n = 3$) underwent the bariatric weight-loss process for their weight-focused treatment, a unique long-term process with numerous interventions in the medical and psychological fields. There are three organizing and seven basic themes. Participants shared that their bariatric process was long-term (e.g., “I did a whole year of prepping”) and began with non-weight-focused goals (e.g., “Not for looks, not for outside people’s satisfaction, but as a tool to get me through my life”). All three participants also had their own unique experiences throughout the treatment process. The one participant who completed the whole process—preparation, surgery, and recovery—shared the negative side effects she experienced, “I almost died losing weight several times. My kidneys shut down. I was in the hospital several times from dehydration.” Others discussed how the mental health part of the treatment was the most impactful aspect of the bariatric process. One of these individuals said, “I didn’t do any other service except for the therapist. And it was because really what I was dealing with was the emotional, the mental stress, all the things in my life and how it impacted my eating.”

Participants experienced medically based interventions. Nutrition was a service that all three participants participated in before surgery. Participants discussed changing their relationship with food, such as “so instead of eating half a gallon of ice cream, I can have two avocados and still feel the same.” Another discussed how she learned to create boundaries with food, “I don’t have the ability to not order Chinese food. Remove the app from your phone. Don’t have food in the house for cheat day. Don’t do it.” All three participants were also prescribed medications (e.g., “they gave me Prozac”).

All three participants had diverse mental health interventions. Participants ($n = 3$) had to complete a psychological assessment to see if they were a good fit for bariatric surgery (e.g., “I

had to do a test on it”). Two participated in psychoeducational groups to assist with preparing for surgery. A participant who was in post-recovery during the interview shared, “They also sent me to DBT training, which is dialectical behavioral training, and that actually helped me figure out how better to cope with things.” The participant who had a negative experience with bariatric surgery shared how the bariatric process changed her view on what the goals of mental health providers are, “I think other people just need to kind of realize the psychiatrists, the mental health doctors, they are more concerned with ‘how do you feel?’ What ... [how does] yourself make you feel?”

Global Theme 6: Participant’s Bariatric Experience

In this network, there are three organizing and seven basic themes. Participants generally expressed satisfaction with their medical and psychological progress in their treatment. A participant beginning her physical preparations for bariatric surgery shared, “Three years I worked with [her psychologist], it was kind of the best I have ever felt in my life.” Two participants reported that the treatment was not holistic; one said:

I was offended, and I was really kind of put out, like ... I already know. Like, why are you telling me about this stupid food triangle? ... I remember being really frustrated. I’m like, can we just get to the stuff that I need to know so I can fix myself?

Another participant shared that it felt that they “didn’t look at the fact that [she] didn’t eat that much” and did not assess her body needs accurately.

Participants underwent several psychological changes, including perspective shifts in how they approached their relationships, bodies, food, and self-blame. A participant shared that she often had difficulty depending on others before her treatment. During her therapy intake, her psychologist asked, “Why? Why won’t you talk to these people? ... They talk to you about their stuff. They lean on you; you take on everybody’s crap. Why can’t they take on yours?” This

discussion assisted her with “talking more about her problems” to others. Another shared that she felt pressure to return to her post-surgery weight after her child but did not want to return to treatment due to negative side effects. She shared that her mental health provider asked, “Well, how do you feel about it? ... Why is how you feel wrong?” she realized through this interaction, “I guess almost. It never had anything it [losing weight] to do with me,” and that it was about others’ desire for her to be in a smaller body. Participants also partook in CBT and DBT interventions ($n = 2$) (e.g., “And then they teach you like grounding things. They teach you opposite of action, all kinds of things. So that was really cool to know that I had that in my toolbox.”).

Participants ($n = 3$) shared that they had a positive rapport with their weight-focused providers but sometimes felt pressure to fulfill their weight-loss recommendations. The participant who experienced challenging side effects shared how her providers would “come in running to the hospital in the middle of the night” and support her while receiving treatments for side effects. However, the same providers continued encouraging her to lose weight, even though she did not want to lose more. Throughout the interview, she referenced how they wanted her to “lose 50 [more] pounds” or reach her “goal weight.”

Global Theme 7: Factors that Assisted and Challenged Body Appreciation Development

Multiple factors assisted or challenged body appreciation development. The network of this global theme has four organizing and 14 basic themes. Participants having health concerns increased their appreciation for their bodies. Two participants experienced health concerns before treatment began, which they reported assisted them in developing body appreciation. One of these individuals shared that she began appreciating her body after learning she was vitamin D deficient and anemic. She shared, “I was learning like I truly was like messing my body up, and

then my body couldn't carry me into like the second half of my life." Through this experience, she began to recognize "that your body is a tool that you carry for your whole life ... This houses my heart. You know, my soul in here ... And so those are really interesting lessons to learn."

Interpersonal relationships also supported body appreciation development. A participant discussed her daughter and wanted to model a positive body relationship for her. She shared:

My daughter, who's eight, and I really want her to know, like, your body is a tool. That's all it is, you know, you feed it well, you work it hard, and then that's all. You don't have to focus on anything more, you know? So, I always tell her we're strong and long.

Another disclosed that having someone to "talk to" and "sharing" her experience with others has also been beneficial to her body appreciation development.

Feeling pressured to fulfill beauty standards diminished the effects of body appreciation. Societal beauty standards were mentioned twice by participants. One participant shared that she often had difficulty liking her body shared due to media representation. She disclosed, "I look at some model on TV and feel bad about myself." Another shared that "the hardest part is not to focus on all the little things that are wrong ... So it's hard not to [deleted word for clarity] focus on those little things because [of] like society."

Participants also shared that others' bias perceptions of them negatively impacted body appreciation. One participant stated, "It was very, very difficult for me to match up that other people were perceiving me as overweight, fat, and stupid. And a lot of the negativity." Difficulty finding clothes also lessened the effects of body appreciation. A participant shared her shopping experience:

I got tired of always having to shop at Walmart for the three x or above. Once I hit that, I'm like ... Yeah, this is bull shii. I'm not doing this like, you know, like I couldn't. Right. So that was very frustrating.

Emotional and psychological health also seemed to affect body appreciation development. Participants who were having difficulty with mental health (e.g., “I do suffer from depression”) reported difficulties with developing body appreciation. Another aspect that challenged body appreciation development was struggling to identify and follow their values. One participant discussed how she took time to reflect on her wants and values when deciding whether to return to weight-focused treatment. The following is her experience:

But it took me, like, after doing that for a few years, to look back and be like, who was happy during that situation? Yeah, like, who is comfortable during that situation? Everyone else but me. Like, that’s not fun.

Body guilt and negative self-perception also prevented body appreciation development. During the interview, a participant reflected on her journey and said, “You know, like, I have not been good to my body, and, you know, I’m changing that.” All three participants also discussed having trauma in their past.

The amount of effort to lose and maintain weight loss may negatively affect body appreciation for the three individuals. The individual beginning her bariatric surgery process disclosed that if she could be “super restrictive for six months,” she knew the weight would “drop off;” otherwise, losing weight was difficult for that participant. The same participant shared how challenging weight loss can be for her and her disappointment that it was not as easy as she had been told to believe. She voiced, “the reality is that just my body type, I have to be extremely restrictive and highly physically active to lose weight.” This basic theme is also related to the following global theme that captures one’s relationship with their body after weight-loss treatment.

Two participants also discussed their discomfort with body positivity or seeing higher-weight people feeling comfortable in the media. The following is one participant's experience,

When they're trying to push body positive stuff on people, like putting a 400 and 500 lbs. person on the front of a magazine, it is going to upset some people, and then it's going to get people talking about it, and it's going to bring more attention to it in the other [bad] way. So how did that just help that person?

Movement was also critical in developing body appreciation; how a participant approached it can promote or challenge body appreciation development. The data displayed that participants struggled to find pleasurable movement when movement was associated with weight loss. A participant discussed how she "work[ed] out 10 times a day" when she began her bariatric surgery preparation. Participants also internalized the idea of "no pain, no gain" as they discussed their movement. One participant disclosed, "that ability to like my feet hurt, my ankle hurt like I was exhausted. But the fact is that I could do all that, and I could keep pushing myself. And like, I didn't feel great during that." Two participants discovered different types of movement that they enjoyed, such as yoga. A participant shared that after she found pleasurable movement, her body began to "crave it."

Global Theme 8: Food and Body Relationship After Weight-Loss Treatment

Following their treatment, participants reported experiencing various changes in their relationship with food and their body. This network has four organizing and 11 basic themes. After treatment, participants experienced more mindful eating (e.g., "It's very important for me to have fresh fruits and vegetables every week") and created food boundaries with foods that they deemed unhealthy (e.g., "I'm willing to give up chocolate cake. But like, I have to have a taco every once in a while.") Participants also shared that they were better able to know what foods were beneficial for their health, such as the following example, "You know, like, I still get

that fullness. I still get that almost mouth satisfaction. But I'm not putting fat in. I'm not putting just processed foods."

All three participants discussed how they continue to restrict or diet after treatment. One participant disclosed, "My relationship with food is very restrictive and planned." According to the data, this approach negatively impacted participants' well-being because weight loss was difficult to achieve and maintain. One participant discussed how she avoids social events due to the amount of "energy and effort it takes to lose weight." She said it means she "can't be doing social stuff."

Global Theme 9: Positive Impact of Body Appreciation

Participants who appreciated their bodies experienced improvements in their intellectual, emotional, and social well-being. Their relationship with their body also improved. There are two organizing and six basic themes. Body appreciation improved participants' mental health (e.g., "So I learned that I was hiding emotions"), increased empowerment (e.g., "I finally learned that if you ask for help. Sometimes, you know, you get help."), and having more in-tune relationships with their bodies (e.g., "I've noticed like, oh, my body does miss moving"). Participants also experienced increased self-esteem and saw themselves as worthy; for example, "I've gained self-confidence ... I am who I am, you know, like this is me."

The participants' external world has also been impacted by body appreciation development. The data shows that participants felt more connected to their loved ones while in treatment. Two individuals discussed increased vulnerability and openness. The following is one example of a participant who discussed how the mental health aspect of treatment assisted her interpersonally:

It's helped me a lot of other areas than food. It's helped me in my relationship with my family. It's helped me in my relationship with my friends. It's, I mean, it's taken a lot of the stress and anxiety out of how I deal with those situations.

The participants' communities also grew. For one participant, this was finding "groups to join" for movement purposes, such as a "Fat Girls Hiking" group. Another began volunteering and teaching painting classes, which brought her "life satisfaction."

Similar Themes Between the Weight-Neutral and Weight-Focused Samples

Due to each group experiencing a different phenomenon, it would have been unlikely for the two samples to have the same themes. However, the two groups had 14 similar basic and/or organizing themes. This section will review the basic themes that were similar in each group. For more information, please see Appendix D.

Body Image Influences

Both groups reported that romantic partners comprised an important factor in how they viewed their bodies. From the weight-neutral group, one participant shared, "I remember being so afraid of, like, physical touch because I was like, 'Oh no, they're going to think I'm fat or I've gained weight, or my body has changed.'" Another weight-focused group participant shared how she was in a "healthy relationship where he didn't care about [her] weight." She reported that this impacted her body image since the acceptance "spurred" her weight gain.

Experiences of Weight Stigma or Discrimination

Participants in both groups shared numerous and various examples of experiencing weight stigma or discrimination. The two areas that both samples reported experiencing weight bias were at their place of employment and by medical providers. At their place of employment, the weight-neutral group experienced implicit and explicit bias. Here is one example from a participant, "At work ... I actually reported one of my managers to HR because she made a

really, really two stupid comments to me directly about my own calorie intake at work.” The weight-focus sample reported more instances of explicit weight discrimination at work, such as “it was like hiking and I telling them that and [her boss] goes in front of everyone, and she goes, ‘Oh, I kind of thought you were getting gastric bypass or something.’”

Another common place where weight bias occurred was at medical appointments by providers. Participants in the weight-neutral sample shared that health providers often encouraged them to lose weight. One participant shared her experience of attending medical appointments, “like just annual checkups where I’ll get weighed ... then be told, well, don’t gain any more weight or what are you doing to exercise and lose weight? Like as if it was an assumption.” The weight loss group disclosed that medical providers often encouraged them to lose weight and attributed their weight as the cause of their health concerns, such as this example from a participant, “they always say ... you need to lose weight ... your back problems are probably because you are so heavy.”

Negative Consequences of Weight Stigma

Participants had two similar basic themes demonstrating weight stigma’s negative consequences. The first negative impact was how both samples felt self-conscious about their bodies, particularly in public. A weight-neutral participant discussed how she would often “compare” her body to others and was frustrated why people in smaller bodies were allowed to eat differently than her due to her size. Here is an excerpt from her experience:

I used to compare a lot ... And so I think that was a huge barrier, was just being around a lot of thin people in my life who didn't ever think about their body in a way that I did or never had really experienced, experienced it.

An individual from the weight-focused group shared how she often felt self-conscious after her bariatric surgery, “everybody looks at me crazy like I have bones sticking out of me everywhere.”

Both samples also experienced anxiety due to weight bias. A participant from the weight-neutral group shared, “I think I had a ton of anxiety about my body and how it looked ... I got a very adversarial relationship with my body.” A member of the weight-focused group discussed how she had anxiety about developing medical conditions that were “self-induced.” She shared that she would have much more anger towards and decrease her “appreciation” for her body if she developed an illness.

Treatment Interventions

Experiencing a “perspective shift” in treatment was common for the weight-neutral and weight-focused samples. The weight-neutral sample often experienced various perspective shifts through psychoeducation. Here is one example of a perspective shift a participant experienced while struggling to integrate weight-neutral theory into daily practice:

I have all of this background information if I’ve read all the books and listened to all the TED Talks if I’ve done X, Y, Z. Why? Why am I still? Why is there still a blocker, and what is that? And, and I feel like seeing [therapist] kind of helps like move that, that blocker ... For me, was that like, OK, well, then it just, like, must be my problem. Like, there must be something fundamentally wrong with me that if I have, like I’ve been given all the tools, why can’t I implement them? And then realizing that, like, no, I didn’t actually have all the tools.

The weight-focused group experienced perspective shifts primarily within their interpersonal and body relationships. A participant who was just completing her post-surgery recovery said this about her relationship with her body:

I don’t feel like I was taught as a woman that your body is important. You know, it’s a tool that you carry throughout your whole life, regardless of babies and stretch marks and, you know, cellulite and all of that. But, like, this is my brain. This houses my heart. You know, my soul is in here. Like, what? What do I need to do with it?

Practicing Body Appreciation

The weight-neutral and weight-focused groups had two similar ways of appreciating the body. The first was practicing functionality appreciation. Those in the weight-neutral group often appreciated their ability to complete differing movements, such as “I walk 11 kilometers. So, I appreciate that my body can endure that.” Others appreciated the daily functions of the body. For example, one participant discussed how she is a “sensory person” and appreciates that she can be “physically affectionate.” Two participants in the weight-focused group appreciated that their bodies could complete movement activities. One example is, “I might be heavy as hell, but I don’t have to, you know. I can just dive right into an exercise routine. I don’t have to work up to it. And that is because of my body.”

Participants from both groups discussed that practicing body appreciation included modeling it for their children. For example, one member from the weight-focused voiced that she wants her daughter to know that her “body is a tool” and that to take care of it, she will need to “feed it well, you work it hard, and then that’s all.” A member from the weight-neutral group discussed how she practices body appreciation by encouraging her son to know “there is an alternative to hating your body.” Another weight-neutral group member discussed how she has “purposely never talked about like being on a diet” in front of her daughter, who is now a toddler. She said she hopes to continue that practice as her daughter grows.

Factors that Increased and Challenged Body Appreciation

Movement was the only factor that both groups reported promoted body appreciation development. The weight-neutral sample discussed when movement came from a “place of care,” it seemed to assist with development. The weight-focused group reported that they often “craved” movement and enjoyed “challenging” their body through exercise.

Both samples struggled to find comfortable clothing that was representative of them. Eight participants discussed the difficulty of finding clothes and how that negatively affected their relationship with their bodies. For example, one participant from the weight-neutral group said it was affirming when her “straight-sized” therapist said it “wasn’t her fault” for not being able to find clothes. Another participant from the weight-focused group shared how it negatively impacted her when she could only shop from a big box store, “I got tired of always having to shop ... for the three x or above ... So that was very frustrating.”

Impact of Body Appreciation

Participants had four similar basic themes regarding how their treatment and development of body appreciation impacted their well-being. Both samples reported having a better relationship with their food after treatment. A participant in the weight-neutral group discussed how she can “now I only cook, eat, and enjoy” without becoming “psychotic” about reading the labels and nutritional information. Another discussed how she “doesn’t have a lot of guilt associated with food” Individuals within the weight-focused group discussed how they experienced increased mindful eating and created food boundaries. Here is one participant’s example of increased mindful eating after her bariatric surgery:

I’ve had to really it requires this presence and focus on what I’m doing. So, I’ll eat a little bowl, and I’ll have like three bites, and then I put it away, you know, like, okay, let that sit, let’s figure it out. And so, I think, I think especially with the surgery, it’s allowed me to like reset how I actually approach what I feel my body.

Most participants experienced an increased sense of worthiness after their treatment. The following is an example of that increased worthiness from the weight-neutral participant:

You know, this little moment where I praised myself and congratulate me because I don’t have those problems to be the perfect one, to look the prettiest, and that’s it. Because I know who I am. I know that I’m pretty, and I know how to put myself above. And I go I can go out without makeup, without a problem, because I don’t feel ashamed, you know?

Another example of this phenomenon is from a weight-focused participant. One participant discussed how she felt in her body post-bariatric surgery,

I've been able to let that go a lot, I've gained a self-confidence ... I'm like, I am who I am, you know, like this is me. And that's been interesting because then you're not I'm not hiding behind anything anymore.

Participants also reported feeling more empowered after treatment, specifically through self-advocacy and setting boundaries. A participant from the weight-focused group shared that she was beginning to realize that if she “asked for help ... sometimes, [she will] get some help.” In the weight-neutral group, this was seen by one participant who terminated her mental health provider after having a weight-bias interaction. The following is her experience, “But that really was a turning point for me, just in terms of, like, I don't know what I want from a provider, but that's not it.”

Developing body appreciation positively affected participants' interpersonal relationships. Both samples found that they felt more connected to their loved ones. A participant discussed how being “appreciative of her body” led her partner “to feel more appreciative” towards her, which increased their physical intimacy connection. A participant in the weight-focused group shared how she is beginning to volunteer more since treatment and feeling more comfortable in her body.

CHAPTER V: DISCUSSION

The current research aimed to describe the experience of women in larger bodies who sought treatment for body image concerns within a weight-neutral framework, hoping to learn what aspects of weight-neutral treatment assisted them with developing body appreciation, contributing to their ability to flourish. A comparative analysis also occurred within the research, comprised of participants who received weight-focused treatment. The comparative analysis provided knowledge about how body appreciation development may differ between the two types of interventions. Body appreciation is the most comprehensive facet of positive body image and is associated with numerous behaviors such as accepting, protecting, care-taking, and respecting one's body (Avalos et al., 2005; Tylka, 2019; Webb et al. 2014). Body appreciation is having gratitude for one's body and everything it does and represents (Avalos et al., 2005; Razmus, 2018; Tylka, 2011, 2019; Tylka & Wood-Barcalow, 2015a, 2015b; Weinberger & Luck-Sikorski, 2020). Learning about the development of body appreciation will assist mental health providers in supporting and treating body image concerns for people in larger bodies.

The research explored the following three questions: (a) How have women in larger bodies found body appreciation within a culture that often stigmatizes and discriminates against them? (b) How have their weight-neutral treatments promoted this development? and (c) If any, what other internal or external factors affect the progression of body appreciation? This chapter will be organized to explore the research questions in-depth by reviewing both samples' results and assessing how they interact with the current literature. Each section will begin by discussing the phenomena that emerged from the weight-neutral sample and then the weight-focused. After each sample's results are discussed, a comparative analysis section will highlight the differences between the two samples, exploring how the data and research understand their differences,

including how the two samples approached romantic relationships and the difference in their BAS-2 scores. After discussing the results, the chapter will conclude by reviewing research limitations, future research recommendations, and clinical implications.

How Was Body Image Developed?

Weight-Neutral Group

The weight-neutral group found that body image development began in childhood and was influenced by family and romantic partners in adulthood. Childhood is a critical time for body image development; family and friends influence body image, particularly in the strive for thinness (Harrison, 2019; Murnen, 2011). Caregivers and family appear to be the main sources of information about how a body should be treated and what it should look like. Most of the participants in this group discussed how their childhood impacted their body image development. Many said that their first messages about the “ideal body” came from family members discussing other people’s bodies or seeing their caregiver’s discomfort with their own bodies and trying to change through dieting. For many of the participants, their caregivers were the ones who introduced them to dieting and encouraged dieting behaviors. Ideal body messaging would be further reinforced when the family would celebrate participants’ weight loss or for having features that were considered ideal. This appears to be a common phenomenon for many people since caregivers often unknowingly partake in weight discrimination (Burmeister et al., 2013; Crandall, 1994; Tomiyama, 2014).

For many participants, restricting one’s food intake started in late elementary or middle school, potentially believing it would increase others’ acceptance of their bodies. Feeling that others accept one’s body is a significant factor for positive body image (Paquette & Raine, 2004; Razmus, 2018). When people feel their body is unaccepted, they internalize negative messages

about it and feel unlovable and unworthy (Burmeister et al., 2013; Crandall, 1994; Tomiyama, 2014). As a result of the internalized messages, many cope by trying to change their body to be more acceptable, thus restricting their food intake like the participants (Brown, 1989; Harrison, 2019; McKinley, 2011; Murnen, 2011). Another reason many participants may have begun dieting is to bond with other women. Dieting provides an opportunity to bond by sharing “dieting secrets” and results (Harrison, 2019; Murnen, 2011). These food-related behaviors seemed to continue into adulthood for many of the participants, which was seen in their pre-treatment food relationship. All participants discussed how they would often label or moralize their food and restrict what they ate.

The body image messages that weight-neutral participants experienced continued into adulthood and were reinforced by caregivers, extended family (i.e., grandparents, in-laws, etc.), and romantic partners. Romantic partners comprised the most important influence on body image for the participants in adulthood, which is supported by current research (Paquette & Raine, 2004; Razmus, 2018). Many participants spoke about how previous partners would body shame them, which caused participants to internalize negative body image beliefs further. Participants also shared that they feared their partners would not accept their bodies if they were not attractive. This fear may stem from the objectification theory, where women learn that their worth is determined by how others perceive and desire them (Fredrickson & Roberts, 1997; Murnen & Smolak, 2019; Tylka & Calogero, 2019).

The weight-neutral group highlighted how values and body changes could influence body image development. Most participants held progressive and feminist values, which caused them to question the “ideal body” and become curious about the dissonance between their values and how they treated themselves. This appeared to improve their relationship with their body, as

research shows. Identifying as a feminist may promote body satisfaction, but it does not mean it is always a protective factor; many still partake in disordered eating behaviors (Borowsky, et al., 2016).

Participants also shared that they experienced numerous body changes throughout their lives (i.e., puberty, aging, pregnancy), which also impacted their body image development. In the interview, the participants often utilized these changes as “timestamps” to demonstrate how their body appreciation developed. For most body changes, they mentioned grief or disappointment with how their body changed, with the exception of pregnancy. This pattern was particularly true with weight gain. The disappointment or grief may be due to their body no longer fitting what society desires and experiencing a decrease in their worth, which the objectification theory suggests (Fredrickson & Roberts, 1997). It may also be due to the loss of privilege that comes with being thin or having a body that is more of the “ideal,” which one participant mentioned (Fikkan & Rothblum, 2012; Fredrickson & Roberts, 1997).

Weight-Focused Group

In the weight-focused group, various factors affected a participant’s body image, such as their relationship with food and interpersonal relationships. Before treatment, participants struggled with their food and body relationships. Two participants discussed how they believed their food intake was a way to cope with their emotions or as an “addiction” to numb their feelings. These participants also shared that their size negatively impacted their lives and emotional and physical health, leading them to weight-focused treatment.

Interpersonal relationships comprised another factor in this group’s body image development, specifically the comments they received or how loved ones may perceive them due to their size. As previously stated, interpersonal relationships are significant for body satisfaction

(Paquette & Raine, 2004; Razmus, 2018). Future or current romantic partners' comments greatly influenced body image, and each participant said that they would change their bodies for their partners if they asked or were uncomfortable with their size. Research shows that romantic partners significantly influence how women perceive their bodies through comments or the values they hold around their bodies and health (Paquette & Raine, 2004; Razmus, 2018).

Participants' children served as another interpersonal relationship that influenced their relationship with their bodies. Weight bias can begin as early as 3 years old, showing that size is a likeability factor for children (Pearl, 2018; Tomiyama et al., 2018). Participants may be concerned that their children's love or acceptance of them will decrease if they are in larger bodies. This fear seems to be why two participants said they would lose weight or change their bodies if their children were embarrassed by them. It appears that the weight-focused group has internalized the belief that women are valued by their looks, and they learned to view their bodies through an outside perspective to be accepted. Since their bodies do not meet the "ideal," it makes them feel less worthy, which is reinforced by weight stigma (McKinley, 2011; Tylka, 2019).

Comparative Analysis

The two samples had similarities and differences regarding their body image development. The first difference was that the weight-neutral group had more awareness about what factors contributed to body image, including values and life changes. The holistic perspective of weight-neutral frameworks may have influenced this awareness. Weight-neutral treatment encourages clients to build a relationship with the body, including understanding what factors impact that relationship (Bombak et al., 2019; Tylka et al., 2014).

Another difference in themes was the lack of mention of the body relationship before treatment by the majority of the weight-neutral group. One participant within the weight-neutral group discussed her baseline body relationship. She shared that she experienced disconnection or disembodiment with her body. Due to societal standards of beauty, many disconnect from their bodies' signals, needs, or desires to fulfill the ideal appearance or thinness (Murnen & Smolak, 2019). Disconnection may also be a way to cope with body dissatisfaction by repressing the discomfort one has in their body. A weight-neutral participant shared that she copes with the discomfort by "not thinking about [her] body." Disconnection from the body may be why many weight-neutral participants did not mention their pre-treatment body relationship.

The similarities between the two groups were their discussion about their relationship with food before treatment and the importance of how their family and friends perceived them and their bodies. Each sample mentioned their baseline food relationship but discussed them differently. The weight-neutral sample had more insight into their food behaviors and the messages they internalized about food intake. The weight-focused group tended to see their relationship with food through an individualistic lens, only looking at themselves and their actions. This contrast may be due to the difference in treatment approaches.

Weight-neutral treatments encourage intuitive eating, following one's internal cues of hunger and satiety rather than relying on external cues (Bombak et al., 2019; Mesinger et al., 2016; Tylka et al., 2014). Creating a subjective relationship between food and the body and learning what factors are interfering with that relationship may assist patients in learning that they are not at fault for their body size and that many aspects contribute to size beyond calorie intake and output (Bacon & Aphramor, 2011; Harrison, 2019, Tribole & Resch, 2012).

Weight-focused treatments, such as behavioral weight-loss treatment programs (BWLT) or

bariatric surgery, often focus on changing the individual's behaviors and encourage a calorie-deficient diet to lose weight; this continues to reinforce the belief that individuals have complete control over their size, which can induce shame when weight loss does not occur or maintained (Bombak, 2014; Butryn et al., 2011; Mesinger et al., 2016; Perdue & Neil, 2020; Tylka et al., 2014).

Family and friends' perceptions of the participants' bodies were significant for both groups. Both groups mentioned the importance of romantic relationships but saw their impact differently. The weight-focused group demonstrated an external locus of control in romantic relationships where they believed their size or weight influenced their romantic relationship status. They discussed how they would change their body for their partner's acceptance. The weight-neutral group did not. They exhibited more of an internal locus of control, believing their behaviors, decisions, and personal connections affected their romantic relationships. This may demonstrate higher body acceptance among the weight-neutral group. When individuals believe their bodies are acceptable, they are less willing to be preoccupied with changing their outer appearance and pay more attention to how it feels and functions (Paquette & Raine, 2004; Razmus, 2018).

How Has Weight-Bias Affected Their Relationship with Their Body?

Weight-Neutral

Participants experienced societal messages that consistently told them that their body size was unacceptable and should try to find ways to change it. These messages occurred in numerous spaces, such as in public (i.e., wedding dress shopping by a store employee or not having modifications in exercise classes), at their place of employment, in healthcare settings, and through the media. They reported experiencing explicit and implicit bias. Explicit bias was often

a comment on their food intake (e.g., “I actually reported one of my managers to HR because she made a really ... two stupid comments to me directly about my own calorie intake”) or the assumption that they were trying to change their bodies by medical professionals or by others in public (e.g., “You plan to lose weight by the wedding?”). Implicit bias appeared more common, such as others assuming their employment based on their size or seeing insufficient space on public transportation.

Weight stigma or bias negatively affected those in the weight-neutral group. Participants reported that their experience with weight stigma caused them to feel pressure to change their bodies, increased anxiety, and promoted preoccupation with their and others’ bodies. They also demonstrated or discussed how they coped with weight bias, such as minimizing the impact of weight bias or avoiding social gatherings. Three participants also discussed how perfectionism was a way they coped. They shared that it provided some structure when it did not feel like they had control. The effects that these participants experienced were similar to research exploring the negative impact of weight stigma (Carrard et al., 2018; Paquette & Raine, 2004).

Weight Stigma in Health Care and Its Effects

Within the weight-neutral sample, weight stigma primarily occurred in healthcare settings by medical and mental health professionals. Healthcare settings are the third most common place weight stigma that occurs, after public settings and insurance (Hatzenbuehler et al., 2009). Participants experienced anti-fat bias by healthcare providers. This bias occurred by providers assuming their health by the participant’s size (e.g., being “shocked” they had healthy blood pressure, cholesterol, and blood sugar levels). They also experienced weight bias comments or assumptions by professionals, such as blaming them for their diabetes diagnosis. When these incidents occurred, it would often induce shame. These incidents of weight bias are common

within these settings and often cause patients to become disengaged or avoidant of healthcare and less forthcoming about their health concerns when speaking with a professional (M. C. McHugh & Chrisler, 2019).

Participants also discussed a lack of awareness of body image, size diversity, or weight-neutral care, particularly for mental health providers. Numerous participants shared that their mental health providers often did not assess for body image or disordered eating, which prevented them from discussing their body image concerns. This has been found as a common phenomenon within the mental health field which often can lead to misdiagnosis (M. C. McHugh & Kasardo, 2012). Some participants were disappointed that mental health providers often lacked knowledge about the fat community and their experiences or weight-neutral care. This may be due to a lack of graduate training about sizeism and the fat community, and neglecting to consider them as an identity within the diversity realm. Size identity is often ignored, pathologized, or seen from a medicalized perspective in graduate programs (M. C. McHugh & Chrisler, 2019).

These enactments of size bias regularly impacted the care participants receive in healthcare settings. Many participants reported increased anxiety when seeking medical treatment, which is concurrent with the research (Phelan et al., 2015; Tomiyama et al., 2018). Participants also reported terminating their healthcare relationship, often due to feeling devalued, ignored, or mistreated (Tomiyama et al., 2018). An aspect that was not seen within the research was the participants feeling that they had to choose between physical or mental health. Many disclosed that staying at a smaller size would have negatively affected their mental health, but they would have been seen as healthy by providers. Two discussed that they “chose” their mental

health over their physical because struggling with their mental health affected them more than their physical health.

Weight-Focused

Participants have experienced explicit and implicit weight stigma and discrimination in numerous realms, including their place of employment, larger systems (i.e., theme parks), health care systems, and interpersonal relationships. Individuals in the weight-focused group primarily discussed incidents of weight bias in their interpersonal relationships. They have perceived others as being uncomfortable with their size and have been given unsolicited advice about their body or health due to being a higher-weight person. Participants disclosed how their friends or family would often not acknowledge their size by denying it (i.e., “You are not fat!”) or would provide advice or blame the individual’s health concerns on their size. These are common occurrences for people in larger bodies because people often see their size as a “health concern” rather than seeing these comments as a form of bias (Major et al., 2012; Tomiyama, 2014). All three participants also shared how they believe others often see them through common stereotypes, such as people in larger bodies being lazy, lacking intelligence or self-control, or being seen as the “funny girl” (Pearl, 2018; Roehling et al., 2009).

Weight bias negatively affects participants’ body relationships and psychological and social well-being. Participants often saw their bodies, or themselves, as “bad” because of their size. This perspective may decrease their body appreciation, which was seen in their preoccupation with theirs’ and others’ weight. Comparing one’s body to others has been seen as a predictor of body dissatisfaction (Myers & Crowther, 2009). Participants also discussed how they would self-isolate to avoid weight bias or to assist them when trying to lose weight, which decreased their opportunities for connection. They were also self-critical when discussing how

they treated their bodies (e.g., two pronounced that they were “harming” their bodies for being of higher weight) or judged themselves for not being in a smaller body. They also reported feeling self-conscious in public and experiencing increased anxiety about their size. It is believed that internalized weight stigma exasperated weight stigma effects.

Internalized weight stigma is the awareness and agreement of negative stereotypes about those in larger bodies and applying those stereotypes to oneself, leading to self-devaluation or self-directed stigma (Latner et al., 2013; Pearl, 2018; Pearl & Puhl, 2016). This was seen in the weight-focused group. They often believed in these stereotypes by projecting those beliefs onto other higher-weight people and believed it was their fault that their body was in a larger size—such as highlighting the stereotype that they lack self-control.

These effects of weight stigma and internalized weight stigma may have made it uncomfortable for the participants to discuss or share their body experiences. While completing data analysis on this group, transcribing was often difficult because their thought processes were consistently non-linear or incomprehensible. This pattern was consistent with studies demonstrating how weight stigma can affect one’s ability to communicate their needs in healthcare settings. Due to the stress and anxiety that weight bias can induce, it can cause impairment of one’s cognitive abilities, decreasing their ability to communicate their needs or symptoms to providers (Phelan et al., 2015). Participants may have feared that the interviewer would place prejudice against them, likely increasing anxiety. Participants seemed to find various ways to cope throughout the interview, such as denial of their desires (i.e., “I don’t care what others think” or “It’s not about being in a bikini”), rationalization of their choice to lose weight, or sharing unrelated stories that highlighted their strengths. Participants also referred to

their weight numerous times throughout the interview. It appeared that their weight served as a timeline for their life or to emphasize that they recognized their larger size.

Comparative Analysis

The weight-neutral and weight-focused groups have had experiences with weight stigma and have felt the negative impacts of such a bias. However, it appears that those in the weight-focused group had more explicit examples of weight bias or discrimination within their interpersonal relationships. This may be due to most of the weight-focused sample being in larger bodies than those in the weight-neutral sample. As body size increases, many people believe it is socially acceptable to comment on another's body because they believe the person's "health is at risk." This would negatively affect how the higher-weight individuals feel in their relationships and community, particularly women (Bookwala & Boyar, 2008; Fikkan & Rothblum, 2012; Major et al., 2012). Also, experiencing more weight discrimination may explain their perceived higher discomfort with their bodies. Weight-focused treatment may also reinforce weight bias messages since many BWLTs do not discuss weight stigma and its impact (Jarry & Cash, 2011; Pokrajac-Bulian, 2018; Rosen, 2001). This may also explain the lack of identifying medical-based discrimination among the weight-focused group. Physicians significantly influence one's body image; due to their influence and expertise, individuals may not question their provider and internalize the belief that to "be healthy," one needs to strive for a thinner body (Paquette & Raine, 2004; Razmus, 2018).

All participants reported experiencing decreased psychological well-being due to weight stigma (i.e., lower self-esteem, body comparing, increased anxiety, increased isolation); however, there was more evidence of internalized fatphobia in the weight-focused group. As previously discussed, participants may not be educated about weight bias and its effects, and

these conversations can assist in decreasing internalized fatphobia. Learning about weight bias assists individuals in gaining awareness of how society oppresses and marginalizes bodies, creating the understanding that it is not one's fault for experiencing discrimination and that it is a societal problem (Kinavey & Cool, 2019). Having this understanding often assists people in larger bodies develop body acceptance and increases feelings of agency (Romano, 2018).

Lastly, the interview behaviors of the two groups were different, potentially demonstrating the difference in comfortability with their bodies. The weight-neutral sample could state when uncomfortable, answer the questions fully, and provide consistent linear and comprehensive responses. This was not the case for the weight-focused group, who had difficulty sharing their experiences.

How Has Treatment Promoted Body Appreciation?

Weight-Neutral

Participants experienced some change in body appreciation due to weight-neutral treatment. They saw their treatment as effective and were grateful for their provider and the treatment process. They reported feeling liberated, safe, and “normal” for the first time due to their treatment experiences. The therapeutic rapport, the provider's expertise, and knowledge about weight-neutral care and size diversity were important for effective treatment. Another important factor was the provider's offices, which demonstrated inclusivity of size and other identities through art and signage. The importance of these factors has also been demonstrated through research (Kinavey and Cool, 2019; Rothblum & Gartrell, 2019; Tylka et al., 2014; Wampold, 2019). Many participants highlighted the importance of the therapeutic relationship, saying that it was the “key” to their success. This is the most significant factor for effective treatment in general (Wampold, 2019). Weight-neutral treatment also provides another layer of

safety for higher-weight people because of the holistic approach to treatment where body size is not the focus, which reduces stigma and increases the client's comfort and disclosure rates (Tylka et al., 2014).

The providers' size was also an important factor for the participants. Five participants shared that it was helpful for their provider to be in a larger body due to their "shared experiences and understanding." This seemed to assist with rapport building. This data is consistent with eating disorder literature that has explored how the therapist's body can impact treatment and how therapists may work effectively with client reactions (Daly, 2016; Jacobs et al., 2010; Lowell & Meader, 2005; Rance et al., 2014; Warren et al., 2008 as cited in Schafer, 2014). This literature has summarized that participants often make assumptions based on the therapist's body size, such as their relationship with food or ability to assist clients with eating disorders (Rance et al., 2014). Schafer (2014) found that women in larger bodies often placed themselves in an inferior position if their therapist was thin or averaged sized, and many had beliefs that a thin therapist could not understand their concerns. However, this was not true for one participant in the weight-neutral group. She shared that her therapist was in an average size body which assisted with rapport and continued to say that working with a provider in a larger body would have been difficult. She disclosed that she felt hypocritical for having that thought, but it stems from a fear of not being accepted by a higher-weight provider since she continues to struggle with internalized fat phobia. She said that sometimes she feels that the fat community would judge her since she is not "body positive" about her body and fears that a higher-weight provider would also hold that judgment. As a result, she disclosed that she would feel pressure to demonstrate "body positivity," which would prevent her from disclosing her body image concerns.

Common Interventions for Weight-Neutral Treatment

Participants experienced a range of interventions while partaking in weight-neutral treatment. The interventions primarily targeted four areas: food, intra-relationship, body, and providing education about weight-neutral care, the fat community, and systematic weight oppression. The following section will complete a summary of each area.

Food-Based Interventions. Providing education about intuitive eating and nutrition was the primary focus of food-based interventions. It appeared that providers would have encouraged participants to be curious or “listen” to their bodies and what their bodies needed to be satisfied, energized, and feel comfortable. This is a key feature of intuitive eating, encouraging individuals to increase their awareness of their body’s response to food and learn how to make food choices based on that knowledge (Bacon & Aphramor, 2011; Harrison, 2019, Tribole & Resch, 2012). Part of this education for participants seemed to be challenging food rules they created throughout their life, such as “needing to have a colorful plate” or “never eating in bed.” Providers seemed to encourage participants to break the rule or utilize cognitive behavioral therapy (CBT) techniques, such as the Socratic method, to assist in identifying food beliefs that prevented participants from eating intuitively.

Intra-Relationship Interventions. Self-acceptance is the cornerstone of self-care, meaning people with strong self-esteem are more likely to care for themselves and their bodies (Bacon & Aphramor, 2011). Increased self-acceptance also seemed to be a goal for many participants’ providers, even registered dietitians ($n = 3$). Providers would often utilize self-compassion or empowerment exercises to assist with increasing self-acceptance. Participants also discussed how gathering insights into their relational and cognitive patterns regarding food, body, and interpersonal relationships was beneficial. This features the importance of providers

utilizing a holistic approach when working with body image. Internal and external experiences impact the body relationship; body image cannot be segregated into one dimension. One must consider the patient's identities, interpersonal relationships, internal experience, behaviors, community, and culture and how they interact with the body to promote body appreciation and PBI (Bombak et al., 2019; Carrard et al. 2018; Paquette & Raine, 2004; Tylka et al., 2014; Tylka & Wood-Barcalow, 2015b, 2015c).

Body-Based Interventions. Body-based interventions seemed to be the primary type of intervention. These interventions encouraged body appreciation by increasing positive embodiment, redefining movement, and their relationship with clothes. All participants discussed how their provider encouraged them to be curious and mindful about their body needs; by “listening to the body” and considering it a subjective experience. This approach encourages participants to connect with their bodies or experience positive body embodiment. Positive body embodiment is described as “positive body connection and comfort, embodied agency and passion, and attuned self-care.” Negative embodiment would be described as “disrupted body connection and discomfort, restricted agency and passion, and self-neglect or harm” (Piran, 2019, pg. 12). PBI and embodiment are similar, but embodiment considers five dimensions of bodily experiences, encompasses negative dimensions, and considers how sociocultural power structures affect the quality of embodiment (Piran, 2019).

Participants also discussed that treatment assisted them with redefining their relationship with movement. They shared that they changed their relationship with movement from utilizing exercise as a way to change the body to an activity that is life-enhancing and enjoyable, regardless of weight, which is part of the weight-neutral paradigm (Bacon, 2010; Bacon & Aphramor, 2011; Bacon et al., 2005; Bombak et al., 2019; Humphrey et al., 2015; Tribole &

Resch, 2012; Wilson et al., 2020). This was also an area where participants discussed listening and connecting to their bodies, highlighting embodiment. Providers who were treating the participants may have utilized the concept of Attunement with Exercise (AWE), which encourages movement to be physically safe and a mindful practice where the purpose of movement is a way to connect to the body by listening to internal cues instead of external and feeling pleasure and enjoyment while completing the activity (Calogero et al., 2019) Many of the participants shared that movement had become more mindful, pleasurable, and a way to appreciate the body demonstrating its connection to AWE.

Changing their relationship with clothing was another body-based intervention that many participants discussed. Clothes are an aspect of life that is often not considered as impactful to one's well-being; however, clothes are a way to express identities and embody who we are; hence clothes and the body are linked. Nevertheless, women in larger bodies often utilize clothing to camouflage their bodies due to needing to cover up their perceived imperfections, disrupting embodiment (Chattaraman & Rudd, 2006; Tiggeman & Lacey, 2009). Throughout their treatment, half ($n = 3$) the participants shared how their providers encouraged them to remove clothes from their life that did not fit, clothes that were too big or small or were uncomfortable, and to buy clothes that fit, were comfortable, and were reflective of the participants' personality and style.

Psychoeducation. Psychoeducation appeared to be a critical part of treatment for much of the weight-neutral group. Two participants discussed how they were introduced to weight-neutral philosophy and core values while in treatment. Providing this knowledge increased the participant's agency in approaching their body relationship (Kinavey & Cool, 2019). Most participants also discussed learning about the systematic oppression of people in

larger bodies, which assisted them in a perspective shift of understanding that societal oppression of larger bodies is “bigger” than them and that it is a “societal problem,” not a problem with them or their bodies. Lastly, most weight-neutral individuals received treatment from a registered dietician ($n = 3$), and they had the opportunity to learn different ways of measuring health, such as how to read their blood pressure or cholesterol levels. This knowledge increased participants’ feelings of agency and empowerment since it expanded their ability to advocate for the health needs in undesirable healthcare conditions.

Weight-Focused

The weight-focused participants had tried other BWLTs before beginning the bariatric process. Each participant shared that their bariatric process was long-term (3–5 years) and involved numerous steps, including medical and psychological interventions. The numerous steps included: preparing for surgery through calorie restriction and exercise, numerous physician visits, a psychological assessment, mental health and nutritional treatment, surgery, and post-operational care that includes calorie restriction and rest. Weight loss is expected at each stage. These steps seem congruent with common bariatric procedures (Cleveland Clinic, 2022; Mayo Clinic, n.d.). In this section, I will briefly summarize the different interventions these participants experienced and summarize their experiences.

Common Interventions for Bariatric Procedure

Medical Interventions. It appears that the participants primarily experienced medical interventions. They had numerous doctor appointments with their bariatric surgeon and primary care provider throughout their process to prepare them for surgery and manage side effects. They also shared that they were prescribed medications, such as psychiatric medicines for depression or anxiety or other vitamin supplements for deficiencies. They also shared that they experienced

nutrition classes or coaching with a registered dietician that taught them food strategies, such as “swapping” out unhealthy foods for healthier options. They also provided education on nutrition in general and eating plans to assist them in lowering their weight.

Psychological Interventions. Two weight-focused participants also shared that they completed a psychological assessment before surgery. The goals of presurgical psychological evaluations are to identify and treat preexisting psychopathology, identify patients who may need additional postoperative care, and identify alternative treatment strategies if the patient is not deemed a candidate for bariatric surgery. The assessment typically includes medical chart reviews and a comprehensive psychodiagnostic interview. The interview will generally gather information about eating patterns/weight loss attempt history, developmental history, history of mental health, substance use, cognitive abilities, social support, current coping skills, adherence, or motivations for surgery. Assessments may also utilize objective tests, such as the Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher et al., 2004) or the Beck Depression Inventory-II (BDI-II; Beck et al., 1996; Block & Sarwer, 2013).

Participants also experienced mental health treatment to assist them with their bariatric process. A participant shared that her primary psychological interventions were through psychoeducational groups focused on emotional regulation and self-esteem, specifically Dialectical Behavioral Theory (DBT). The other participants saw a provider through individual therapy or in both individual and group. Two reported that their mental health treatment provided insight into their relationship with food and how they used it to cope with distressing emotions.

Participants’ Bariatric Experience

The weight-neutral group had diverse treatment experiences. Most of the sample expressed satisfaction with their treatment progress and had a positive rapport with their

providers. While all participants reported positive rapport, one shared that her provider relationships were not salient and did not affect her progress. Two other participants shared that they often experienced pressure from their providers to lose weight throughout the bariatric process. One disclosed her disappointment with that approach because she felt they were not listening to what she needed for her psychological well-being. They continued encouraging her to lose weight, even though she deeply struggled with her body image after surgery and losing over 300 lbs. She reported having better overall well-being before participating in the bariatric process.

Much of the weight-focused sample also desired more of a holistic approach to their treatment. They often felt that the education was “too basic,” and their providers did not consider other aspects of their life, which seemed to interfere with their ability to listen to their bodies and needs. Research has shown that BWLTs are often utilized to prepare for surgery, primarily focusing on weight loss, calorie restriction, and psychological needs and behaviors that may prevent them from losing weight (Grilo et al., 2011). This narrow focus may be what participants experience as non-holistic.

Participants reported experiencing psychological changes or “shifts in perspective” in how they approached their interpersonal and body relationships and life satisfaction due to their mental health treatment. Due to treatment, they began to consider their body more and how they wanted to be in it. Their behavioral education, such as CBT and DBT, was also beneficial in helping them understand how they utilize food to cope with emotions and how to reduce self-blame.

Each participant had a unique bariatric experience. All reported feeling that the mental health interventions benefitted them most. Two individuals shared that their mental health

providers appeared more client-centered than their medical providers. The only participant to finish the entirety of the bariatric process shared that she had many negative side effects that caused her to be hospitalized numerous times. Due to the side effects and her negative body image in a smaller body, this participant has returned to being in a larger body and reports higher life satisfaction. This decision came after she conversed with her mental health provider about her values and what would lead her to live a fulfilled life.

Comparative Analysis

Since the two body image treatments hold different perspectives, there appears to be only one similarity between the two samples regarding how treatment promoted body appreciation development: the importance of psychoeducation. Psychoeducation is a humanistic approach that includes the client in understanding and treating their psychological concerns. It increases self-awareness and self-efficacy by providing patients with the tools to set goals, increase feelings of universality and control, and overcome challenges as they progress in treatment (Bäumel et al., 2006; Donkers et al., 2009). It also increases patients' agency for improving their health, relationships, and overall well-being (Bäumel et al., 2006; Donker et al., 2009; Kinavey and Cool, 2019). In both groups, one can see how psychoeducation has benefited them in gathering awareness of their relationships with food, body, and others, and in providing them the tools to continue their growth.

The difference between the two groups is quite apparent. First, the weight-neutral group's treatment appeared to be more holistic, which can be seen by the different areas of interventions used in treatment. The weight-focused group appeared to be more individualistic, meaning it was primarily based on the participants' ability to follow through with the treatment plan. There also appeared to be no body-based interventions completed by the weight-focused sample. One

weight-focused participant said her group therapy cohort discussed their discomfort with wearing swimsuits but did not allude to any interventions occurring. Body image interventions appear uncommon in the bariatric treatment process due to the belief that weight loss will improve body image. However, it is highly recommended for this population to complete body-based interventions due to the common body image difficulties that occur after treatment (e.g., adjusting to a smaller body and the attention they receive, “phantom fat,” etc.; Latner & Wilson, 2011; Pokrajac-Bulian, 2018; Sarwer et al., 2011).

Two other areas that seemed to differ are the importance of the therapeutic relationship and the participants’ ability to identify interventions. In the weight-focused group, the provider-patient rapport was not salient. While these participants said that their providers were helpful, they struggled to mention specific aspects of the relationship that were beneficial. One participant even said that the “relationship wasn’t important.” The weight-focused sample also had difficulty labeling different areas they discussed in treatment. These two phenomena may be due to the treatment’s primary focus on food relationships and exercise, or the motivations of participating in bariatric weight-focused treatment. To receive insurance coverage for surgery, weight-focused participants must follow a prescribed program, which may cause them to see interventions as an arbitrary step toward their goal of surgery versus integrating a practice of these interventions into their lifestyle (Cleveland Clinic, 2022; Mayo Clinic, n.d.).

What Other Factors Impacted the Progression of Body Appreciation?

Weight-Neutral

The weight-neutral sample had numerous factors, besides treatment, that impacted their progression of body appreciation. This section will review external and internal factors in depth.

It will begin by reviewing the factors that assisted body appreciation and then review those that negatively affected its development.

Factors that Assisted Body Appreciation Development

Community, movement, and learning about fat activism and perspectives through self-education were outside factors that significantly contributed to body appreciation development. When considering one's community, two participants discussed "wanting better" for the next generation, and other participants discussed how they wished others could experience body liberation. These desires increased their participation in social justice activities and fat activism, positively impacting their body appreciation development. This pattern has also been found in research on other psychological factors. Feminist-based research has found that when patients participate in activism or social justice activities, it can empower them and increase their feelings of self-efficacy because they are causing a change, which promotes psychological well-being (Kinavey & Cool, 2019). Participants also advocated for more inclusive health promotion policies at their place of employment and/or adopting a weight-neutral approach in their work as healthcare providers. Two participants shared that they modeled how to appreciate their bodies for their children since they recognized the importance of family influence, but also so their children recognize that "there is an alternative to hating your body."

Participants also shared that their body appreciation increased when others accepted their bodies. That emphasizes the research that was discussed in the "How Body Image Was Developed?" section that stated positive body image is highly correlated to one perceiving that others accept their bodies (Paquette & Raine, 2004; Razmus, 2018; Tylka & Wood-Barcalow, 2015c). Movement was another important outside-of-treatment factor that assisted with body

appreciation development. Participants discussed that when their movement practice came from “a place of care” and not attempting to change the body, it increased the body appreciation, similar to the AWE research (Calogero et al., 2019).

Last, self-education was an unexpected factor that promoted body appreciation. Half of the participants discussed how they introduced themselves to the fat community and weight-neutral treatment through self-education. After they became familiar with the literature, they began to seek weight-neutral healthcare providers. Many participants were introduced to weight-neutral philosophy and fat literature through social media. Social media and online communities, such as the Fatosphere, benefit people in larger bodies since it often provides a sense of inclusion in a world that excludes or harms them (Dickins et al., 2016).

Factors that Negatively Impacted Body Appreciation Development

Participants in the weight-neutral group experienced external and internal factors that challenged their body appreciation development. The primary external factor mentioned by all participants was the pervasiveness of “diet culture” in our society. When participants mentioned diet culture, they alluded to the social construct predicated on the fear of fatness, which states that some bodies, particularly thin, muscular, White, and able, matter more than others. It also perpetuates the thinking that these bodies equate health and moral virtue. As a result, it oppresses people who do not match its picture of health (Harrison, 2019; Kinavey & Cool, 2019). Due to diet culture, participants experienced other factors that impacted their body appreciation, such as weight stigma and discrimination; not feeling that their body is accepted; completing disembodied movement to change the body; and difficulty finding clothing they felt represented them and their identities. Two participants also shared that they feared being diagnosed with an illness associated with people in larger bodies, like diabetes. Participants stated that they were

nervous that their health providers would blame them—which one provider did—or that it would be their fault for developing a disease. This is an example of internalized fatphobia, where an individual believes it is primarily their fault for the onset of an illness due to their size rather than considering other factors, such as family history or environment. This belief stems from diet culture’s messaging about body size and health (Harrison, 2019).

Another external factor mentioned is the lack of representation of higher-weight people or accessibility for larger bodies in public spaces, exercise classes (i.e., demonstrating movement modifications in class), or within health-care settings. Representation can serve as an opportunity for non-dominant people to find community support and validation, as seen in other research discussing the importance of representation for marginalized gender and sexual identity, and Black, Indigenous, and other People of Color communities. Representation can also help reduce negative stereotypes about higher weight-people by increasing more exposure of this community to others who are not part of the larger size community. It would likely decrease the prejudice that others hold (Nadal, 2021). Two participants noticed the lack of representation of larger bodies in the mental health field and difficulty accessing weight-neutral mental health care. Both discussed their experience of working with clinicians who do not know about weight-neutral care or cannot continue services with a weight-neutral provider due to them not being insured. These participants desire more representation and weight-inclusive spaces in the mental health field.

Participants also experienced internal factors that affected their body appreciation development. Participants demonstrated self-criticism about their body appreciation progression, thinking it should be more consistent or at a higher level. This is similar to the research surrounding body positivity. Legault and Sago (2022) found that when individuals received messages that body acceptance or love was the only way to be happy, the participants

experienced higher levels of pressure than the groups that received messages that body positive comes from body acceptance from others or having authorship of one's body relationship. Those in the "must accept your body" group experienced as much pressure as those who were in the "thin ideal" messaging sample (Legault & Sago, 2022). When considering this research, participants in the weight-neutral group may feel pressured to demonstrate body appreciation and, when unable, become self-critical.

Three participants also shared that they sometimes feel unsafe in their bodies due to weight stigma. One participant discussed how she experiences a "trauma response," such as difficulty breathing and racing thoughts, when taking public transportation. She shared that most of her treatment has focused on reducing those symptoms. Others shared that they often become self-conscious in public, compare their sizes to others, or try not to "take up as much space." Safety and acceptance are important. When we do not feel safe in our bodies due to internal or external aspects is difficult to have body appreciation (Piran, 2019).

Last, all participants discussed how challenging it is to filter out negative body messages from society and others consistently. Filtering is rejecting the body-negative threats or messages and absorbing positive ones, and it is a facet of PBI (Tylka & Wood-Barcalow, 2015c). Filtering is an important coping skill because it builds a sense of agency and functionality with individuals' bodies and assists them in maintaining a positive body relationship. However, diet culture's pervasiveness can be challenging to filter consistently, negatively impacting an individual's self-esteem and body relationship (Wood-Barcalow, Tylka, & Judge, 2021).

Weight-Focused

The weight-focused group also identified factors outside of treatment that assisted or challenged body appreciation. The first factor that induced body appreciation was experiencing a

health concern or illness. Two participants shared that they began to appreciate their bodies after they experienced a health crisis or their bodies had difficulty functioning. Other factors included feeling accepted by others in their lives and not being only seen as a higher-weight person. Two participants also mentioned that modeling how to be healthy and have a healthy relationship with one's body for their children was beneficial for body appreciation.

The weight-focused sample also recognized that they had external and internal factors that negatively impacted their body appreciation development. External factors included a narrow depiction of beauty in the media or beauty industry, others' perceptions of their size, and difficulty finding clothing. Common internal factors were the guilt they experienced over how they treated their bodies in the past, low self-esteem, their trauma histories, and difficulty losing weight. Two participants also discussed their discomfort with body positivity or size diversity in the media. They disclosed that they were unsure how having larger bodies represented in the media would be helpful to those individuals or higher-weight people in general. They believed it caused more harm since the public's reactions were often negative, thus intensifying societal weight-stigma beliefs. Last, it was noted that the weight-focused participants had difficulty labeling their values and distinguishing what they wanted from others, making it challenging to develop ownership in how they would like to approach appreciating their bodies (Webb, 2019).

Movement also appeared critical in developing body appreciation for the weight-focused sample. However, it was mixed if movement benefited body appreciation. Consistent with previously discussed research, those who found movement pleasurable or connected to the body demonstrated higher levels of body appreciation (Calogero et al., 2019).

Comparative Analysis

The weight-neutral and the weight-focused groups shared similarities in how outside factors affected their body appreciation. Movement is the first factor that participants mentioned. Movement was a critical component of developing body appreciation, but it can also cause distress for them. Movement was a topic that the participants discussed without inquiry from the interviewer and was not asked about in the interview. Its connection to body appreciation should be explored further in research. Another similarity between the two groups was that they had difficulty with the concept of body positivity. However, the weight-neutral group appeared to struggle with achieving the concept, versus the weight-focused group had difficulty accepting that higher-weight people can promote body positivity. This difference may be due to perceived higher levels of internalized fatphobia in the weight-focused group, where they have internalized the idea that people in larger bodies should not accept their bodies until in a smaller size (Pearl & Puhl, 2018). Both groups also said that body appreciation was challenged when they did not feel that their body was accepted by others and when they struggled to find clothes.

There were three primary differences between groups in what factors affected their body appreciation. The first difference between the groups was using values to guide their relationship with their body. The weight-focused group had difficulty labeling their values and differentiating what they wanted versus what others and society said they should want for their body. Not clearly labeling their values may have caused cognitive fusions, where their thoughts or others' beliefs become a reality, preventing them from having cognitive flexibility that could impact their agency and embodiment (Webb, 2019). The weight-neutral group could identify their values, which provided them with a guide on how to pursue body appreciation. Second, the weight-focused group did not seem to have an active protective body filter like the weight-

neutral group, which may have caused them to internalize more societal beliefs about their bodies than those in the weight-neutral group (Wood-Barcalow, Tylka, & Judge, 2021). Third, self-education was prominent in the weight-neutral group. Self-education appeared to increase consciousness-raising and feeling empowered, which likely led them to experience increased agency in how they approach their body relationship (Brown, 2010).

Finding Body Appreciation

The Body Appreciation Scale-2 (BAS-2) shows that both the weight-neutral and the weight-focused groups have some level of body appreciation, which is respecting and approving of one's body and praising the body for what it can do, what it represents, its unique features, and its health, regardless of its shape, weight, ability, or imperfections (Avalos et al. 2005; Razmus, 2018; Tylka, 2011, 2019; Tylka & Wood-Barcalow, 2015b, 2015c; Weinberger & Luck-Sikorski, 2020). The mean score was 3.60, meaning participants showed an average level of body appreciation where they could sometimes display appreciation towards their bodies. The weight-focused groups had higher scores of body appreciation, with a mean of 3.9 and a range of 3.6 to 4.4. The weight-neutral group had a mean of 3.4, ranging from 2.9 to 3.7. There are numerous potential reasons why the weight-focused group may have had higher body appreciation scores. The length and level of treatment could be one factor. The bariatric process is an intensive long-term process where the participants experience repetition of education on what it means to have a healthier relationship with their body and food. As a result, they may be better able to label body appreciation but have difficulty internalizing it, as will be discussed later. Another factor that may affect levels of body appreciation is how weight-neutral treatments see the relationship with the body as a relationship, where one can have “good and bad body image days,” meaning that they recognize that it is normal not to feel positive about one's body

consistently, which may lower their scores. The weight-focused group tended to have a more dichotomous relationship with body image, reflecting the structure common among weight-focused approaches. These individuals may have selected higher scores to be perceived as having body appreciation and that they reached their goal of attaining a positive body image. This section will summarize how the two groups practice body appreciation and how body appreciation and treatment affected their well-being.

Weight-Neutral

Three global themes highlighted how participants practiced and developed body appreciation and how it affected their well-being. In this section, a review of these themes will occur. The unique practice of body appreciation will be the first theme.

Practicing Body Appreciation

Body appreciation is unique to each individual and can be practiced individually and socially. It was uniquely defined for participants, as well. For some participants, appreciating appearance was not a factor in appreciating their bodies; for others, it was. The participants' definitions seemed to impact how they practiced body appreciation.

The participants practiced body appreciation in diverse ways, from wearing clothes that fit and were comfortable to seeing the body as a “companion” and caring for its needs. Functionality appreciation was the most common type of appreciation for the weight-neutral group. Functionality appreciation is appreciating everything the body can do, including physical capacities, internal processes (e.g., digesting foods), bodily senses and perceptions (e.g., touch), and the ability to complete creative endeavors and self-care (Alleva & Martijn, 2019). Participants shared that they appreciated that their bodies could complete movement, did not experience chronic pain, could hug others, and could digest foods easily.

Body Appreciation Has a Developmental Process

There appears to be a developmental process for body appreciation, which was not seen in the literature. It is unclear what the developmental process would be, but three steps appeared while analyzing the data. One possible step observed was gaining awareness about the complexities of the body relationship. Each participant discussed developing understanding that their body relationship is complex and has numerous contributing factors. They also recognized that body appreciation fluctuates throughout life and is an ongoing process that one must practice daily. Each participant also experienced a “perspective shift” that provided permission to appreciate their bodies more. This shift in perspective may be another step. Many shared that gathering a different awareness about weight bias, dieting and societal standards allowed for that perspective shift to occur and for them to understand that “it is bigger than them” and their body is not the problem.

Last, many participants felt like they were “rebellious” against society when they began to listen to their bodies rather than fitting them into societal expectations. In feminist theory, individuals “resisting” societal influences that decide whose bodies are worthy and valuable is celebrated because resisting the system promotes societal change and psychological well-being (Kinavey & Cool, 2019). Participants’ resistance was demonstrated by wearing clothes that would not be considered “appropriate” for a higher weight-person to wear, intuitively eating, and advocating for themselves and others, such as writing letters to cool-sculpting centers about how they impact people’s body image or asking their employer to remove calorie labels on the food in the breakroom.

Body Appreciation is Transformational

Developing body appreciation positively impacted numerous facets of well-being for the participants. The first area that participants noticed change was in their ability to be cognitively flexible by having strong body-positive filters and being able to challenge negative body messages when they occur. They also noticed a change in their interpersonal relationships after treatment. They experienced more profound connections with family and friends, and had more meaningful relationships. They also shared that they created and maintained boundaries with others that would negatively affect their relationships with their body, such as not allowing “food or body talk” around their child or ending relationships based on food restriction and exercise. Body appreciation and treatment also improved their intra-relationship, and they experienced increased worthiness, authenticity, liberation, and happiness. They also disclosed that they felt more empowered to advocate for themselves and others through activism or setting boundaries. These areas of transformation are congruent with other research on body appreciation, positive body image, and positive embodiment (Piran, 2019; Razmus, 2018; Tylka, 2011, 2019; Tylka & Wood-Barcalow, 2015a, 2015b).

Improved Food and Body Relationships. Participants disclosed better relationships with their food and body after weight-neutral treatment. Participants experienced increased intuitive eating and decreased or stopped labeling their food through a morality lens. They also reported a better relationship with their body. Increased body embodiment, acceptance, and appreciation, and decreased appearance investment were common for the participants. The positive change that participants experienced from weight-neutral treatments replicates studies that evaluate the effectiveness of weight-neutral approaches (Bacon & Aphramor, 2011; Bientner

et al., 2019; Humphrey et al., 2015; Mesinger et al., 2016; Razmus, 2018; Schaefer & Magnuson, 2014; Tylka et al., 2014; Wilson et al., 2020).

Weight-Focused

The weight-focused group also experienced positive effects of body appreciation, such as experiencing more connection and freedom with their body. Body appreciation also had a positive impact on their mental health. Participants shared increased emotional intelligence, self-esteem, and “confidence.” They also disclosed that they had greater ownership of who they were and could readily create boundaries and advocate for their needs. Treatment also taught participants they could ask for help and experience increased connection with friends and family. Two participants’ communities also grew as they became more comfortable in their bodies since they were more willing to socialize and try new things, such as one participant becoming a volunteer art teacher. These findings were similar to other studies that demonstrated the effects of body appreciation and PBI (Razmus, 2018; Tylka, 2011, 2019; Tylka & Wood-Barcalow, 2015a, 2015b).

Food and Body Relationship After Treatment

Participants from the weight-focused group reported experiencing various changes in their relationships with food and body. They saw numerous changes in their food relationships, such as increased mindful eating (i.e., paying attention to the food you are eating, on purpose, moment by moment, without judgment), creating food boundaries, eating fewer unhealthy foods, and being able to follow their dietitians’ guidelines to induce weight loss. BWLTs and bariatric research have demonstrated similar results to weight-focused treatment (Busch et al., 2013; Palmeira et al., 2010; Presnell et al., 2008; Pyrkö et al., 2021; Sarwer et al., 2011). Participants continued to practice restricting their food intake and planned to continue throughout their lives.

The practice of restricting food appeared to affect their well-being negatively. Participants shared that they isolated more to prevent overeating at social events and discussed how they became anxious when in the presence of food.

Throughout the weight-focused treatment, participants experienced increased body acceptance and appreciation. All participants shared that they appreciated their bodies for their physical capabilities. The weight-focused sample practiced body appreciation by physically caring for the body and seeing it through a lens of neutrality. Participants continued to feel disconnected from their bodies after treatment and displayed body dissatisfaction. They often talked about their body as a “problem.” Research shows that women who complete weight-focused programs often see an increase in body satisfaction as they lose weight; however, they continue to display body preoccupation and more dysfunctional appearance investment (e.g., self-worth is connected to weight; Latner & Wilson, 2011; Sarwer et al., 2011; Schwartz & Brownell, 2004). This pattern also appears within the weight-focused sample, suggesting that these individuals may need additional body image treatment to address their concerns (Latner & Wilson, 2011; Pokrajac-Bulian, 2018; Sarwer et al., 2011).

The weight-focused group is experiencing increased body satisfaction due to weight loss. Yet, one could argue that they may not be experiencing body appreciation since the appreciation seems conditional on weight. Body appreciation is showing gratitude towards one’s body and everything it does and represents *regardless* of its shape, weight, ability, or imperfections (Avalos et al., 2005; Razmus, 2018; Tylka, 2011, 2019; Tylka & Wood-Barcalow, 2015a, 2015b; Weinberger & Luck-Sikorski, 2020). Nevertheless, it does not mean that these individuals are not experiencing body satisfaction (i.e., the degree to which individuals are satisfied with their physical appearance, specifically weight and shape) or functionality appreciation (i.e.,

appreciating everything that the body can do, including physical capacities, internal processes, bodily senses, and perceptions, etc.), which can be seen by their increased comfortability with their bodies and themselves and their gratitude that their body can participate in movement activities (Alleva & Martijn, 2019; Holesen et al., 2012). It also seems that these individuals are basing their body satisfaction or appreciation on how their body changes or on weight loss. If this is the case, that means the positive changes they have currently gained in treatment may decrease or dissipate when they stop losing or re-gain weight, which is a common occurrence among BWLTs and bariatric procedures (Latner & Wilson, 2011; Palmeira et al., 2010; Pokrajac-Bulian, 2018; Rosen, 2001; Sarwer et al., 2011; Schwartz & Brownell, 2004).

Comparative Analysis

When developing body appreciation, the two groups had two primary differences. The first was that the weight-focused group had difficulty identifying body appreciation and how they practiced it, which seems incongruent with their BAS-2 scores. Another difference was that the weight-focused group appeared to have higher levels of body disconnection after treatment than the weight-neutral group, where there was increased embodiment and psychological flexibility.

The weight-neutral and the weight-focused groups did benefit from their treatment and developing body appreciation. They reported experiencing improved interpersonal relationships and increased self-esteem, life satisfaction, and emotional intelligence, as well as a decrease in body dissatisfaction. These findings are congruent with other body image treatments that viewed the effectiveness of weight-neutral and weight-focused treatments (Busch et al., 2013; Palmeira et al., 2010; Presnell et al., 2008, Schaefer & Magnuson, 2014).

A point of tension is that, while the weight-focused group had higher levels of body appreciation according to the BAS-2 scores, they had more difficulty with body appreciation. They had difficulty identifying and discussing their body appreciation practice, whereas the weight-neutral group could. They also demonstrated body image inflexibility, which is inversely related to body appreciation. Body inflexibility is the unwillingness to experience negative appearance-related thoughts and emotions and the attempts to change the body to deal with the discomfort versus learning how to cope (Sandoz & Webb et al., 2019).

The difference in manifestations of body appreciation may be due to the holistic approach that weight-neutral treatment utilizes. Weight-neutral treatment considers the body's and self's external and internal experiences, as seen in how the weight-neutral group conceptualized their body appreciation (Cook-Cottone, 2015; Tylka & Wood-Barcalow, 2015b). They were aware of how their experiences impacted their ability to appreciate their body and how their internal and external experiences must be attuned to appreciate one's body fully. This is compared to the weight-focused group, where external experiences are the primary targets of their treatment, such as behavior modification, weight loss, and reduced calorie intake. Body appreciation and PBI depend highly on considering a whole person's context; not understanding the context may prevent the development of body appreciation.

Another aspect that may have caused differences in participants' body appreciation development is how weight-neutral treatments emphasize body acceptance and learning about the societal impacts of weight stigma. Developing this knowledge seemed to give the weight-neutral sample permission to accept themselves, which allowed them to appreciate their bodies without changing them. This knowledge contributed to transformation and the ability to flourish.

Study Limitations

The current study had numerous limitations. Given the small sample size and the lack of diversity in demographics, the generalizability of the current findings is limited. Further, some specific demographic characteristics of the current sample may have impacted the findings regarding one's weight-neutral treatment experience or body appreciation development. Most weight-neutral participants wore 16–18 pant sizes, which is slightly above the average size (size 14) of American women (George-Parkin, 2018). This may mean that they have experienced less weight stigma than those in larger bodies, like the weight-focused sample, who wore above the pant size 20/22. Having more incidents of weight stigma would likely affect one's body appreciation development through weight-neutral treatment. Another limitation was that most participants came from one source, an international technology company's body positivity affinity group. While this was a large affinity group, body positivity was the group's focus. This may cause sampling bias, where people with specific characteristics would be more likely to participate in this study. For example, those with higher body positivity would be more inclined to participate to explore their body positivity further.

Utilizing a self-report measure was also a limitation of the study, which could affect the reliability and validity of the data. One example of such an effect could be that participants recording higher levels of body appreciation to appear more socially acceptable. Last, the study did not include a baseline of participant body appreciation before they began treatment; thus, it is unclear whether body image treatment was what assisted them with developing body appreciation.

Implications for Future Research

Despite these limitations, these findings have important implications for future research. First, it may be beneficial to complete a similar quantitative study utilizing more measures where participants are asked to record the data before treatment and throughout their treatment process. Measures that may enhance the study are the Weight Bias Internalization Scale (WBIS; Durso & Latner, 2008), Body Image Acceptance and Action Questionnaire (BI-AAQ; Sandoz & Wilson et al., 2013), or the Experience of Embodiment Scale (EES; Piran et al., 2020). Utilizing a more comprehensive set of measures and a treatment baseline may provide a comprehensive understanding of how positive body image, not just one facet, was developed for women in larger bodies and diminish reliability and validity concerns associated with self-report measures.

Another consideration for future research is to develop a positive body developmental model or a fat identity model. The data showed that the participants were at different stages of developing body positivity or increasing their acceptance of their fat identity. Similar theories have already been developed, such as the “Developmental Theory of Embodiment” (Piran & Teall, 2012). An identity model for higher-weight people called the “Positive Fat Identity Development Model” (PFIDM) was created by Huelsman (2012) through a dissertation, but the research has not been replicated. A developmental theory would provide a clearer understanding of one’s experience as one develops a positive body image or fat identity. Also, further investigating positive fat identity would enhance the opportunity to understand the experiences of fat individuals beyond seeing them as a stigmatized group. It would provide knowledge that a fat identity can be positive (Huelsman, 2012).

Implications for Clinical Work

Training and Supervision

There is little education in psychology graduate programs about weight stigma or the fat community through a multicultural lens. Multicultural education, required for all developing psychologists, assists with acknowledging one's biases about cultures that are not part of the dominant culture or that are different from one's own. Even though people in larger bodies are not part of the dominant culture, they continue to be excluded from the diversity conversation. Kasardo (2019) researched the coverage of size bias in diversity textbooks and reported that anti-fat bias and size diversity concerns were rarely addressed in textbooks designed for graduate training. Size was either pathologized or ignored. If size diversity was taught or considered, it may assist psychologists in becoming aware of the biases they hold towards higher-weight people and how they engage in weight stigma or discrimination and prevent the bias many participants experienced.

It may also benefit graduate students to learn more about PBI and weight-neutral care. There is a significant focus on negative body image and how it correlates with eating disorder pathology in classes; however, there is limited education on working with individuals with body image concerns. A 2008 national survey by researchers at the University of North Carolina at Chapel Hill with *Self* magazine found that 65% of American women between the ages of 25–45 struggled with disordered eating and body image concerns and that another 10% would meet the criteria for eating disorders. It is expected to be higher today (Harrison, 2019). This statistic demonstrates how ubiquitous body image and disordered eating concerns are, yet disordered eating and body image are considered a specialization. These areas being considered a specialization limits access to treatment to people who would benefit. Body image concerns

affect many people with diverse identities. Treating body image should be part of a generalist practitioner's education, especially due to the psychological benefits of body appreciation and PBI.

Weight-inclusive treatment should be an intervention that is taught to developing psychologists. Weight-neutral care allows for providing a treatment that is holistic and affirming, and non-pathologizing of larger bodies. It would also increase the competency of working with this population due to its destigmatizing nature, protecting the therapeutic rapport and increasing client participation in treatment (Tylka et al., 2014). Increased training and education would likely increase the provision of supervision around weight-neutral care, which would likely increase accessibility to body image treatment and decrease the prevalence of weight stigma in mental health care.

Clinical Interventions

The phenomenological experiences of the participants demonstrated how beneficial weight-neutral care can be to those in larger bodies who struggle with body image. As a result of their transformation, psychologists should consider how weight-neutral care could benefit their patients. In this section, there will be an exploration of how to integrate this approach within the clinical practice.

Self-Assessment

The first step in creating a space for weight-inclusive treatment is for clinicians to become aware of their biases towards higher-weight people and how they have engaged in weight stigmatization or discrimination (Brown, 1989; Romano, 2018; Rothblum & Gartrell, 2019). As with all biases, not being aware of one's internalized weight stigma may make it challenging to discuss weight and body image with patients, a frequent topic for most, regardless

of the presenting concerns, age, or gender (Rothblum & Gartrell, 2019). This examination requires an in-depth look at how mental health clinicians intentionally or unintentionally promote weight bias or discrimination, like utilizing body weight as a health measure (Kinavey & Cool, 2019).

Continuing Education

Since the 1980s, research has reported the prevalence and negative implications of weight bias by mental health clinicians; nevertheless, it continues to be widespread (Akoury et al., 2019; Kinavey & Cool, 2019; Puhl et al., 2014). Clinicians must prioritize developing knowledge about size diversity, weight stigma, weight-neutral treatments, and the impact of diet culture. This knowledge can be obtained through personal work, continuing education, reading literature about the fat community or weight-neutral care, or clinical supervision.

Developing knowledge about weight-neutral care and higher-weight people's experiences can be beneficial for numerous reasons, such as building strong therapeutic rapport. The therapeutic relationship continues to be a critical factor in positive treatment outcomes, which was endorsed by the weight-neutral participants (Wampold, 2019). Weight-neutral participants identified that one of the main reasons their relationship with their provider was strong was their knowledge about weight stigma, higher-weight people's experiences, and weight-neutral care. This knowledge made the participants feel "normal," experience unconditional regard, and feel accepted. It can also assist patients in lessening their dependency on their body for self-esteem and building self-acceptance, increasing the likelihood of them retaining the skills they learned in therapy and other behaviors (Bacon & Aphramor, 2011).

Body image is another crucial area for mental health providers to expand their knowledge. Since sizeism and weight stigma impact everyone and oppress the relationship that

we all have with our bodies, it is essential to consider how those factors affect patients and therapeutic outcomes. Clinicians having more knowledge about PBI would enhance their ability to provide holistic assessment and treatment of body image concerns. This is important since body dissatisfaction can significantly affect one's health (Carrard et al., 2018; Paquette & Raine, 2004; Weinberger & Luck-Sikorski, 2020). Acquiring this knowledge may also assist clinicians in discussing body image with their patients. Weight-neutral participants shared that their previous mental health providers did not assess or discuss body image, preventing them from receiving the desired treatment. For many, body image or dissatisfaction can be uncomfortable or shameful; patients may not readily disclose their concerns about their bodies. It may be helpful for clinicians to initiate conversations about body dissatisfaction through assessment to have a holistic view of the patient's treatment needs. This assessment may also assist with reducing the shame and stigma patients experience. Clinicians discussing topics normalize patients' concerns and may encourage disclosure. Consultation and continuing education are crucial for clinicians learning to discuss body image and weight in various settings, including intake, where the body relationship should be the focus, not size or shape.

Last, clinicians are encouraged to stay current on how the health community considers and measures health and interventions to improve one's well-being, since the field is changing rapidly. In June 2023, the American Medical Association (AMA) recommended that the BMI should not be the sole measure of health because it is an imperfect measure of body fat and does not account for differences across race and ethnic groups, sexes, genders, and ages. They recommend utilizing other forms such as measurement of visceral fat, body composition, waist circumference, body adiposity index, relative fat mass, and genetic and metabolic facts (AMA, 2023). Clinicians should also be aware of the history of BMI and its use for race-based exclusion

(Strings, 2019). With this knowledge, clinicians should consider clients' autonomy of choice regarding health interventions and the role of culture in their perception of health.

Psychoeducation is Critical for Effective Treatment

Another reason to learn more about weight stigma, weight-neutral care, and size diversity is the impact psychoeducation had on the participant's progress in treatment. Participants disclosed that the psychoeducation they received caused a perspective shift that increased their ability to appreciate their bodies. Knowledge can empower patients to take ownership of how they would like to approach their body relationship by clinicians providing information about the benefits and consequences of weight-neutral and weight-focused care, the health benefits of intuitive eating, the impact of weight-stigma on health, and how to practice PBI so they can flourish (Rothblum & Gartrell, 2019). Common topics for the weight-neutral sample were introducing the weight-neutral philosophy, self-compassion, and diet culture, as well as providing resources such as podcasts, books, and tv shows about body image, the fat community, or the impact of weight bias.

Common Interventions

The current analysis shows that common interventions within weight-neutral treatment assist higher-weight individuals with developing a better relationship with their bodies. Food seemed to be the initial focus of treatment. Many participants said their relationship with food was easier to change than their relationship with their bodies. Food-based interventions included: challenging food rules, listening to one's body's nutritional needs, being curious about how your body reacts to certain foods, etc. These interventions seemed to encourage intuitive eating (Tribble & Resch, 2012). Regarding mental health, this is an area around which clinicians may

want to consider their competencies and may want to refer patients to a weight-neutral dietitian to assist with its development.

The relationship with oneself was another area that was approached in weight-neutral treatment. Intra-relationship interventions included: developing self-compassion, empowerment exercises, and gathering information about how their body image affected their relational and internal patterns. Body-based interventions were often the last interventions that participants discussed. Many of the body-based interventions encouraged body embodiment. The primary way to intervene was to assist participants in creating a subjective relationship with their bodies and becoming curious about their bodies' needs and desires. It also seemed that externalizing their relationship with their body, such as seeing it as a companion, assisted participants in developing that subjective relationship and meeting the body's needs versus trying to change it.

Clinicians having inclusive spaces were also important to participants. When a space is not welcoming to people in larger bodies, it is further disempowering and may decrease the likelihood of them feeling safe enough to bring themselves authentically into the therapeutic relationship. Mental health clinicians must also consider the physical spaces where they provide services. Clinicians ought to ensure that couches and chairs will accommodate larger bodies comfortably. Office accessibility should also be considered; for example, ensuring hallways are wide enough for higher-weight people to fit easily. Other ways to create an inclusive weight space include offering body-positive magazines, pictures that display diverse body sizes, and anti-diet or fat liberation materials within the waiting room or office space (Kinavey & Cool, 2019).

It is also recommended that clinicians take a client-centered and multicultural approach. The weight-neutral sample emphasized how they "felt seen" by their provider due to the holistic,

person-centered approach. They also shared that the weight-neutral approach provided choice in how they approached their body relationship, allowing for liberation. Societal standards of beauty, associated with weight, are inextricably tied to race, among other demographic factors. Thus, as clinicians conceptualize and intervene in body image concerns, they must listen to clients' individual goals, desires, and needs, and attend to the bidirectional influence of their intersecting identities.

Weight-Focused Treatment

Weight-focused care is not the primary focus of this study; however, it is important to acknowledge areas of potential growth. Weight-focused treatments often assume that body image will improve with weight loss (Chao, 2015). However, these results are highly based on if these individuals maintain their weight loss, which studies demonstrate is unlikely (Latner & Wilson, 2011; Palmeira et al., 2010; Pokrajac-Bulian, 2018; Sarwer et al., 2011; Schwartz & Brownell, 2004). This pattern will likely cause individuals to participate in weight cycling, which has numerous negative consequences (Bacon & Aphramor, 2011; French & Jeffery, 1994; Mesinger et al., 2016; Montani et al., 2015; Tylka et al., 2014). Bariatric research also shows that many people have difficulty with the body after treatment, which was seen with one participant who completed the weight-loss surgical process. Many individuals continue to have high anxiety levels after the process due to their bodies and struggle with internalized bias that often manifests because of “phantom fat” (Lindberg et al., 2021; Perdue & Neil, 2020). Due to these factors, more body image interventions should be completed more often with this population and in this type of treatment.

Clinicians should also consider the numerous messages bariatric patients have internalized from society about their bodies and how it may continue to affect their body relationships after treatment. Clinicians may assist patients by increasing their levels of self-acceptance by providing psychoeducation on weight stigma and discrimination. This education can assist patients in recognizing that they are not responsible for the pain and discomfort they experience and that it is “larger than they are.”

Another clinical recommendation would be for weight-focused providers to have more transparent informed consent where treatment goals are well-defined. All three weight-focused participants received mental health care at a weight-loss clinic but believed they were receiving weight-neutral care since they did not discuss weight loss. The lack of information is an issue of integrity. Misrepresentations of this nature can result in patients being subjected to inaccurate and potentially harmful information. It is also an issue of autonomy since the care provided is unclear and misleading, preventing the client from choosing the best treatment for their therapeutic goals and needs (Romano, 2018).

Advocate for Weight-Inclusiveness

Participating in weight-inclusive advocacy may also be considered an intervention since the pervasiveness of weight stigma in our culture is significant and causes an exorbitant amount of harm to individuals worldwide, including patients. Clinicians participating in activism empower patients and help them build self-efficacy, which is necessary to make a difference. The end of oppression begins when people start resisting oppressive systems, such as diet culture. Clinicians must become advocates for size acceptance in and outside of their work (Kinavey & Cool, 2019; M. C. McHugh & Chrisler, 2019). This type of work is done in numerous ways, such as encouraging federal and local legislators to create and promote laws that

prohibit discrimination by weight; encouraging clinician employers, like schools and health settings, to have anti-discriminatory policies on weight and training around size diversity; and advocating for public health initiatives to focus on adopting healthy habits versus weight loss and to show people of all sizes in programs' materials. All are steps in lowering weight bias and reducing its harmful impact (Pearl, 2018).

Conclusion

The current study demonstrates the power of acceptance and how it can transform one's life when one can be accepted for who they are, including the size and shape of their body. As seen in the data, one's body being accepted empowered the participants to consider their bodies as part of them versus an object to be controlled and measured. This shift in perspective appeared to allow the space to appreciate their body for what it can do, what it represents, its unique features, and its health, which created respect for their body and themselves. This developmental process began by questioning societal dialogues about bodies and size, and through weight-neutral treatment.

Weight-neutral treatment was consistently the first environment within which participants experienced acceptance for their bodies, which allowed the body appreciation developmental process to thrive. I hope the results from this study encourage health fields to shift their perspective on positive body image and higher-weight people by acknowledging that one can love, celebrate, and experience embodiment at any size, to believe that these individuals can flourish. I hope that providers can assist patients' ability to flourish by accepting them for who they are without changing their bodies.

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APPENDIX A: INTERVIEW PROTOCOL

Interview Questions

- 1. What is your current relationship with your body and food?**
- 2. How did that relationship change through treatment?**
- 3. What has been your past experience with health or mental health providers, particularly around your body size?**
- 4. What was it like for you when you first began working with a weight-neutral provider?**
- 5. How do you appreciate your body?**
 - a. How would you define body appreciation for yourself?
 - b. One possible definition is respecting and approving one's body and praising it for what it can do, what it represents its unique features, and its health regardless of its shape, weight, ability, or imperfections. How do you think that fits your viewpoint of body appreciation?
- 6. What parts of your weight-neutral treatment assisted with developing body appreciation for your body?**
 - a. What type of activities or skills did you do with your provider you think assisted the most with developing body appreciation?
 - b. What were the most common topics of conversation in treatment (e.g., ideal body types and the cultural influence on one's body; weight-stigma and how to cope with it; what is positive body image or any other topics that are related to PBI such as body acceptance, filtering out negative body messages, creating your own definition of beauty, interpersonal support)?

7. How much did your relationship with your provider assist you in developing body appreciation?

- a. What role did your relationship with your provider play in that development?
- b. Anything specific you would like to share?

8. What were the outside factors that contributed to your development of body appreciation?

- a. What aspects played a role? How? (i.e., relationships, movement, exposure work, recognizing diet-culture and its influence)

9. What were the most challenging aspects of developing body appreciation?

10. How has developing body appreciation affected your mental, physical, and relational health or well-being?

- a. Please provide any specifics

APPENDIX B: WEIGHT-NEUTRAL GROUP GLOBAL THEMES

| Global Themes | Organizing Themes | Basic Themes |
|---|---|---|
| <p>1. Body image development begins in childhood. Caregivers and family are the main sources of information about the body and its cues. This messaging continues with family but is reinforced by romantic partners. Values and how participants' bodies change also seem to influence body image.</p> | <p>Participants internalized body image messages from their caregivers in childhood, influencing their body image and how they would approach their bodies.</p> | <p>In childhood, caregivers often influence how participants listen to their bodies.</p> |
| | | <p>Caregivers modeled discomfort in their bodies, and children noticed by seeing them diet or displaying weight stigma towards their parents.</p> |
| | | <p>Thin often being the ideal. Participants observed family members discussing bodies and labeling them as good or bad. They also observed that when they lost weight, they would be celebrated, reinforcing the belief that thin bodies are good.</p> |
| | <p>In adulthood, body image beliefs from childhood continue to be reinforced through caregivers, romantic partners, and extended family.</p> | <p>Caregivers in adulthood often reinforce body beliefs that participants experienced in childhood by encouraging weight loss or being curious about weight gain.</p> |
| | | <p>Participants shared that they were often body shamed by romantic partners, which further internalized body image beliefs (i.e., smaller bodies are better). They also shared that they feared their partners' responses to their bodies if they weren't ideal.</p> |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|--|
| | | In adulthood, extended family members influence body image beliefs by labeling body types or commenting about the participant's body. |
| | Other factors can significantly impact body image, such as values and how the body can change. Grieving body changes are significant for adaptable body image. | Participants experienced body change throughout life (i.e., puberty, aging, pregnancy, etc.). With numerous of these changes, they experienced grief or disappointment with how their body changed. This disappointment and grief were primarily associated with gaining weight. |
| | | Participants with progressive or feminist values demonstrate a healthier body image. |

| Global Themes | Organizing Themes | Basic Themes |
|---|--|---|
| 2.Before treatment, participants experienced disconnection with their food and bodies, meaning they were not listening to their body's needs or desires and did not experience intuitive eating. | Before treatment, participants regularly labeled their foods within a morality lens (i.e., good vs. bad food, "sinning") and practiced restricting eating. | Participants would often label or moralize their food before treatment. |
| | | Participants would often try to restrict what they ate before treatment. |
| 3.Weight stigma negatively affects an individual's community and internal experience. It often causes them not to feel safe in their body while in their communities and negatively impacts their well-being. | Participants experience societal messages that consistently tell them that their body size is unacceptable and, as a result, they should try to change it. | Participants experienced people assuming that they were trying to lose weight or a healthcare provider encouraging them to lose weight. These assumptions provide messaging around the ideal body type, "thin being the best." |
| | | Participants experienced weight bias at their place of employment through explicit and implicit methods. |
| | | Participants received messages or believed their bodies were unwelcome in different environments due to the lack of space or intention to provide size-accommodating spaces. This also includes not considering that they may need modifications in movement classes. |
| | | Media reinforces diet culture and healthism, which perpetuates weight-stigma messages. |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|---|
| | <p>Weight stigma negatively impacts people's inner experiences, which often causes shame, anxiety, and internalized weight stigma. All would negatively impact well-being.</p> | <p>Participants felt pressure to make their bodies fit into societal standards. They continued to feel that pressure when spending time with people who continue to follow diet culture norms.</p> |
| | | <p>Participants experience anxiety due to fear of weight bias and how it will affect them.</p> |
| | | <p>Participants experienced pressure to see their bodies through a "body positivity" lens.</p> |
| | | <p>Participants cope by utilizing different defenses to manage the effects of weight stigma and bias, such as minimizing their experiences, avoiding social things, and trying to perfect their bodies.</p> |
| | | <p>Participants experience internalized fatphobia. This manifests as blaming oneself for not being thin, feeling unworthy due to size, avoiding the fat community, or accepting diet culture as a fact.</p> |

| Global Themes | Organizing Themes | Basic Themes |
|--|--|---|
| | | <p>Participants often felt disconnected from their bodies or their body relationships due to weight stigma. It appears to be a way to cope with body distress.</p> <p>Participants compare their bodies to others or feel self-conscious about their bodies.</p> |
| <p>4. Participants experienced weight stigma with previous healthcare providers. These experiences were more often explicit. There were more examples of previous medical care than mental health.</p> | <p>Participants experienced weight stigma with non-weight-neutral providers.</p> | <p>Participants experienced anxiety when seeking medical services due to expected treatment or feeling that they must advocate for themselves due to size.</p> <p>Participants felt they have to choose between physical and mental health when working with providers.</p> <p>Participants terminated provider relationships because providers demonstrated weight bias towards them.</p> <p>Providers would often assume a participant's health based on their size. They would be surprised if the participant were healthy and placed judgment when a health concern arose.</p> |

| Global Themes | Organizing Themes | Basic Themes |
|--|---|--|
| | | Health providers induce shame with weight-bias comments or assumptions. |
| | | Providers would not assess for body image concerns or lacked knowledge about weight-inclusive treatments or people with larger bodies. |
| | Participants' healthcare experiences have mostly occurred within the medical area, where there were consistent examples of anti-fat bias. While previous mental health experiences were less, there was a lack of understanding or assessment of body image concerns. | Previous mental health experiences were rare; many did not discuss body image or demonstrate anti-fat bias. (n=7) |
| | | Most past medical-based experiences exhibited anti-fat bias rather than weight-inclusive care. (n=21) |
| 5. Participants often experienced change due to weight-neutral treatment. The therapeutic rapport, provider's knowledge, and provider's size identity were significant factors in treatment effectiveness. | The provider-patient relationship was crucial to the effectiveness of weight-neutral treatment. The provider's knowledge and size identity also impacted the therapeutic relationship. | Participants experienced their weight-neutral provider as approachable, validating, supportive, non-judgmental, and knowledgeable. Rapport was an essential factor for participants. |
| | | Providers' size highly influenced the amount that participants were willing to disclose, impacting treatment and the therapeutic relationship. Providers being in larger bodies and knowing they have similar experiences to their clients helped develop rapport. |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|---|
| | | The therapeutic relationship was often considered the “key” to successful weight-neutral treatment. |
| | Characteristics and participants’ reactions to the weight-neutral experience. Treatment was often seen as challenging but effective. The experience often transformed participants due to common factors, such as being client-centered, non-judgmental, holistic, and knowledgeable about the fat community and weight-neutral treatment. | Participants often saw the treatment as effective and were grateful for their provider and treatment. While the work was challenging, they felt seen and disclosed more. |
| | | Characteristics of weight-neutral treatment that assist with body appreciation are shared vocabulary between provider and patient, holistic, client-centered, and non-judgmental. Providers also knew about people in larger bodies’ experiences, weight-inclusive treatments, weight stigma, and how it negatively impacts well-being. Physical space was also important such as having fat representation in art or reading materials, medical gowns that fit, and comfortable seating. |
| | | Participants shared that they felt liberated, transformed, safe, and, for the first time, “normal” because of weight-neutral treatment. |

| Global Themes | Organizing Themes | Basic Themes |
|--|--|--|
| <p>6. Weight-neutral providers are holistic in their approach and interventions and encourage non-weight-loss goals. Psychoeducation is a critical intervention.</p> | <p>Weight-neutral providers utilized food-, intra-relational and body-based interventions to promote body appreciation. They also utilized non-weight-loss goals to assist in measuring treatment progression.</p> | <p>Providers did food-based interventions such as challenging food rules, providing psychoeducation about nutrition, and problem-solving in easily incorporating food when busy.</p> |
| | | <p>Providers did intra-relationship interventions such as assisting participants in developing insights about their relational and internal patterns, inducing empowerment, and developing self-compassion and self-trust.</p> |
| | | <p>Providers did body-based interventions such as being curious and mindful of what the body needs, exposure work, redefining movement, and getting clothes that fit and are comfortable.</p> |
| | | <p>Participants utilized non-weight loss goals to help body appreciation development.</p> |

| Global Themes | Organizing Themes | Basic Themes |
|---|---|--|
| | Providers provided psychoeducation in numerous areas to promote understanding of body appreciation, weight discrimination, and health. Salient psychoeducation was on introducing weight-neutral philosophy, self-compassion, diet culture and its impact, and different ways to measure health. | Many of the weight-neutral providers introduced participants to weight-neutral philosophy and core values. |
| | | Providers would induce a perspective shift through psychoeducation. |
| | | Providers taught participants different ways to measure health (i.e., understanding blood labs, etc.) versus utilizing weight loss as a primary indicator of health. |
| | | Providers providing weight-neutral, or fat-liberation resources were important in treatment. |
| 7. Community, movement, and learning about fat activism and perspectives through self-education were outside factors that significantly contributed to body appreciation development. | Community and relationships were significant for body appreciation development. If one's body felt accepted and represented, body appreciation increased. Participants also wanted to model having a positive relationship with their bodies for their children, which positively impacted body appreciation. | Participants reflected on the next generation and how they would be impacted by weight stigma helped change their body relationships. They found modeling body appreciation and acceptance helpful in body appreciation development. |
| | | Participants felt that their bodies and self were accepted by their community, which was beneficial for body appreciation development. |

| Global Themes | Organizing Themes | Basic Themes |
|---|--|--|
| | Self-education and movement are critical factors in developing body appreciation for many of the participants. | Many participants completed self-led education on fat studies, weight-inclusive theories and treatment approaches, or on the fat community through numerous mediums (e.g., literature, social media, podcasts, etc.). They reported that this education was crucial in their development of body appreciation. |
| | | When participants find movement pleasurable and coming from a place of care, it assists in body appreciation development. |
| 8. Diet culture is pervasive, challenging one's ability to develop body appreciation. Participants have found that external and internal risk factors decrease the opportunity for body appreciation development. | Emotional, relational, and intellectual risk factors of body appreciation development are: being self-critical, the painful process of learning about diet culture and its impact, feeling self-conscious in their body, not feeling safe, their weight-neutral perspective not being accepted, and struggling to challenge or filter negative body messages consistently. | Participants were often self-critical of their level of body appreciation or how they saw their progress. They felt that they should be farther along in their development. |
| | | Participants said that feeling self-conscious or comparing their size to smaller bodies negatively impacted their body appreciation development. |
| | | Participants do not always feel safe in their bodies which can impact their body appreciation development. |

| Global Themes | Organizing Themes | Basic Themes |
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| | | Participants share that it can be difficult to filter or challenge negative body image messages consistently. |
| | External risk factors that could negatively impact body appreciation development are not feeling supported or safe in relationships due to weight bias, experiencing a lack of representation or space for higher-weight people, the threat of developing a diagnosis associated with larger bodies, and the amount of energy it takes to cope with diet culture. | Participants sometimes felt that their body was not accepted or unsupported on their body appreciation journey, negatively impacting their development. |
| | | Participants not finding clothing that was comfortable or representative of them negatively impacted body appreciation development. |
| | | A lack of representation or more extensive body accessibility negatively impacted body appreciation development. |
| | | A diagnosis or a threat of a diagnosis that is associated with higher-weight people (i.e., diabetes, high blood pressure, etc.) can impact body appreciation development. |
| | | Participants having exposure to implicit or explicit diet culture or weight-bias messages from personal relationships can negatively affect body appreciation development. |

| Global Themes | Organizing Themes | Basic Themes |
|---|---|--|
| | | The persuasiveness of diet culture negatively impacts participants' body appreciation development. |
| | | Not having access to weight-inclusive modifications or seeing movement as a way to change your body negatively impacted body appreciation. |
| 9. Body Appreciation is unique to everyone. It can be practiced in diverse ways and individually or socially. | Body appreciation was unique to each participant, and there were some common appreciation practices among them. | Participants wearing clothes they like, that fit, and are comfortable is a form of body appreciation. |
| | | Participants appreciating what their bodies can do was a significant way to demonstrate body appreciation. |
| | | Being connected to one's body and caring for it is a way to demonstrate body appreciation. |
| | | An individual's definition of body appreciation can be unique and reflect their relationship with their body. |

| Global Themes | Organizing Themes | Basic Themes |
|---|---|--|
| 10. There is a developmental process that seems to occur when developing body appreciation. | Participants experience their relationship with their bodies as complicated. They acknowledge that body appreciation development is a process because of its complexity and ever-changing status. | Participants acknowledge that developing body appreciation is a process-it is not a linear journey- and needs to be practiced regularly. |
| | | The relationship with one's body tends to fluctuate in life. Participants share that they experience “good and bad” days or moments with their body image and that it is a fluid relationship. |
| | | Participants feel that their relationships with their bodies are complicated. |
| | Participants displaying anger at diet culture and externalizing their body relationships could be critical processes that had to occur for body appreciation development. | Participants are angry at diet culture and its impact on them and “rebel” by trying to accept their bodies as is. |
| | | Participants externalize the body relationship by listening to the body's needs, being kind, celebrating its developments or changes, and not seeing it as a problem. They try to see their body as “a companion.” |

| Global Themes | Organizing Themes | Basic Themes |
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| | Participants experienced a perspective shift around their size and body to increase the likelihood of body appreciation development. | Participants experienced a shift in perspective that expanded their worldview regarding weight, dieting, and diet culture's impact. Many discussed having to “unlearn” the messages that diet culture created. |
| | | Participants learning about diet culture and its impact on systems, communities, and themselves caused them to shift their perspective, primarily that the problem is “bigger” than them and recognize there is a privilege being in a smaller body. |
| 11. Developing body appreciation is transformational. It positively affects numerous facets of well-being (i.e., social, emotional, intellectual, environmental, and health) and improves one’s relationship with their body and food. | Developing body appreciation positively impacts numerous facets of well-being, including social, emotional, intellectual, environmental, and physical. | Participants increased their cognitive coping skills (i.e., challenging cognitive distortions, filtering negative body messages, etc.) to prevent internalizing negative societal or community messages about their bodies. |
| | | Body appreciation development can positively impact interpersonal relationships. Participants experienced more meaningful relationships, deeper connections, shared more mutuality. |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|--|
| | | <p>Body appreciation development positively affected participants' relationship with their bodies, seen by their body acceptance, embodiment, gratitude for their bodies, and decreased appearance investment.</p> |
| | | <p>Participants experienced a positive impact on their relationship with themselves, such as increased worthiness, ability to be authentic selves, feeling liberated in their bodies, and happier.</p> |
| | | <p>Participants felt more empowered as they developed body appreciation, which can be seen in their interest in size activism, advocacy for themselves and others, and challenging weight bias when it occurs.</p> |
| | <p>Participants' body and food relationships improved.</p> | <p>Participants had a better relationship with food after weight-neutral treatment. They experienced increased intuitive eating and decreased valuing or labeling of their food.</p> |
| | | <p>Participants' body dissatisfaction decreased, and there was an increase in participants' considering their bodies.</p> |

APPENDIX C: WEIGHT-FOCUSED GROUP GLOBAL THEMES

| Global Themes | Organizing Themes | Basic Themes |
|--|---|---|
| 1. Various factors affect a person's body image, such as their relationships with food and body and their interpersonal relationships. | Before beginning treatment, participants struggled with their relationships with their bodies and food. | Participants shared that they saw their relationship with food as a way to cope with emotions or as an addiction to numb feelings. |
| | | Participants believed that their size was negatively impacting their life and if it was affecting their emotional and physical health. |
| | Interpersonal relationships influence body image development through comments or how family and friends may perceive the participant. | Romantic partners' comments influenced participants' body image, positively or negatively. |
| | | Participants' body image was influenced by how their children viewed their bodies or how they would like their children to see them (i.e., healthy, strong, etc.) |
| 2. Discussing body image and size appeared to increase anxiety among participants. To cope, they seemed to utilize differing defenses. | Participants displayed numerous defense mechanisms throughout the interview, demonstrating their anxiety about body image and weight. | Participants rationalized their desires, actions, or choices, specifically around why they were their size and the preferences they made around their size. |

| Global Themes | Organizing Themes | Basic Themes |
|--|---|--|
| | | Participants denied their desire to change their body size or wanting others to like them. |
| | | Participants would share their strengths or positive perceptions that other people have of them when not related to the question. |
| | Participants referenced their weight numerous times throughout the interview, emphasizing its importance. | Participants would disclose their weight at different times throughout their life, potentially to measure weight-loss success, as a timeline, or to emphasize their size. ($n = 22$) |
| | | Participants seemed pressured to note that they recognized and acknowledged their size. ($n = 15$) |
| 3. Participants have experienced weight stigma and discrimination in numerous areas. | Participants have experienced weight discrimination in most areas of their lives. | Participants experienced weight discrimination at their place of employment. |
| | | Participants have experienced discrimination in larger systems (i.e., being unable to ride a roller coaster or shopping). |

| Global Themes | Organizing Themes | Basic Themes |
|---|---|--|
| | Participants experienced weight stigma or bias in their interpersonal relationships. | Participants shared that they were told by medical providers to lose weight. |
| | | Participants have experienced others being uncomfortable with their size or providing unsolicited advice about their body or health due to being in a larger body. |
| | | Participants have experienced weight discrimination in platonic and romantic relationships. |
| 4. Weight stigma negatively impacts participants' well-being, body image, and interpersonal relationships. Participants also internalized weight-stigma beliefs and, as a result, perpetuated weight stigma onto others and themselves. | Weight stigma negatively affects participants' relationship with their body and their intellectual, emotional, and social well-being. | Participants see their bodies or themselves as "bad" due to their size. Participants blame themselves for their size and the "harm" they have caused their bodies. |
| | | Participants are self-critical about how they treat their bodies and often judge themselves for not being a smaller size. |
| | | Participants feel self-conscious in public due to weight stigma or their size (e.g., not being comfortable in a thinner body). |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|---|
| | | Participants show anxiety about how they are being perceived due to size and fulfilling anti-fat stereotypes or beliefs regarding health, life expectancy, and other personal attributes. |
| | | Participants isolated themselves to avoid weight bias or to assist them in losing or maintaining weight. |
| | Participants would often compare their body and body experience to others. This affected their ability to develop body appreciation and increased negative body image or discomfort. | Participants compare their bodies or their body relationship to other people's. |
| | | Participants compare their weight to other people's weight. |
| | Participants perpetuate weight stigma due to their beliefs and actions, negatively impacting well-being and body appreciation development. | Participants accept the consequences of diet culture and internalize its beliefs, which causes them to see their bodies or choices as a problem or unacceptable. |
| | | Participants have internalized anti-fat bias beliefs, such as believing fat people cannot be happy in their bodies, seeing their weight as a problem, stereotyping other fat people, etc. |

| Global Themes | Organizing Themes | Basic Themes |
|--|---|--|
| | | <p>Participants hold stereotypes about body size (i.e., fat people are miserable, can't love their bodies, etc.) or share the stereotypes they are worried about due to their size.</p> |
| <p>5. Participants underwent the bariatric process for their weight-loss treatment. It is a unique, long-term process with numerous interventions in the medical and psychological fields.</p> | <p>Bariatric surgery is a long-term and intensive process. The process began with creating goals that were not weight-focused and ended with post-op care. Each experience is unique.</p> | <p>Participants shared that they had other motivations for losing weight besides becoming thinner, such as a decrease in discrimination or becoming healthier.</p> |
| | | <p>Participants had to take numerous steps in the bariatric process: preparation, numerous health provider appointments, surgery, and post-op care. Participants are expected to continue losing weight in each throughout the process.</p> |
| | <p>Participants experienced medically based interventions when preparing for bariatric surgery.</p> | <p>Participants described their unique experiences their treatment such as negative side effects, feeling that education was too basic, and that mental health was significant for their weight loss.</p> <p>Nutrition classes or appointments service were part of bariatric surgery prep. Services focused on food strategies, education on metabolism, and what nutrients your body needed to function.</p> |

| Global Themes | Organizing Themes | Basic Themes |
|---|---|---|
| | | Participants were prescribed medications or vitamins to assist with nutritional deficits and psychiatric concerns such as anxiety or depression. |
| | Participants were provided different mental health interventions to assist with their weight loss/body appreciation development. | Participants had to complete an assessment to see if they were psychologically a good fit for bariatric surgery. |
| | | Participants experienced psychoeducational groups, such as DBT skills or individual therapy, to prepare them for bariatric surgery. |
| 6. Participants expressed satisfaction with their treatment progress and experienced positive rapport with their weight-loss providers. However, they would prefer a more holistic approach to treatment and experienced continuous pressure to lose weight from providers. | Participants had positive experiences and suggested that the bariatric process could be more consistently holistic. They felt that weight loss was the main goal and wanted a more balanced approach. | They were satisfied with the treatment and appreciated the progress they gained throughout. |
| | | Participants sometimes felt that the treatment was not holistic and felt like they had to reach their weight-loss goal and not listen to their or their body's needs. |
| | During treatment, participants underwent several psychological changes, including a shift in their perspective on interpersonal and body relationships. | Participants experienced a shift in perspective in how they approached interpersonal relationships, happiness, and life satisfaction. |

| Global Themes | Organizing Themes | Basic Themes |
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| | | Participants experienced a perspective shift within their relationship with their body or weight loss. (i.e., is weight loss necessary to me, what does my body represent, etc.) |
| | | Participants received CBT or DBT treatment to assist in changing their relationship with food and self-blame. |
| | Participants shared that they had a positive rapport with their weight-focused provider but sometimes felt pressure to fulfill their recommendation of losing and maintaining weight loss. | Participants experienced positive rapport with their weight-loss providers. |
| | | Participants experienced pressure from medical providers to lose or continue to lower their weight. |
| 7. Some factors assisted and challenged body appreciation for the participants. Movement was the only factor that could encourage or discourage its development. | Participants' interpersonal relationships and when they experienced health concerns assisted with body appreciation development. | Participants experienced health concerns, which increased their appreciation for their bodies. |
| | | Interpersonal relationships and modeling body appreciation for children assisted with body appreciation development. |
| | The pressure to fulfill beauty standards or experience weight-based bias challenges one's body appreciation development. | The media lacking size and beauty diversity may impact participants' ability to develop body image. |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|---|
| | | Participants experience other's weight-biased perceptions of them negatively impacted body appreciation development. |
| | | Participants' difficulty finding clothes that fit decreased body appreciation development. |
| | Participants have emotional and psychological factors that challenge their ability to develop body appreciation. | Participants struggling with mental health can negatively impact body appreciation development. |
| | | Participants found it difficult to label and follow their values and priorities negatively impacted body appreciation development. Not knowing these prevented knowing what they wanted vs. others. |
| | | Participants felt guilt for how they treated their bodies in the past or when they could not connect with people in previous ways. |
| | | Participants reported that having a negative self-perception of their body prevented them from developing body appreciation. |

| Global Themes | Organizing Themes | Basic Themes |
|---------------|--|--|
| | | <p>Body appreciation was challenged due to the amount of effort it took to lose and maintain weight loss. It was also difficult when others did not acknowledge the effort it took to lose weight.</p> |
| | | <p>Participants were uncomfortable with body positivity or seeing higher-weight people feeling comfortable in their bodies or being shown in media.</p> |
| | | <p>Participants' trauma histories would likely impact one's ability to develop body appreciation.</p> |
| | <p>Movement is a critical part of developing body appreciation. It can promote or challenge body appreciation development.</p> | <p>When movement is associated with weight loss, participants struggled to find exercise that was pleasurable to them. This may make them feel disconnected from their body.</p> |
| | | <p>Participants found joyful movements and "craved" those movements. This includes challenging the body and appreciating what it can do.</p> |

| Global Themes | Organizing Themes | Basic Themes |
|--|--|--|
| 8. After treatment, participants reported experiencing various changes in their relationship with food and body. They noticed improvements in their relationship with food and body appreciation while continuing to diet. They struggled with body dissatisfaction and disembodiment and dieting negatively affected parts of their well-being. | Participants experienced more mindful eating and created boundaries with unhealthy foods after treatment. | Participants saw increased mindful eating and listening to their food choices after treatment. |
| | | Participants created boundaries with unhealthy foods. |
| | | Participants shared that they learned what foods benefited their health and body. |
| | Participants continue to restrict food intake or diet, which seems to negatively impact one's well-being, specifically mental and social health. | Participants continued to diet, restrict their food intake, or cut out certain foods. |
| | | Dieting negatively impacts one's well-being, specifically mental health and social aspects. |
| | Participants continue to struggle with negative body image and disembodiment | Participants continued to feel disconnected from their bodies. |
| | | Participants continued to struggle with negative body image after treatment. |
| | | Participants continue to see the body as a problem to fix after weight loss treatment. |
| | Participants began to experience increased body acceptance and appreciation after treatment. | Participants reported feeling more accepting of their bodies. |
| | | Participants appreciate how their body functions and how resilient it can be. |

| Global Themes | Organizing Themes | Basic Themes |
|--|--|---|
| | | Participants appreciate their bodies by physically caring for them and seeing them through a lens of neutrality. |
| 9. Participants who appreciated their bodies experienced improved well-being and body image. | Body appreciation has improved participants' intra-relationship and mental health. | Participants experienced more connection to and freedom in their bodies as body appreciation increased. |
| | | Participants experienced improved mental health and were more in-tune with their emotions and thought processes. |
| | | Participants saw increased self-esteem and saw themselves as worthy. This increase led to positive self-talk and self-compassion practice. |
| | | Participants seemed to be more empowered. This can be seen in increased ownership of who they are, creating boundaries, and increased advocating. |
| | Participants' external world was also impacted by body appreciation development. They have more profound and vulnerable relationships, and their communities have grown. | As participants developed a sense of appreciation for their bodies, they felt more connected to their loved ones and friends. Additionally, they became more vulnerable and open. |
| | | Participants' community grew as their body appreciation developed. |

APPENDIX D: SIMILAR BASIC THEMES FROM BOTH GROUPS

| Body Image Influences | | | |
|--|--|---|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| Participants shared that they were often body shamed by romantic partners, which further internalized body image beliefs (i.e., smaller bodies are better). They also shared that they feared their partners' responses to their bodies if they weren't ideal. | Romantic partners' comments influenced participants' body image, positively or negatively. | <p>"The person I was married to, and I can talk all day about this, but like we basically we never had sex. Like he never wanted to touch me. He never was not he wasn't affectionate. And I think I really like for a while, I think I was convinced myself like, oh, this is fine. This is just how we are. I don't need this stuff."</p> <p>"Like, I just so I remember being so afraid of, like, physical touch because I was like, Oh, no, they're going to think that I'm fat or I've gained weight, or my body has changed."</p> | <p>"In fact, when I started this weight loss, I was in a very healthy relationship where he didn't care about my weight, which is what spurred it [weight gain]."</p> <p>"But if it was like they would be more preference for me to look differently, I would probably have no problem putting myself more in that desirable stage for them because, at that point, they're going to protect me. They're not going to let other people be trying to hit on me in the first place. I don't like that."</p> |

| Experiences of Weight Stigma or Discrimination | | | |
|--|--|---|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| Participants experienced weight bias at their place of employment through explicit and implicit methods. | Participants experienced weight discrimination at their place of employment. | <p>“At work, even I’ll I actually I’m going to say this because she knows I actually reported one of my managers to HR because she made a really, really two stupid comments to me directly about my own calorie intake at work.”</p> <p>“But I did mention to her, like, you know, I had taken some time off of my work as a nutritionist, and I was looking to go back to work, but I was feeling like the profession judges you based on what you look like your body is your calling card type of thing.”</p> | <p>“Where she made me go during the middle of the day and, like, jog around the block.” [discussing her boss]</p> <p>“It was like hiking and I telling them that and [her boss] goes in front of everyone and she goes, ‘Oh, I kind of thought you were getting gastric bypass or something.’”</p> |
| Participants experienced people assuming that they were trying to lose weight or a healthcare provider encouraging them to lose weight. These assumptions provide messaging around the ideal body type, “thin being the best.” | Participants shared that they were told by medical providers to lose weight. | <p>“Doctors’ visits like just annual checkups where I’ll get weighed. And then, and this is before I knew that I could opt out or choose to be blind. Wait, be, wait, and then be told, well, don’t gain any more weight, or what are you doing to exercise and lose weight? Like as if it was an assumption. So those are some of the experiences I</p> | <p>“Honestly, doctors would always say, like; obviously, you need to lose weight. Obviously, you would need to lose your back problems are probably because you’re so heavy.”</p> <p>“When it was talking about my weight in general, it was I’d go see someone for my</p> |

| Experiences of Weight Stigma or Discrimination | | | |
|--|-----------------------|---|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| | | <p>can remember.”</p> <p>“I remember when I went to try on wedding dresses, but like the, the people in the dress shop were very much like, ‘oh, okay, well, you know, like, well. You know, we could maybe let this out a little bit, but I’m sure you’ll have your diet plan’ or whatever like that. That was just presumed because that’s apparently what, you know, people, and then I and I remember I said like I’m like, nope, I don’t like I’d love to find something that fits today. And they’re like, ‘Oh, okay.’ It seemed kind of like taken aback by that.”</p> | <p>annual physical or something like that, and they wouldn’t be like, ‘Oh my God, you’re going to die.’... If you want to lose weight, you probably should do it now because when you’re 30, when you’re 45, it’s just going to get harder.”</p> |

Negative Consequences of Weight Stigma

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|--|--|--|--|
| Participants compare their bodies to others or feel self-conscious about their bodies. | Participants feel self-conscious in public due to weight stigma or their size (e.g., not being comfortable in a thinner body). | <p>“I used to compare a lot, or at least like try to understand or like, ‘oh, well, if this person’s eating burgers every day, why can’t I eat burgers every day?’ I had to kind of figure out what worked for me. And so, I think that was a huge barrier, was just being around a lot of thin people in my life who didn’t ever think about their body in a way that I did or never had really experienced, experienced it. Or if they did, it was like. I feel like I’ve run into a lot of people in my life, like body dysmorphia where they can’t see and I was like [in my] early twenties, I was always like, ‘How can you not see that you’re already so thin? Like you are so lucky? Why are you, like, fighting this?’”</p> <p>“Ask me how I feel about that. I commute sometimes to the office, and it involves going up three flights of stairs from the train to the street. And so, it’s</p> | <p>“Gradually, after college, where like as I started to gain more weight and as I started to just like be out of those types of social circles anyway. It just got harder for me to have kind of that positive social interaction that had nothing to do with my weight or positive social interaction that I didn’t somehow feel self-conscious about my weight, whereas I wasn’t at all before that.”</p> <p>“Everybody looks at me crazy like I have bones sticking out of me everywhere.” [Participant discussing her experience after bariatric surgery]</p> |

 Negative Consequences of Weight Stigma

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|---|---|---|---|
| | | not just me, right? It's like a pack of commuters trudging up these stairs. And definitely since I mean, since the pandemic, since working from home, since I bought a house, since, I don't know, whatever. But it was easy to compare before the pandemic and after." | |
| Participants experience anxiety due to fear of weight bias and how it will affect them. | Participants show anxiety about how they are being perceived due to size and fulfilling anti-fat stereotypes or beliefs regarding health, life expectancy, and other personal attributes. | <p>"I think I had a ton of anxiety about my body and how it looked, very specifically, how it looked. It felt very I got a very adversarial relationship with my body."</p> <p>"She always she's always talked to me about, like, how I act like I'm waiting for the other shoe to drop. Like, I'm like, okay, I've done all these things, like I'm trying to prevent diabetes, and she's like, okay, but there's nothing indicating that it's coming for you except family history, which is only on my dad's side."</p> | <p>"And that's really nice because I mean if you think about it like, I don't want to be seen as the dumb fat girl. I don't want to be the fat girl who's always funny. You know, I don't want to be the entertainer, you know?"</p> <p>"If I had medical issues that were not self-induced or even self-induced, I think there'd be a lot more anger or lack of appreciation or kind of hopelessness there."</p> |

| Treatment Interventions | | | |
|---|---|--|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| Providers would induce a perspective shift through psychoeducation. | During treatment, participants underwent several psychological changes, including a shift in their perspective on interpersonal and body relationships. | <p>“And then realizing that like, oh, but, but also like, okay, but if I have all of this, if I have all of this background information, if I’ve read all the books if I’ve listened to all the TEDTalks if I’ve done X, Y, Z. Why? Why am I still why is there still like a blocker, and what is that? And, and I feel like seeing [therapist] kind of helps like move that, that blocker or like helped me see that it was there because I think that part of what. For me, was that like, okay, well, then it just, like, must be my problem. Like, there must be something fundamentally wrong with me that if I have, like I’ve been given all the tools, why can’t I implement them? And then realizing that, like, no, I didn’t actually have all the tools.”</p> <p>“Like, for me, it helped have that perspective. For one thing,</p> | <p>“And she challenged me on that day one; she basically shut me down from telling me what me telling her what I need. And she said, ‘This is where we’re going to start. Why? Why won’t you talk to these people?’ And it was just this idea, like she pointed out, ‘They talk to you about their stuff. They lean on you; you take on everybody’s crap. Why can’t they take on yours?’”</p> <p>“I don’t feel like I was taught as a woman that your body is important. You know, it’s a tool that you carry throughout your whole life, regardless of babies and stretch marks and, you know, cellulite and all of that. But, like, this is my brain. This houses my heart. You know, my soul is in here. Like, what? What do I need to do with it? And so those are</p> |

| Treatment Interventions | | | |
|-------------------------|-----------------------|---|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| | | <p>like, I've always felt better knowing I'm not alone in something. So, if I'm suffering with something and I know I'm not alone, that really helps me feel better about it, I think. And also, just having the perspective that it's bigger than me, that it's not just a me problem. It's like a culture-wide, society-wide problem. And that it's. Sort of indicative of this like the greater stigma that exists."</p> | <p>really interesting lessons to learn in the past few years."</p> <p>"Yeah, I think there were two main topics, which were one kind of removing the responsibility of self and self-blame."</p> |

| Practicing Body Appreciation | | | |
|--|--|--|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| Participants appreciating what their bodies can do was a significant way to demonstrate body appreciation. | Participants appreciate how their body functions and how resilient it can be | <p>“I started working to go to the job and it’s like six kilometers on one now in total I walk 11 kilometers. So, I appreciate that my body can endure that.”</p> <p>“I like to like feel like I’m a pretty sensory person. I like to like to touch other people. I’m a hugger. I’m a like a physically affectionate person.”</p> | <p>“And so, then it comes to the appreciation of, yeah, I might be heavy as hell, but I don’t have to, you know. I can just dive right into an exercise routine. I don’t have to work up to it. And that is because of my body.”</p> <p>“I got the thumbs up to go to the gym. So, for me, it’s really a balance and appreciating what my body can do for myself.”</p> |
| Participants reflected on the next generation and how they would be impacted by weight stigma helped change their body relationships. They found modeling body appreciation and acceptance helpful in body appreciation development. | Interpersonal relationships and modeling body appreciation for children assisted with body appreciation development. | <p>“I guess. I mean, just because of phobia. Right. And like, he’s going to hear all kinds of messages that perpetuate fat stigma and, like, just body shame and. He’s in a thin body. Like, I don’t know that he’s internalizing anything yet, but I can tell that, you know, he hears it from friends at school, and he’s going to hear it from his friends, parents probably at their house. And, you know, it’s I’m never going to be able</p> | <p>“And also, I mean, like having two sons before and now my daughter, who’s eight, and I really want her to know, like, your body is a tool. That’s all it is, you know, you feed it well, you work it hard, and then that’s all. You don’t have to focus on anything more, you know? So, I always tell her we’re strong and long.”</p> <p>“Body appreciation and</p> |

| Practicing Body Appreciation | | | |
|------------------------------|-----------------------|---|--|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| | | <p>to shield him from hearing messages and seeing things. But I guess I just want I want better for him. I want him to grow up in a world where he knows that there's an alternative. And that alternative is you can appreciate your body regardless and that you don't have to spend your life hating your body."</p> <p>"And I very purposely talked never talked about like being on a diet. And it's a little early to, I don't think she would pick it up the subtleties of that yet, but I intend to continue that as well."</p> | <p>external factors made a difference was when I can talk to someone and enjoy. And it's not about the negativities; it's not about talking about my feelings. It's not about this. It's about sharing in it."</p> |

Factors that Endorsed and Challenged Body Appreciation

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|---|---|--|---|
| When participants find movement pleasurable and coming from a place of care, it assists in body appreciation development. | Participants found joyful movements and “craved” those movements. This would also include challenging the body and appreciating what it was able to do. | <p>But I think I also like I took a really long time off of exercise because my relationship to exercise was always rooted in weight loss. And now I wouldn't say that I exercise a lot, but when I do, it's always from a place of caring for my body and not from a place of punishment or, you know, manipulation.”</p> <p>“Other than that, I'm doing the same thing now that I own a house and I'm gardening. And by that, I just mean pulling weeds. Right now, I don't have any idea what I'm doing, but that's. That's something I can do. I'll go pull some weeds. Okay. And that is also hard. So, it's definitely like muscles I'm not used to using or whatever. And it's also sort of meditative. And I listen to podcasts and listen to birds and whatever. And so that's been interesting to appreciate that new sort of movement. Not new, but a new</p> | <p>“I liked working out. Yeah, I'm very energetic. I like. I like stretching, like, I like yoga.”</p> <p>“I have noticed that because for the first three weeks after surgery like you're in a lot of pain and you don't move like you're basically just laid up in bed. I've noticed that my body craved movement, which was interesting because I was doing all the gym and everything right up until surgery.”</p> |

Factors that Endorsed and Challenged Body Appreciation

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|---|--|--|--|
| | | <p>type of movement.”</p> <p>“I just moved into a new neighborhood, which is really nice and walkable. And so, I like to, like, walk.”</p> | |
| Participants not finding clothing that was comfortable or representative of them negatively impacted body appreciation development. | Participants’ difficulty finding clothes that fit decreased body appreciation development. | <p>“So anyway, we do talk about clothes and the, the issues with shopping for clothes and all that stuff, which is very, very related because if you can’t because hearing someone say, especially someone she straight sized. So, hearing someone say it’s not your fault that there aren’t clothes out there that fit you. It’s actually a really big deal.”</p> <p>“My French girlfriends are always looking about what they’re eating because if they eat too much, then they’re not going to be part of the size of that that the French appreciate. And it’s a really it’s a big problem because the clothing there is very different from</p> | <p>“I got tired of always having to shop at Walmart for the three x or above. Once I hit that, I’m like, ‘This is This is this is really. Yeah, this is bull shii. I’m not doing this’ like, you know, like I couldn’t. Right. So that was very frustrating.</p> |

Factors that Endorsed and Challenged Body Appreciation

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|-----------------------|-----------------------|--|------------------------------|
| | | <p>what we're used to here in Mexico or even in the United States. The size is really smaller. So, if you're a little bit bigger than the norm, the majority of the people, then for me it has a direct impact because I saw the size of my pants and I was like, 'whoa, la la'...And here in Mexico, I don't even look anymore at the size of my pants. And when I see it and compare it with my friend's pants, the size are smaller here than what I used to wear there, but it's because of the labeling. And my French girlfriends don't have that comparison."</p> | |

Impact of Body Appreciation

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|---|---|---|---|
| Participants had a better relationship with food after weight-neutral treatment. They experienced increased intuitive eating and decreased valuing or labeling of their food. | Participants experienced more mindful eating and created boundaries with unhealthy foods after treatment. | <p>“And now I only cook, eat, and enjoy.”</p> <p>“And every once in a while, you know what, you just have to go eat that food because it’s the most available option for you. And the guilt doesn’t need to live there because the only reason I ever feel guilty about that is because I am in a fat body.”</p> <p>“But, yeah, but I feel like I’m at a point now where it’s not like I don’t. I really don’t have a lot of guilt associated with food in terms of, like, [the] coded language we use to talk about like sinful or like I’ve earned it and stuff like that. I really do feel like I’ve let most of that go.”</p> | <p>“I’ve had to really it requires this presence and focus on what I’m doing. So I’ll eat a little bowl and I’ll have like three bites and then I put it away, you know, like, okay, let that sit, let’s figure it out. And so I think, I think especially with the surgery, it’s allowed me to like reset how I actually approach what I feel my body with, how I even feel my body like you can’t guzzle 32 ounces of water anymore. You can only have like two ounces at a time.”</p> <p>“So, I’m like, I’m not willing to give that up if I have to, like, walk ten miles and I guess I’ll figure that out. But like how? Because I’m not willing to give that up. I’m willing to give up chocolate cake. But like, I have to have a taco every once in a while.”</p> |

Impact of Body Appreciation

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|---|--|--|---|
| Participants experienced a positive impact on their relationship with themselves, such as increased worthiness, ability to be authentic selves, feeling liberated in their bodies, and happier. | Participants saw increased self-esteem and saw themselves as worthy. This increase led to positive self-talk and self-compassion practice. | <p>“But like coming from that place of that, like, I deserve this and I can and I deserve to be able to seek this care. I deserve to take care of myself. I deserve good things for my body because my body, like I said before, it is a part of me. It’s not a disembodied thing.”</p> <p>“Being my fullest self is the best thing I could do for my kid and myself. That’s more what I want.”</p> <p>“You know, this little moment where I praised myself and congratulate me because I don’t have those problems to be the perfect one, to look the prettiest, and that’s it. Because I know who I am. I know that I’m pretty and I know how to put myself above. And I go I can go out without makeup, without problem, because I don’t feel ashamed, you know?”</p> | <p>“And again, so I’m not saying that I naturally can think that way, but by assigning success or assigning kind of like a pat on the back for a behavior that I consider commonplace, it kind of makes it easier to. To want to continue to succeed in my own mind like I want.”</p> <p>“And the other thing I would say is that because I’ve been able to let that go a lot, I’ve gained a self-confidence. You know, I’m like, I am who I am, you know, like this is me. And that’s been interesting because then you’re not. I’m not hiding behind anything anymore.”</p> |

| Impact of Body Appreciation | | | |
|---|---|--|---|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| Participants felt more empowered as they developed body appreciation, which can be seen in their interest in size activism, advocacy for themselves and others, and challenging weight bias when it occurs. | Participants seemed to be more empowered. This can be seen in increased ownership of who they are, creating boundaries, and increased advocating. | <p>“Knowing that I am helping other people hate themselves less is super, super good. That is one thing I have gotten out of it that I can say has changed.”</p> <p>“But that really was a turning point for me, just in terms of, like, I don’t know what I want from a provider, but that’s not it.”</p> <p>“I know it was really, really awful. And I just like, I went up to our HR, and I said, like, hey, this actually makes me uncomfortable. Like, here’s why. Here’s like, you know, I know that like I have a semi-checkered past with like disordered eating, but I can only imagine there’s some people here that have like a very strong history with disordered eating that this kind of stuff would be really triggering for.”</p> | <p>“It isn’t really that there’s someone saying there’s like a problem with you. It’s kind of you realizing you don’t have a problem with yourself, I guess. And. Yeah, that’s okay. And it’s fine. You settle for that. I don’t. And we’re not perfect.”</p> <p>“And yet I’m okay with it for the first time because yeah, I finally learned like if you ask for help. Sometimes, you know, you get help.”</p> |

Impact of Body Appreciation

| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
|---|---|---|---|
| Body appreciation development can positively impact interpersonal relationships. Participants experienced more meaningful relationships, deeper connections, shared more mutuality. | As participants developed a sense of appreciation for their bodies, they felt more connected to their loved ones and friends. Additionally, they became more vulnerable and open. | <p>“But there’s I feel like the embodiment piece has been so huge for that relationship being as good as it is because I feel like it’s okay to want what I want and to ask for what I want and that like I don’t feel like I need to apologize constantly for like how I look or how I move or how I am. And then in like non-romantic relationships, you know, I’ve had some, I’ve been able to have some really good conversations with people that bring us closer. Like my sister has struggled with disordered eating for a long time, and we’ve had so many good conversations about how we view our bodies and why and how and where that comes from and how we can maybe dismantle some of that and like that.”</p> <p>“I think it has affected my relationship because if I feel okay and appreciative of my body. My partner is going to</p> | <p>“It’s helped me a lot of other areas than food. It’s helped me in my relationship with my family. It’s helped me in my relationship with my friends. It’s, I mean, it’s taken a lot of the stress and anxiety out of how I deal with those situations.”</p> <p>“But because I’m helping others, I’m helping other addicts. I’m helping my daughter, you know like I’m contributing to my sons’ lives.”</p> |

| Impact of Body Appreciation | | | |
|-----------------------------|-----------------------|------------------------------|------------------------------|
| Weight-Neutral Themes | Weight-Focused Themes | Weight-Neutral Text Excerpts | Weight-Focused Text Excerpts |
| | | feel appreciative too.” | |