Relationships Harm, Relationships Heal: Exploring Larger Bodied People's Experiences of Weight Stigma and Eating Disorders in the Context of Family Relationships

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RELATIONSHIPS HARM, RELATIONSHIPS HEAL: EXPLORING LARGER BODIED
PEOPLE’S EXPERIENCES OF WEIGHT STIGMA AND EATING DISORDERS IN THE
CONTEXT OF FAMILY RELATIONSHIPS

A Dissertation

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Antioch University New England

In partial fulfillment for the degree of
DOCTOR OF PHILOSOPHY

by

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RELATIONSHIPS HARM, RELATIONSHIPS HEAL: EXPLORING LARGER BODIED PEOPLE’S EXPERIENCES OF WEIGHT STIGMA AND EATING DISORDERS IN THE CONTEXT OF FAMILY RELATIONSHIPS

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DOCTOR OF PHILOSOPHY

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ABSTRACT

RELATIONSHIPS HARM, RELATIONSHIPS HEAL: EXPLORING LARGER BODIED PEOPLE’S EXPERIENCES OF WEIGHT STIGMA AND EATING DISORDERS IN THE CONTEXT OF FAMILY RELATIONSHIPS

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Eating Disorders are the second deadliest mental illness, after opioid addiction, and affect a significant amount of the population, with some studies estimating that almost one in ten people will struggle with an eating disorder in their lifetime and that many more will suffer from subclinical eating disorder symptoms like disordered eating (Deloitte Access Economics, 2020). The majority of people struggling with an eating disorder are not medically underweight, and traditionally eating disorder research and treatment has failed to address eating disorders in people in larger bodies (Galmiche et al., 2019). To better understand the needs and experiences related to eating disorders in people in larger bodies, research needs to explore the emotional, relational, and psychological impact of experiences of weight stigma in people in larger bodies who are recovering from an eating disorder/eating-related distress. Specifically, there is little information about how experiences of weight stigma during eating disorder recovery impacts the course of recovery, and particularly stigma from family and partners. Accordingly, this qualitative phenomenological research aims to understand said experiences. The study consisted of semi-structured interviews with 12 participants yielding results comprised of four themes and
16 subthemes. The four primary themes are: It Matters That It Comes From Family, It’s Different When You’re Fat, Weight Stigma Harms Relationships, and Relationships Heal. The results highlight the importance of understanding the pervasive and lasting impact that family relationships have on people in the context of eating disorders and the specific experiences of people in larger bodies. Similarly, the results clearly show the importance of relationships in recovery overall. The results and subsequent discussion shed light on the importance of working directly with and combatting weight stigma at the family system and societal levels in order to create more significant and meaningful change for people struggling with eating-related distress, and particularly for people in larger bodies. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

**Keywords:** eating disorders, weight stigma, family, intimate partners, relationships, Health At Every Size®, larger bodied people.
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CHAPTER I: INTRODUCTION

Problem Statement

Eating disorders are the second deadliest mental illness, after opioid addiction, and affect a significant amount of the population (van Hoeken & Hoek, 2020). Studies estimate that almost one in ten people will struggle with an eating disorder in their lifetime, and it is estimated that many more will suffer from subclinical eating disorder symptoms like disordered eating which still have negative mental and physical health effects (Deloitte Access Economics, 2020). Eating disorders are also a social justice issue; thin, white women are overrepresented in eating disorder research and treatment, despite the fact that less than 6% of people with an eating disorder are considered “medically underweight” (Galmiche et al., 2019). Eating disorders affect people of all sizes, races, and genders, and yet people in larger bodies are half as likely to be diagnosed with an eating disorder (Nagata et al., 2018). People in larger bodies are also at increased risk for developing an eating disorder and are exposed to increased weight stigma which is correlated with negative body image, increased eating disorder pathology, and increased anxiety and depression (Calogero et al., 2016; Hayward et al., 2018; Puhl & Suh, 2015). The research on understanding and treating eating disorders in people in larger bodies is severely lacking despite the prevalence and severity of this issue.

Purpose and Significance of Study

To better understand the needs and experiences related to eating disorders in people in larger bodies, research needs to explore the emotional, relational, and psychological impact of experiences of weight stigma in people in larger bodies who are recovering from an eating disorder or eating-related distress. Specifically, there is little information about how experiences
of weight stigma during eating disorder recovery impact the course of recovery, and particularly stigma from family and partners.

Understanding the experiences of people in larger bodies is of particular significance because access to quality and equitable care is a social justice issue, and weight stigma itself is a systemic social justice issue that negatively impacts all people, but disproportionately impacts people in larger bodies who are the main target of discrimination (Meadows & Calogero, 2018; Puhl et al., 2008). More specifically, the existing literature misses key socioemotional factors of eating disorders such as how experiencing or witnessing fatphobia impacts the course of recovery for people in larger bodies. People in larger bodies experience greater weight stigma and more fatphobia than straight size individuals, both in the world and within eating disorder treatment (Meadows & Calogero, 2018). Further, these experiences may be especially harmful when they come from close family or partners (Puhl & Himmelstein, 2018). Therefore, there is a need to better understand the experiences of this population while in recovery from eating-related distress in order to improve prevention and treatment of eating disorders.

**Introduction to Methods**

To accomplish the stated purpose, this qualitative phenomenological research consisting of semi-structured interviews sought to understand some of these experiences. Specifically, phenomenology is a philosophical theory that posits that all knowledge is socially constructed and is determined through our own experiences of the world. Therefore, there is no objective “truth” and instead there can be multiple and even contradictory “truths” at the same time. Phenomenological research values everyday knowledge and each person’s experience and aims to gather a “rich and thick” understanding of what and how people have experienced a particular phenomenon. I chose this method for this study because it aligns with the feminist, relational,
and systemic foundations of the study and my lens of understanding the connection between weight stigma, relationships, and eating disorders. In addition, this approach offers an opportunity to give voice to people whose experiences are largely absent from existing eating disorder literature, something that is aligned with social justice and feminist theory.

This study consisted of 12 participants. Inclusion criteria were being in a larger body, (discussed later in the methods section), and experiencing distress in their relationship with food and body. Throughout this research, I use the phrases eating disorder, disordered eating, and eating- or body-related distress. Eating disorder is defined as a clinically diagnosable eating disorder (according to the Diagnostic and Statistical Manual of Mental Health Conditions, Fifth Edition (DSM-5)); disordered eating is defined as a subclinical eating disorder (meets many but not all of the criteria for diagnosis in the DSM-5), and significant emotional distress related to body/eating has been defined below. I focused on any eating- and body-related distress in order to include experiences of people who struggle with disordered eating and eating- or body-related distress and not just people who have a clinical diagnoses. I defined eating and body-related distress as endorsing one of the following: significant emotional or psychological distress relating to food and/or body, struggles with food/body have had an impairing influence on some aspect of their life, or engaging in one or more behavioral symptoms (restriction, binging, or purging). I also focused on the experience of experiencing weight stigma while trying to recover from eating-related distress. For this study, I defined trying to recover as the subjective experience of someone acknowledging their eating-related struggle and attempting to improve their relationship with food and/or body. I have chosen these criteria in order to be able to capture the phenomenon I am focusing on while also attempting to avoid reinforcing existing
research and treatment biases in the eating disorder field about who struggles with eating disorders and who has the opportunity to recover.

Research questions addressed by this research include:

1. What are the emotional, relational, and psychological impacts for people in larger bodies who experience weight stigma from family and/or intimate partners while trying to recovery from eating-related distress?

2. How do these impacts affect the development of and course of recovery from eating-related distress?

**Theoretical Framework**

I used feminist theory and relational-cultural theory (RCT) as the overarching theoretical frameworks to ground this current study. Feminist theory is a framework that attempts to explain as well as critique social phenomena and offer opportunities to change the world for the better (White et al., 2018, p. 209). Feminist theory has core tenets of looking at how gender shapes society and people’s experiences and highlights that women’s experiences are central and that each person’s story is valuable. It also posits that there can be multiple contradictory truths that are all valid and important to understand. Under the umbrella of feminist theory is RCT, a theory used in psychotherapy. RCT explicitly values multiple perspectives, and challenges Western society’s individualistic perspective of self-development. Instead, RCT proposes that people develop through connection and that relationships are central to our sense of self and personal development (Frey, 2013). RCT also incorporates societal and systemic contexts into the understanding of the challenges people struggle with, and views eating disorders as part of a larger societal context as well (Frey, 2013). Researchers have applied RCT and feminist theory to eating disorders and highlight that key aspects when considering eating disorder development
and treatment include connection, relationships, and social support. Lastly, feminist theory and RCT share the goal of creating change in social systems as a whole instead of focusing on the individual (Piran, 2010). This goal of creating larger societal change aligns with this study as this research focuses on the systemic issue of weight stigma and the relational elements of family relationships. Focusing on larger systems and creating change something that I align with profoundly and that you will see as a thread throughout this study.

**Summary**

This chapter introduced the importance of research on eating disorders in people in larger bodies with a particular focus on research about experiences of weight stigma. This study aimed to fill gaps in existing literature and provide insight into how experiences of weight stigma from family and close intimate partners impact the development of and recovery from eating-related distress. People in larger bodies experience greater weight stigma from all areas; societal, familial, and within eating disorder treatment itself (Meadows & Calogero, 2018). Therefore, understanding the experience of people in larger bodies provides a framework for improving the prevention and treatment of eating disorders. Chapter 2 reviews literature and explores the intersection of weight stigma, eating disorders, and family impact on eating disorders. Chapter 3 describes the methodology including the research design and rationale, procedures, data collection and analysis, validity and ethics, and researcher reflexivity. Chapter 4 presents the results of the study and consists of four themes with three to five subthemes each. Chapter 5 presents a discussion of the results and provides limitations, implications, recommendations for future research, and the conclusion.
CHAPTER II: LITERATURE REVIEW

Introduction

There has been substantial research and clinical intervention emphasis placed on treating eating disorders (Grilo & Mitchell, 2012; Maine, M., McGilley & Bunnell, 2010; Puhl et al., 2014). While there appears to be significant findings and supports for various treatments of eating disorders, there is the gap in the literature regarding the experiences and treatment for eating disorders in people in larger bodies (Grilo & Mitchell, 2012; Maine, McGilley, & Bunnell, 2016). In fact, eating disorders affect people of all backgrounds and all sizes, and only 6% of people diagnosed with an eating disorder are medically diagnosed as “underweight” (Galmiche et al., 2019). Further, people in larger bodies experience weight stigma in addition to the other challenges in eating disorder recovery (Harrop, 2019). Existing research about weight stigma has shown many harmful effects to mental health, physical health, and eating disorder pathology (Calogero et al., 2016; Hayward et al., 2018; Puhl & Suh, 2015). Eating disorder research has often focused on thin white women, despite eating disorders affecting people of all identities including sizes, genders, races, ethnicities, ages, and religious orientations (Cheng et al., 2019). Newer research supports the importance of taking an intersectional approach to eating disorders research and considering how intersecting identities impact eating disorder prevention, development, and treatment (Burke et al., 2020). This includes understanding how different aspects of social location including gender, race, ethnicity, class, disability status, and weight impact the development, persistence, and treatment of eating disorders. While each aspect of identity is intersectional and cannot be separated from another, for the purposes of this study this research will focus primarily on the experience of people in larger bodies taking into account the context of participants’ other identities. In order to explore the question of how weight stigma in
families impacts eating disorder development and recovery in people in larger bodies and to contextualize the research, the following section examines the existing literature surrounding weight stigma, eating disorders in people in larger bodies, and family impact on weight stigma and eating disorders.

**Weight Stigma**

Weight stigma is a social justice issue that impacts larger bodied individuals in every domain of life including work, school, and relationships, among others (Meadows & Calogero, 2018). Weight stigma is defined as negative attitudes and behaviors towards higher weight individuals because of their weight and size (Meadows & Calogero, 2018). Weight stigma can be experienced as macro-aggressions such as being denied healthcare or getting fired for being higher weight, but it can also be experienced in micro-aggressions such as comments about dieting or “feeling fat” (Meadows & Calogero, 2018). Micro-aggressions are smaller but frequent experiences that result in psychological, emotional, and physiological harm and are a useful framework to understand how many people experience weight stigma (Munro, 2017). Weight stigma is discrimination and oppression based on body size and includes a variety of micro and macroaggressions such as, comments about body size/weight, a person saying they are going on a diet, being complimented for losing weight, and more (Calogero et al., 2016).

**Weight Stigma Research is Stigmatizing**

It is important to note that much of the research around weight stigma is in obesity studies and is full of weight bias itself. For example, many studies look at the negative impacts of weight stigma and find that weight stigma actually prevents “health behaviors” and prevents weight loss, thus still focusing on the need for weight loss (Meadows & Calogero, 2018). Some current literature has noted this weight stigma within the research. Calogero, Tylka, and
Mesinger (2016) reviewed the existing literature about weight stigma from a feminist perspective and note that weight stigma research often perpetuates stigma. Such a critical feminist lens is crucial in looking at weight stigma because much of the existing literature around weight stigma is stigmatizing in and of itself. The feminist perspective is a unique lens that specifically looks at oppression, dynamics of power and privilege, privileges lived experience, and aims to end oppression. Often, the messages of weight stigma research remain focused on obesity and only view weight stigma as problematic because it reduces the probability of weight loss. In these situations, the focus is still on weight loss, instead of on ending the oppression of weight stigma in the first place. Calogero, Tylka, and Mesinger (2016) poignantly states that when the focus of mainstream literature is on people in larger bodies and the problems they suffer, it leaves out the causes of weight stigma and therefore does not hold the perpetrators accountable.

Where People Experience Stigma

Although this literature review focuses on stigma in close relationships, it is important to note that people experience weight stigma in practically all domains of life and from a wide variety of sources (Puhl & Heuer, 2009; Vartanian et al., 2014). These areas include employment settings, healthcare settings, educational settings, media, and interpersonal settings and sources include media, external/cultural messages, strangers, health providers, teachers, and peers (Puhl & Heuer, 2009; Vartanian et al., 2014).

Existing research about weight stigma is extensive, and researchers have looked at many different aspects of weight stigma. Much of the research that exists is retrospective in nature, although a few studies have tried to remedy this by collecting data about the experiences of weight stigma in real time. For example, Vartanian, Pinkus, and Smyth (2014) conducted a study in which they gathered information about people’s experience with weight stigma in real time.
over the course of a two week period. The study intended to explore the experience of weight stigma in people’s day to day lives to explore in which settings and from which sources people experienced weight stigma, adding important data about the prevalence of weight stigma in day-to-day life. Vartanian et al. (2014) found that 91% of their participants experienced weight stigma over the course of the two-week study, and the average was 11.12 episodes of weight stigma. People experienced weight stigma from a variety of places but the most frequent were strangers, partners, friends, family, and media. Family members accounted for 35% of all stigmatizing experiences, and participants cited parents as the most significant and painful source of weight stigma.

Puhl, Moss-Racusin, Schwartz, and Brownell (2008) considered how people in larger bodies identify and experience weight stigma and found that “close relationship partners,” including spouses, parents, and friends, were the most common source of stigma and their worst stigma experiences. Consistent with other research, the study found that the most frequent type of weight stigma was verbal comments such as teasing, insults, and negative comments. They highlight the importance of continuing to look at weight stigma in interpersonal relationships and emphasize the need to find ways to reduce this stigma in addition to helping people cope with stigma.

Overall, interpersonal experiences of weight stigma are very harmful as compared to structural or systemic forms (such as not being able to fit into an airplane seat) although all experiences of weight stigma are harmful (Meadows & Calogero, 2018; Puhl & Heuer, 2009; Vartanian et al., 2014). For adolescents, research has found that the most frequent experiences of weight stigma are from peers and siblings, and that stigma from adults/parents are reported as the most damaging to experience (Magson & Rappee, 2022). Weight stigma from trusted loved ones
being especially harmful is consistent with research on attachment theory which posits the importance of having safe, secure relationships (Ainsworth & Bowlby, 1991). It is also reinforced by eating disorders research that has looked at the importance of social support on eating disorder recovery (Quiles Marcos & Terol Cantero, 2009; Wacker, 2008b). Experiencing weight stigma from family and partners would likely erode secure attachment and the feeling of being supported in recovery.

**Internalized Weight Stigma Versus Experienced Weight Stigma**

One way researchers have examined weight stigma and its impact is by distinguishing experienced or externalized stigma from internalized stigma (Calogero et al., 2016; Meadows & Calogero, 2018). External weight stigma are experiences of stigma or oppression that occur from outside the individual, such as negative comments from others, whereas internalized weight stigma is weights stigma directed towards the self (like believing negative stereotypes about the self because of one’s weight.) The difference between external and internal weight stigma, as well as the impact of these types of stigma, has been studied previously. Many studies have focused on and found that the level of internalized weight stigma significantly predicts negative outcomes and is the mediator for the negative psychological, emotional and physical effects of experienced weight stigma, and thus emphasize interventions related to reducing internalized weight stigma and improving coping responses to weight stigma (Hayward et al., 2018; Himmelstein & Puhl, 2019; Meadows & Calogero, 2018; Pearl & Puhl, 2016). Hayward et al. (2018) considered how people cope with weight stigma and identified adaptative and maladaptive coping responses. They studied whether frequency of weight stigma experiences and level of internalized weight bias had an impact on how people coped with weight stigma, and therefore how harmful the experienced weight stigma was. The study found that the more
frequently someone experiences weight stigma, the more likely they were to use maladaptive coping responses which then predicted poorer psychological outcomes. Significantly, the study noted that weight stigma may be such a stressful event that certain types of coping can only do so much in mitigating the negative effects. In effect, just learning how to cope with weight stigma does not solve the problem. Also, the study found that more frequent experiences of weight stigma predicted higher levels of internalized weight bias, and higher levels of internalized weight bias predicted poorer coping and psychological outcomes. Although the level of internalized weight bias is significant for understanding and attempting to mitigate the harmful effects of maladaptive coping, the level of internalized weight bias is correlated with the amount of experienced weight stigma and therefore cannot be isolated as a measure to target.

Similarly, Mensinger, Calogero, and Tylka (2016) conducted a study to explore the impact of internalized weight stigma on eating behavior and found that only participants with low internalized weight stigma and weight neutral interventions experienced a reduction in eating disorder pathology. Participants with low internalized weight stigma and weight loss interventions showed improvement in adaptive eating but not in eating pathology, and participants with high internalized weight stigma and weight neutral interventions showed little to no improvement in eating pathology (Mensinger et al., 2016). It is clear that weight stigma is a pervasive issue that undermines improvement in eating pathology, even in weight neutral settings.

Meadows and Calogero (2018) came to similar conclusions when evaluating how studies have looked at externalized or internalized weight stigma. These authors noted that internalized weight stigma has a specific feature of blaming oneself for ones’ appearance or size. In terms of intervention studies aimed reducing internalized weight stigma, all of the studies including in
Meadows and Calogero’s (2018) review targeted internal factors and coping responses and did not consider how to address systemic or interpersonal factors as a means to reduce weight stigma. Much of the research around weight stigma considers how people cope with weight stigma but fails to acknowledge the larger social, structural, and interpersonal contexts that enact this weight stigma (Hayward et al., 2018; Himmelstein & Puhl, 2019; Vartanian et al., 2014). While focusing on reducing internalized weight stigma is important, such efforts miss an important piece of understanding and reducing the negative impacts of weight stigma: systemic contexts. By only focusing on the level of internalized weight stigma, research and interventions miss a significant opportunity to target the source of the weight stigma which could address the issue at the root and create more effective and widespread change.

**Impact of Weight Stigma**

Weight stigma, both internalized and experienced, has many negative effects, including increased levels of internalized weight stigma, increased negative body image and body image dissatisfaction, depression and anxiety, low self-esteem, and eating pathology (Major et al., 2012; Meadows & Calogero, 2018; Myers & Rosen, 1999; Puhl & Heuer, 2009). Puhl and Heuer (2009) reviewed literature on weight stigma and found that the harmful effects of experienced weight stigma include vulnerability to depression, low self-esteem and poor body image, avoidance of physical activity, negative cardiovascular health outcomes, and maladaptive eating behaviors. Major et al. (2012) also found through an experimental study that weight bias is related to identity threat and is associated with increased stress and decreased self-control. Myers and Rosen (1999) also found that increased stigmatization led to increased risk for body image issues, decreased self-esteem, and worse mental health symptoms. In a longitudinal study of adolescents, Paxton, Eisenberg, and Neumark-Sztainer (2006) found that weight-related teasing
predicted increase body dissatisfaction later on. Recent research continues to support these findings in showing that weight stigma is correlated with anxiety and depression, body dissatisfaction, and self-harm (Magson & Rappee, 2022). Relationally, research has shown that experiencing weight stigma from romantic partners is correlated with reduced relationship satisfaction, less sexual intimacy, and lower perceptions of their partner as an ideal mate (Carels et al., 2020a; Carels et al., 2020b).

**Impacts of Weight Stigma in the Context of Eating Disorders**

Weight stigma is an issue in and of itself, but it is crucial in understanding eating disorders especially in higher weight individuals. Because higher weight individuals experience more weight stigma than others, it would follow that there are more negative effects psychologically, emotionally, and on eating disorder pathology (Meadows & Calogero, 2018). Meadows and Calogero (2018) reviewed literature on the connection between weight stigma and body image and found ample support for the link between the frequency of experienced weight stigma and body image distress. This review notes that research around weight stigma and body image includes a variety of types of studies including cross-sectional, longitudinal, experimental, and intervention studies, with the majority being cross-sectional studies.

Weight stigma also correlates with disordered eating and eating disorder pathology (Eisenberg et al., 2012; O’Brien et al., 2016; R. M. Puhl et al., 2008; Vartanian & Porter, 2016). This is true for both experienced and internalized weight stigma, and existing research shows that the level of internalized weight stigma often mediates the relationship between experienced weight stigma and eating pathology (Hayward et al., 2018). Vartanian and Porter's (2016) review of the intersection of weight stigma and eating disorder literature indicated that in both correlational and experimental studies, experiences of weight stigma were associated with
unhealthy eating behaviors as well as eating pathology. While there is a general link between experiences of weight stigma and eating pathology, there research also that shows that weight stigma from family and partners specifically also has an impact on eating pathology (Eisenberg et al., 2012). In terms of how weight stigma leads to eating pathology, O’Brien et al. (2016) considered the mediating role of weight bias internalization and the amount of psychological distress caused by the experiences of weight stigma and found that higher levels of psychological distress and internalized weight bias were correlated with eating pathology as a result of weight stigma experiences.

However, within the research on how stigma relates to eating pathology is a bias and thus another gap in the research. Most of the research looking at the link between weight bias and eating pathology is steeped in weight stigma itself and obesity research, and primarily looks at whether weight stigma is connected to increased eating and bingeing with the aim of showing how weight stigma impedes efforts of weight loss. A crucial gap exists in understanding how weight stigma impacts other types of eating pathology such as restriction, food preoccupation, and purging behaviors. There has been extensive research that has shown that comments about weight and emphasis on weight and body image are predictors of dieting, disordered eating, and eating disorder pathology (Eisenberg et al., 2012; Kluck, 2010; Meno et al., 2008; Quick et al., 2013; Quiles Marcos et al., 2013; Shomaker & Furman, 2009). However, most of this research does not classify these weight-focused comments as weight stigma, and this research does not focus on the potentially different experiences of people in larger bodies or when people already are struggling with an eating disorder.

Body image may also be a mediating factor in the connection between weight bias and eating disorder pathology. The extant research is clear that weight bias is correlated with
increased body image dissatisfaction. An improved understanding of how body image dissatisfaction is linked to eating pathology is needed (Myers & Rosen, 1999; Puhl & Heuer, 2009). Meadows and Calogero (2018), in their review of existing literature on weight stigma and body image in higher weight individuals, state that understanding weight stigma and its impact on body image and eating disorders is essential because fear of fat, negative body image, and the overvaluation weight and shape are central features of most eating disorders. They also note that these concerns have emerged because of experienced and internalized weight stigma, as well as a result of living in a fatphobic society.

Gaps in the Literature

There are some significant gaps in the literature on weight stigma. Calogero et al. (2016) point out other gaps in the literature, such as the lack of focus on intersectionality and how people with different social identities are impacted by weight stigma. Specifically, these authors highlight how gender intersects with weight stigma, but also that there is a general lack of research on other identities such as race, class, ethnicity, sexual identity, religion, and disability. Meadows and Calogero (2018) also note that most of the existing research on weight stigma relies on student samples and “normal weight” populations. This leaves out the experience of people in larger bodies and contributes to a gap in the research because the experiences of people in larger bodies are very likely different than the experience of those who are in the “normal” range.

Eating Disorders in Larger Bodied Individuals

Eating disorders are complex disorders that have biological, psychological, and social components (Culbert et al., 2015). There has been substantial research aimed at understanding the etiology, maintenance, and treatment of eating disorders (Grilo & Mitchell, 2012). Research
has found significant risk factors for eating disorders using integrative biopsychosocial approaches, including sociocultural idealization of thinness variables (media exposure, thin ideal internalization, etc.) and personality traits such as negative affect and perfectionism. Biologically, eating disorders have moderate-to-high heritability, and a combination of environmental and biological/psychological factors contribute to eating pathology (Culbert et al., 2015). Only recently has the DSM acknowledged that people in larger bodies can suffer from anorexia in the absence of significantly low weight (DSM-5). One of the fundamental criteria for meeting a diagnosis of Anorexia Nervosa (AN) is low body weight, specifically, “restriction of food intake leading to weight loss or a failure to gain weight resulting in a ‘significantly low body weight’ of what would be expected for someone’s age, sex and height” (American Psychological Association, 2013). This criterion fails to capture the many people who suffer from AN or other eating disorders but remain in a larger body who typically will fall into the diagnosis of Other Specified Feeding and Eating Disorder (OSFED). In the publication of the DSM-5, a new category of OSFED–Atypical Anorexia (A-AN)–was added, which includes the same criteria as AN with the exception of “significantly low body weight”; the diagnosis still requires “significant weight loss” but allows for the person to be at a “normal” or high BMI (American Psychological Association, 2013). Acknowledging and producing research around A-AN as well as OSFED is crucial in providing a better understanding and better treatment for people in larger bodies experiencing eating disorders.

**Eating Disorders in Larger Bodied Individuals vs. Straight Sized Individuals**

Research on A-AN has found that individuals with A-AN present with the same symptoms, comorbidities, and similar severity and levels of impairment as those diagnosed with AN (Fairweather-Schmidt & Wade, 2014; Sawyer et al., 2016; Thomas et al., 2009). Essentially,
there are a few clinical difference between individuals suffering from AN versus A-AN, with a primary difference being whether the individual has a low BMI or not. Individuals with A-AN encounter barriers to treatment and recovery as a result of weight stigma because of their body size (Sawyer et al., 2016). Individuals with A-AN typically are diagnosed later, have a longer duration of symptoms, experience more weight loss, and suffer from more psychological distress related to the disorder (Sawyer et al., 2016). A-AN is also associated with significant medical issues such as bradycardia and amenorrhea, and research has shown that patients with EDNOS (Eating Disorder Not Otherwise Specified) also suffer from similar levels of medical issues as patients with AN or Bulimia Nervosa (BN) (Peebles et al., 2010; Sawyer et al., 2016). Therefore, eating disorders in higher weight individuals carry similar negative effects and yet these individuals face more barriers to treatment and recovery than straight sized individuals (Sawyer et al., 2016; Harrop, 2019).

Fairweather-Schmidt and Wade (2014) looked at whether there is a meaningful differentiation between Threshold Eating Disorders (TED)—AN, BN, and Binge Eating Disorder (BED)—labeled as such because there are specific severities that are required to meet diagnosis, and “OSFED” (Other Specified Feeding and Eating Disorder), in which many symptoms are met but not enough to meet the full criteria for a TED. Examples of this include A-AN, BN of low frequency or limited duration, BED of low frequency or limited duration, and purging disorder. Many people in larger bodies are diagnosed with OSFED or A-AN because while they may have most of all of the criteria required to meet a TED, there is the absence of “significantly low weight,” although they may still experience significant weight loss. The study looked at level of impairment and risk factors to determine whether there is a meaningful difference between TED and other ED diagnoses. The study found that of the participants
diagnosed with an eating disorder, 48% were identified as OSFED cases. The study also found that there was no difference in level of impairment between threshold and non-threshold cases and found that there was no genetic difference in terms of risk factors. While there was a statistically significant difference between the two groups in terms of specific environmental risk factors, both groups were similar in terms of genetic risk factors (Fairweather-Schmidt & Wade, 2014).

Unique Challenges Associated with Eating Disorders in Larger Bodies

There is a significant gap in research about the etiology, treatment, and experiences of larger bodied individuals with eating disorders since most eating disorder research has been done focusing on thin or straight size women. As such, there is little known about how these may differ for larger bodied individuals and other populations who suffer from eating disorders. There is a critical need for future research on eating disorders to focus on this population and their experiences in order to provide better prevention and treatment.

Weight Stigma/Provider Bias in Treatment

One concern is that larger bodied individuals may delay or avoid healthcare due to societal stigma and weight stigma from healthcare providers (Drury & Louis, 2002). This is a valid concern because people in larger bodies will inevitably experience weight stigma when seeking eating disorder treatment as they experience this in all domains of life (Puhl & Heuer, 2009). Because people in larger bodies already experience weight stigma from many sources in their day-to-day life, it follows that they will experience it when seeking treatment for an eating disorder. Research has shown many experiences and issues of provider bias and weight stigma in healthcare, psychotherapy, and eating disorder treatment specifically (Chrisler & Barney, 2017; Puhl & Heuer, 2009). These experiences are harmful to any person in a larger body but may be
especially damaging to someone seeking treatment for an eating disorder who already has an intense fear of weight gain.

In a review of the literature, Puhl and Heuer (2009) found that people in larger bodies experience a great deal of weight stigma from health professionals. The study found that over 50% of physicians in one study held negative attitudes towards “obese” clients such as that they are unattractive, ugly, and noncompliant (Puhl & Heuer, 2009). Another 1/3 of these physicians also believed their obese patients to be “weak-willed, sloppy, and lazy.” Despite extensive research to the contrary, most physicians viewed obesity as a behavioral problem that should be managed by the patient. In other studies of implicit bias, a large percentage of the participants endorsed both implicit and explicit biases towards “obese” people (Puhl & Heuer, 2009). Similar findings exist for a variety of healthcare professionals including nurses, fitness professionals, and dietitians (Puhl & Heuer, 2009).

Research has also looked at weight bias specifically in psychosocial care and treatment and found that consistent levels of weight bias exist in this field as well (Puhl et al., 2014; Veillette et al., 2018). Veillette, Serrano and Brochu (2018) looked at the effect of BMI on mental health trainees’ perceptions and treatment recommendations for a client with eating disorder symptoms. The study found that the participants’ perception, diagnosis, and treatment recommendations for the diagnosis of AN varied depending on client BMI. When presented with two identical case summaries that different only in BMI, participants were less likely to diagnose a larger bodied client with anorexia, recommended fewer treatment sessions, and assigned more stereotypical traits to these clients. This supports the findings that weight bias may contribute to barriers to treatment for larger bodied clients. The study also hypothesized that weight stigma and stereotypes enacted by providers may contribute to internalized weight bias and shame,
which may deter individuals from seeking further treatment and reduce the effectiveness of treatment.

Evidence suggests that similar patterns exist among professionals who treat eating disorders. Puhl et al. (2014) looked at weight stigma in eating disorder treatment providers. They used measures such as the Fat Phobia Scale, Universal Measure of Bias-FAT, perceived causes of obesity, attitudes about treating obesity, perceptions of treatment compliance and success of obese patients, perceptions of weight bias among practitioners, personal history of disordered eating, dieting, and fear of fat, and finally personal history of weight victimization. The study found that weight bias was present in this population at similar rates as the general population of health practitioners. While the scores of weight bias were slightly lower than other professionals, participants reported that they had frequently heard or witnessed negative comments/biases about “obese” patients and believed other providers had biases. Participants also still endorsed biases such as the belief that “obese” patients are non-compliant with treatment recommendations (Puhl et al., 2014). While the consequence of weight bias among eating disorder treatment professionals has not been studied, there may be harmful effects of the outcomes of treatment when providers hold these biases.

Treatment providers also may be less knowledgeable about and less equipped to work with clients in larger bodies, which may result in reduced quality of care for these individuals. Kimber et al. (2019) explored the experiences of practitioners working with adolescents with A-AN and found a variety of challenges. Participants reported that clients with A-AN had higher pre-morbid weights and experienced more frequent weight-based teasing by family and peers. They also described body image concerns as closely tied to weight loss efforts, and practitioners reported struggling with wanting to validate this experience but also not collude with the eating
disorder and desires to stay at the same weight or lose additional weight. Practitioners also reported challenges with convincing parents that their child had a severe eating disorder even though they did not appear thin. They also identified struggling with mixed messages and challenges around weight gain or loss and health, “justified” fears of weight gain, and the need to be more aware of parent collusion with the eating disorder. This study highlights the unique challenges that providers experience working with this population, and thus the potentially lower quality of care and challenges with treatment that this population may experience.

While there are few qualitative studies that focus on the experiences of people in larger bodies with weight stigma in eating disorder treatment, Harrop (2019) gives a detailed and personal look at the harm caused by experiencing weight bias. Harrop examines their experience with weight bias from a primary therapist while in eating disorder recovery and has a unique perspective because they had previously sought out treatment when they were in a smaller body and were diagnosed with typical AN, and later sought treatment as a fat identified A-AN patient. They detailed experiences of explicit and implicit weight bias consistently throughout their treatment. Examples include the therapist not believing they were in treatment for an eating disorder based on their weight, and repeated assertion that their primary problem was substance abuse and not an eating disorder, despite the patient being clean for four years. The therapist compared them to other patients with typical AN and invalidated their struggle with the eating disorder. Harrop (2019) identified various negative effects of these interactions including increased denial of their eating disorder, the therapist modeling eating disorder behaviors, disrupted therapeutic alliance, enacted body shame, and reinforced feelings of lack of self-worth. Harrop (2019) also briefly reported other experiences of weight stigma while in treatment from other sources including dietitians, physicians, and peers. While this is just one person’s
experience, the harm done is clear and there are likely many more stories such as this one if research were to be done focusing on larger bodied patient’s experiences.

**Family Impact on Eating Disorders and Weight Stigma**

**Family Impact on Eating Disorders**

Many researchers have also looked at the family influence on eating disorders from various perspectives. Some have examined how weight and body image concerns develop through family interactions. Often, body image and weight concerns are the first symptom which end up leading to eating disorder pathology (Meadows & Calogero, 2018). Therefore, understanding how family relationships impact body image issues and weight concerns is crucial in understanding eating disorder development. As a whole, research has found that weight-related talk and teasing from peers and family is harmful and influences dieting behavior, body dissatisfaction, and bulimic symptoms (Quiles Marcos et al., 2013). For example, Kluck (2010) considered the role of body image dissatisfaction in relation to disordered eating and a family culture that focuses on appearance. The study found that parental comments about weight/appearance and a general appearance focused family cultural were significantly associated with body dissatisfaction and bulimic symptomology. Similarly, Shomaker and Furman (2009) analyzed the influence of interpersonal factors on disordered eating and found that pressure from family and friends to be thin predicted disordered eating. Weight comments and weight-related teasing is common in youth and adolescents, and research has found that weight talk continues into adulthood and is often experienced from family (Eisenberg et al., 2012). Unsurprisingly, higher weight individuals experience more weight talk and weight-related teasing (Eisenberg et al., 2012). In a master’s thesis exploring the medical provider and family influence on eating disorders in higher weight clients, Dios (2019) found that participants
experienced harmful messages from family members about their bodies. The two primary themes were problematizing bodies, such as receiving direct negative comments about what was wrong with their bodies, and messages that contributed to internalized fatphobia and normalizing dieting such as encouraging disordered exercise and eating behaviors in order to lose weight. While this study is not published in a peer reviewed journal, it highlights the importance of family messages on eating disorder development and recovery and poignantly describes the harm caused by these messages.

Similarly, Gowers and Shore (2001) considered the etiology of weight and shape concerns as they connect to eating disorders and found that there were some genetic/personality risk factors, but environmental factors were more closely linked to these concerns. Environmental and family factors that were found to contribute to the development of weight and shape concerns included parental overconcern with weight and dieting, as well as modeling dieting behaviors by parents. Research has found that parent weight talk and family weight teasing affects individual’s weight status, body dissatisfaction, and disordered eating, and in no instance was weight talk associated with better outcomes (Neumark-Sztainer et al., 2010). This research shows that both hearing weight talk and having weight talk directed at a person is harmful. Meno et al. (2008) also explored family and individual factors and found that similar family factors (such criticism and emphasis on weight and shape) predicted dieting and binge eating. Additionally, a poor emotional family environment even when weight stigma is not explicitly experienced can contributed to eating disorder pathology. Arroyo and Segrin (2013) found that high family conflict, high levels of rigidity and control, and especially high expressed negative family emotion contributed to poor social competence and psychological distress in adolescents which then contributed to disordered eating.
Understanding the influence of family on eating disorders and weight stigma is crucial because prior research has found that family members are the most common and frequently cited sources of weight stigma, and some studies have found that when stigma comes from family it is more harmful (Himmelstein & Puhl, 2019; Puhl & Heuer, 2009). When specifically considering weight stigma, research has found that family communication can be a way that the family communicates societal attitudes and behaviors, and in this context communicates messages of weight stigma (Fitzpatrick & Ritchie, 1994). This aids in understanding both how individual body image concerns and eating disorder pathology may develop due to family, but also how societal attitudes about weight and shape are passed on and reinforced throughout familial generations.

**Eating Disorder Treatment and Recovery**

There is a gap in the research regarding specific ways that family can support or hinder the course of recovery for eating disorder patients. The rationale for considering family support and involvement in treatment, even in adults, is consistent with many models that emphasize family systems and the importance of relationships such as family systems, relational-cultural, attachment theory, and more. These models reflect that the family and social relationships that the person experiences are deeply connected to their functioning, and it follows that an individual’s ability to create change and recover from an eating disorder would be highly affected by these relational components as well. The emphasis on the importance of the family is also consistent with anecdotal research showing that people identify social support as a significant factor in their recovery from an eating disorder (Linville at al., 2012).

In terms of existing research about family involvement in eating disorder treatment, most of the research focuses on family-based treatment (FBT). While there is substantive research on
the effectiveness of FBT for children and adolescents with eating disorders, there is little research about the role of family in the treatment of eating disorder in adults (Lock et al., 2005; Pisetsky et al., 2016). FBT is an effective treatment that focuses primarily on the behavioral components of eating disorders with the main goal of nutritional rehabilitation. However, FBT does not give much attention to underlying dynamics, or issues of weight stigma within the family. Therefore, more research is needed to understand the impact of family as someone is recovering from an eating disorder.

FBT and other models of family involvement also do not incorporate an understanding of the impact of weight bias on people in larger bodies in general, nor in the context of eating disorder recovery. Additionally, there are few studies focusing on utilizing FBT for people in larger bodies, and one study showed that while patients with A-AN went through FBT protocol and improved in eating disorder pathology and depressive symptoms, the BMI of participants did not change (participants did not gain weight), highlighting the lack of attention to physical rehabilitation when patients are at higher weights (Hughes et al., 2017). For people in larger bodies, there may be unique issues that present if family perpetuates weight stigma as the person is trying to recovery. For example, parents may fear their heavier child gaining weight, and fail to support the patient in gaining weight back to their pre-morbid developmental trajectory. On the other hand, there is also an important opportunity for family to be involved and be supportive of the person in recovery from an eating disorder. Since people in larger bodies are likely to experience weight stigma while in treatment for eating disorders, having supportive family who do not perpetuate weight stigma and can help advocate for unbiased treatment for their loved one could provide a significant path to improved treatment and outcomes for people in larger bodies recovering from eating disorders.
One study looked at family involvement in eating disorder treatment in adults more generally. Reyes-Rodríguez et al. (2019) explored family involvement in eating disorder treatment among Latinas and analyzed six family sessions attended by individuals struggling with eating disorders and their families. The topics discussed in the family sessions covered a breadth of important topics such as psychoeducation about eating disorders, communication, and issues of body image, self-esteem, and weight loss. Some of the participants specifically addressed issues of weight and body image within the family or couple. For example, in one couple, the partner with an eating disorder expressed that she felt that weight loss was a condition for their marriage. Another participant expressed that her binge eating was connected to feeling rejected by her partner (Reyes-Rodríguez et al., 2019). This clearly shows that family relationships and interactions around weight and bodies may be important issues to address in treatment and recovery. The majority of the participants also specified the need for family support in recovery, which included both practical and emotional supports (Reyes-Rodríguez et al., 2019).

Another significant study that looked at the role of social support in eating disorder recovery is Linville et al. (2012). This qualitative study explored the experiences of people in recovery from an eating disorder and identified various factors of social support that aided or hindered recovery. Factors that aided in recovery included connection to others, close relationships, statements of support, compassion, and an understanding of eating disorders, among others. Harmful factors included trivializing the disorder, isolation, being stereotyped and stigmatized, and hearing hurtful comments about weight. Many participants recalled experiences in which they felt they were not thin enough according to their support systems, and that family or healthcare providers focusing on weight was harmful (Linville et al., 2012). Another study
looked at sources of support in eating disorder recovery and found that the most frequent sources of support included mothers and partners, again highlighting the importance of understanding the role of this support in recovery (Quiles Marcos et al., 2013).

**Feminist Theory and Relational-Cultural Theory**

Feminist theory is a useful and versatile theory that can be applied to a variety of social issues. Feminist theory was born of the feminist movement, and therefore is unique in that as a theory it aims to explain phenomena as well as evaluate them. It is used to critique the social phenomena being studied and offer solutions to change the world (White et al., 2018). One of the central features of the theory, a feature that presents both challenges and strengths, is its diversity of thought; there are various waves of the feminist social movement, and consequently a variety of thinkers and voices that are all encompassed by feminist theory. While this makes it difficult to singularly identify the overarching beliefs of feminist theory, it adeptly exemplifies one of the core tenants, that women’s experiences are central and that legitimizing and empowering each person’s story is valuable (White et al., 2018).

More specifically, I am also utilizing relational-cultural theory (RCT) to frame my research questions. RCT is a mid-level theory that is grounded in feminist theory. RCT was developed in the 1970’s through the work of Jean Baker Miller, Judith V. Jordan, Janet Surrey, and Irene Stiver (Jordan, 2017). The theory combines feminist theory with psychodynamic principles, and as such is in line with many of the key assumptions of feminist theory. RCT aligns with the core principles of feminist approaches to therapy, such as valuing client perspectives and experiences, viewing clients as collaborators, valuing strengths and diversity, exploring intersectionality, emphasizing therapist self-reflection and the therapist’s impact on the therapeutic relationship, modeling empowerment, and considering societal change as part of the
treatment (Frey, 2013). Most fundamentally, RCT proposes that people develop through connection and relationship and rejects the idea that the epitome of self-development is individuation or autonomy. Meaningful, shared connection leads to the development of a healthy self, and it identifies core components of growth-fostering relationships (Frey, 2013).

Other researchers have applied feminist and relational-cultural theories to understanding eating disorders (Piran, 2010; Trepal et al., 2012; Wacker, 2018a, 2018b). Wacker (2018a) identifies core aspects of the feminist-relational model when considering eating disorders such as connection, social support, voice, empowerment, and feminist identity. The feminist-relational framework suggests that connection, relationships, and support are crucial factors in the development of eating disorders. Eating disorder development disconnects people from their support systems, and therefore reestablishing that connection, emphasizing one’s voice, and empowerment are keys to recovery (Wacker, 2018a). Similarly, Wacker (2018b) identified lack of social support as a significant barrier to treatment, and social support and strong relationships as facilitators to seeking treatment for subclinical eating disorders.

In terms of weight stigma, the feminist concepts of intersectionality and looking at power and oppression are key in conceptualizing the problem. Feminist perspectives on eating disorders include understanding how structures of power and privilege, gender, and self-worth impact eating disorders (Piran, 2010). Weight stigma is a societal phenomenon that serves to oppress people in larger bodies, but it also oppresses everyone (and women especially) by creating preoccupation with appearance and weight. Weight stigma is a social justice issue and the feminist focus on social justice and equality support this view. By focusing on people in larger bodies with eating disorders, I center the feminist principle of valuing different experiences and uplifting marginalized voices. Similarly, a goal of feminist work is to change social systems as a
whole instead of focusing on the individual (Piran, 2010). Wacker (2018a) also explores the feminist critique of eating disorder research that not enough attention is given to the systemic issues and understanding the social, relational, and political environment in addition to individual risk factors.

**Conclusion**

This review of existing literature addressed weight stigma, eating disorders, and family influence, specifically focusing on how these three factors impact and are experienced by people in larger bodies. Eating disorders are a significant and challenging illnesses, and although significant research has been done to understand and treat eating disorders, there is a lack of research and understanding about eating disorders in higher weight individuals. It is clear from the existing research that eating disorders and weight stigma are interconnected, and that weight stigma increases negative body image which then correlates with increased eating disorder pathology, especially in higher weight individuals. It is also clear that family influence is significant when it comes to the development and treatment of eating disorders, as well as experiences of weight bias, but there is also a gap in the literature about how these two may be connected. Further research is needed to continue to understand the effect of family/partner weight stigma on higher weight individuals while recovering from an eating disorder.

Understanding and addressing weight stigma is an essential part of ethical and effective eating disorder treatment, and it is even more crucial for people in larger bodies. While it is important to address weight stigma in all areas—like from society, media, and treatment providers—research shows strong support for the importance of understanding the family impact on both the development of and recovery from eating disorders. Family members, partners, and close loved ones are some of the most influential relationships in someone’s life, and it follows
that the same would be true for eating disorder recovery. The relational component of eating disorder development and recovery is often ignored in eating disorder treatment, despite the fact that it may be an essential vehicle for creating change. If family relationships are the way in which people learn about the world and about themselves, the messages received from family and partners clearly impact people’s sense of self and internalized weight stigma. Anecdotally, in my clinical work I have seen how challenging it is for someone in recovery to be fighting against stigmatizing messages from the world about their body not being acceptable and fighting the internalized eating disorder voice saying the same thing, and the harm it causes to hear the same messages echoed from family and loved ones. According to relational-cultural theory and attachment theory, secure and safe relationships create a buffer from the challenges of life and harms of the world and allow people to become the fullest versions of themselves (Ainsworth & Bowlby, 1991; Jordan, 2017). Eating disorder recovery emphasizes self-trust, expansion, and connection, and this mirrors people’s relationships as well (Wacker, 2018a). Exploring the full impact of weight stigma from family and close loved ones is crucial in improving the field’s understanding of the development, maintenance, and treatment of eating disorders especially for people in larger bodies. Therefore, this study aimed to provide insight into the experience of weight stigma from family and partners on people in larger bodies in recovery.
CHAPTER III: METHODS

Qualitative Methodology

Qualitative research, and more specifically phenomenological qualitative design, is a useful approach for exploring the research questions of weight stigma, eating disorders, and family impact. Because the purpose of the study was to elucidate and understand the experiences of people in larger bodies with eating disorders, qualitative research was the best method to explore these topics. Instead of seeking to confirm or deny a specific hypothesis, qualitative research aims to gather a “rich and thick” narrative of the topic. As such, for this study I used phenomenology-informed reflexive Thematic Analysis. Specifically, phenomenology is a method that focuses on how people experience any given phenomena, and values understanding this from the person’s perspective as opposed to fitting this into a pre-determined understanding of the world (Pietkiewicz & Smith, 2014). Phenomenology is a useful way to explore the meaning of a similar phenomenon for multiple people as a way to better understand the concept being studied (Creswell & Poth, 2016). The important questions in phenomenology include what people have experienced and how they have experienced it (Creswell & Poth, 2016). In addition to phenomenology, I used Reflexive Thematic Analysis (TA) to ground my analysis. Reflexive TA is a qualitative method for “developing, analyzing, and interpreting patterns across a data set” that highlights the importance of researcher subjectivity in the data analysis process. Rather than aiming to eradicate this influence on the data, reflexive TA provides guidance for how to reflexively engage with the data and think critically about the way our own biases shape our interpretation of it (Braun & Clark, 2021b). Reflexive TA is a flexible approach that can be combined with many other theoretical foundations, such as phenomenology, so long as this is done intentionally and thoughtfully. To illustrate this intentional process, I will now provide my
theoretical foundation and rationale for both phenomenology and reflexive TA, and how I integrated the two.

**Phenomenology Theory and Rationale**

Phenomenology has a rich philosophical and psychological tradition. Phenomenology is often seen as emerging from the writings of Edmund Husserl and later philosophers such as Heidegger, Sartre, and Merleau-Ponty (Creswell & Poth, 2016). There have been various successors and perspectives on phenomenology and the philosophy has been used in sociology, nursing and health sciences, psychology, and education (Creswell & Poth, 2016). While the various perspectives differ in certain ways, all phenomenological research rests on similar philosophical assumptions. Phenomenology asserts that knowledge is socially constructed, that “objective” knowledge is not knowable, and that because knowledge is constructed, and there can be multiple perspectives and contrasting “truths” at the same time. Phenomenology also values everyday knowledge, and experiences that may not seem significant; instead, everyday life is significant (Creswell & Poth, 2016). Since everyday life and meanings are the focus of this qualitative inquiry, the best way to study this is in the real world (and not in an artificial place like a laboratory). Similarly, phenomenology also acknowledges the fact that the researcher themselves is part of the research process and that bias unavoidable. Instead of this being a limitation, it is simply a fact of life and must be considered thoughtfully (Dahl & Boss, 2005).

Merleau-Ponty’s (1964) idea of incarnate subjectivity is a foundational idea in phenomenology and one that applies to this research topic. In his essay *The Primacy of Perception* (1964), Merleau-Ponty argues that the mind and body are connected in perception in his idea of incarnate subjectivity. The way in which humans perceive and interact with the world is determined by our subjective experience, and much of this happens in and through the body. This is directly connected to the idea of
embodiment, which is also a core construct in eating disorder recovery and body image work. Merleau-Ponty approaches perception from a phenomenological standpoint and places the body in the center of perception. He writes, “The perceiving mind is an incarnated mind…these philosophies commonly forget – in favor of a pure exteriority or of a pure interiority – the insertion of the mind in corporeality, the ambiguous relation which we entertain with our body and, correlative, with perceived things” (Merleau-Ponty, p. 4, 1964). Merleau-Ponty argues against other philosophies that focus only on the body or only on the abstract mind or soul, and instead argues for a collective view. He says that since the “perceiving mind” is “incarnated,” or within a body, the body necessarily has an impact on how people perceive things. Further, he discusses how the body exists in the world. He writes, “We grasp external space through our bodily situation. A ‘corporeal or postural schema’ gives us at every moment a global, practical, and implicit notion of the relation between our body and things, of our hold on them” (Merleau-Ponty, p. 5, 1964). Again, Merleau-Ponty focuses on the body and argues that our “bodily situation,” or where we exist in space and in the world, also affects how we perceive and understand things around us. This is essential to understanding how people in larger bodies experience the world and experience weight stigma specifically. Sonya Renee Taylor, body liberationist and author of *The Body is Not An Apology* (2018) writes, “For me, this work is social justice work. I’m using the site that is most impacted by social injustice, which is the body.” We cannot understand weight stigma and how people in larger bodies experience it without considering the body. The body is the vehicle for perceiving, and it is also the site of trauma for so many people.

Additionally, phenomenological inquiry is appropriate for exploring the experiences of people in larger bodies, because the goal of phenomenology is to understand an often-unrepresented experience, and to create new knowledge of these experiences which may inform better therapeutic treatment. Because people in larger bodies with eating disorders are also a
marginalized, under-represented, and vulnerable group, phenomenology is also an important way to explore their experiences, because it privileges the person’s perception instead of imposing the dominant narrative onto an already oppressed group. Phenomenology also allows for a complex understanding of experiences and can make space for what could be considered discrepancies within the research, in order to honor people’s full and nuanced experiences (Dahl & Boss., 2005). While phenomenology is not inherently or exclusively a feminist framework, it aligns well with feminist theory and values disrupting hierarchy within the research process and in the greater society; a philosophical underpinning of phenomenology is that “everyday knowledge is shared and held by researchers and participants alike” (Dahl & Boss, 2005). The present study, by nature of the design and topic, aimed to create social change and to center the voices and experiences of people in larger bodies who are usually marginalized in society and in eating disorder research.

**Reflexive Thematic Analysis and Rationale**

Phenomenology-informed, reflexive thematic analysis (TA) was used to analyze and interpret the data. I integrated phenomenology and reflexive TA in order to stay consistent with the philosophy and methodology of phenomenology, and to use the practical guidance and benefit of reflexive TA. Phenomenology is the epistemological and ontological foundation as previously described in this chapter; it asserts that we understand and make meaning about the world through our experience, and that we cannot understand the world separate from our experience and interpretation. As such, the overarching goal of this phenomenological research was to explore the meaning that participants have made about their experiences with weight stigma in their family relationships. Reflexive TA has many variations and can be used with different theories so long as the rationale is explained. In this case, I used an experiential,
relativist orientation to TA. Relativism is an ontological position that asserts that there is no singular reality, and that reality is the result of human action and interpretation. This informed my approach to TA in many ways, specifically by establishing the intention to “offer a reading” of the data trying to arrive at the meaning (Braun & Clarke, 2021b, p. 174). With relativist TA, there is potential for many different readings and analysis, because the belief is that there is no absolute truth that can be “found” by the researcher. The analysis is an interpretation co-created by the researcher. Similarly, an experiential orientation to TA “centers the meaning and experiences articulated by participants,” and stays closer to the meaning as participants understand it and less extrapolation by the researcher (Braun & Clarke, 2021b, p. 160), which fits directly with the overarching theory of phenomenology. Experiential orientations are grounded in a “hermeneutics of empathy,” which directly informs the analysis and interpretation of data. A hermeneutics of empathy is underpinned by the view that language is a tool that aims to understand and explain the data in a way that stays close to the intended meaning of the participants (Braun & Clarke, 2021b, p. 160). As such, engaging in reflexive practices and explaining the process of research is at the core of validity and credibility, instead of proving that an “absolute truth” has been found by the researcher. Later in this chapter I detail the reflexive practices I engaged in in order to provide opportunities for the reader to assess the validity and credibility of this study.

Ethical Considerations

Because of the sensitive nature of the research topic and an already marginalized population, careful consideration of ethical issues was important. In addition to previously mentioned ethical issues, such as protecting data and researcher reflexivity practices, the study had a thorough process of informed consent and provided resources for further support during
and after the interviews, if the participants needed this. Referrals for additional support such as support groups, psychoeducational resources, and therapy resources were available if the participants required this. There was also a debriefing time after the interview to ensure participants felt supported. The majority of the participants expressed appreciation and gratitude for the research being done and for having a supportive space to discuss these issues.

**Credibility and Trustworthiness**

The design of this study addressed credibility and trustworthiness. First, in line with the concept of researcher reflexivity, I kept a reflective journal throughout the entire process, providing a place to record and reflect on my own reactions and feelings throughout the study, which assisted with identifying and working through researcher bias. Secondly, following each interview, I wrote brief summary and reflexive practice, and shared this reflection with my dissertation chair as a form of peer debriefing. Thirdly, since capturing the meaning of the participant is one of the main goals of phenomenological research, I also practiced member checking twice. First, by providing the transcript to the participant and asking for any follow up or clarification and then towards the end of the project participants were given a copy of the results section to ensure that participants agreed with the identified themes and to give them the opportunity to correct or change any themes. Another aspect of ensuring trustworthiness is that each transcript was also analyzed in light of the data collected from other participants and with the existing literature. I compared the data from various participants and gave special attention to aspects of the data that did seem to align. Finally, the study overall involved consultation with others as part of the dissertation process and peer review. I have also provided an in-depth explanation of research methods and rationale to allow the consumer of the study to determine credibility and trustworthiness for themselves.
**Researcher Reflexivity**

Researcher reflexivity is a concept that highlights the importance of critical reflection of the researcher and acknowledges that researcher influence on the process is inevitable and that this is not necessarily a bad thing. Instead, this approach embraces subjectivity and views the process of research and knowledge creation as a shared endeavor, consistent to qualitative theories. However, it does mean that as researchers we must “critically interrogate what we do, how and why we do it, and the impacts and influences of this on our research” (Braun & Clarke, 2021b, p. 5). Acknowledging researcher reflexivity and incorporating an explanation of reflexive practices is an essential part of phenomenology research. This section highlights the work I have done to be reflexive and aware of the ways in which my own biases and identity has impacted this research. Inevitably, I have made choices about the study design and interpreting and analyzing data through my own lens of knowledge and experience. The practice of being reflexive aims to acknowledge this influence and is aligned with the goal of phenomenological design and thematic analysis to focus on and privilege the lived experiences of the participants. This is especially important due to the sensitive nature of the study, and my goal to be sensitive to issues of social justice and stay grounded in feminist theory which aims to create change in the systems of power and oppression that exist in the world, especially when it comes to weight stigma.

One aspect of researcher reflexivity is to acknowledge and be explicit about the ways that the researcher’s identity influences the research process (Olmos-Vega et al., 2023). To do this, I engaged in an exercise prior to beginning the study to explore my own biases around the topic of eating disorders and weight stigma and how my identity may influence the process. One
particular challenge I was aware of is that I do not hold the same identities that my participants do and often times will be in the “out group” position. While I have lived experience with disordered eating and body image, I am not and never have been in a larger body and therefore have thin privilege, in addition to other potential privileged identities as I am white, upper class, cisgender, heterosexual, and non-disabled. This is of particular importance when it comes to interviewing the participants and creating a context that feels safe enough to explore these sensitive topics, and in not interpreting the data from a place of privilege that ignores the realities of the participants.

I was also aware of the need for me to balance the context and experience that I brought to the work with being open to understand and explore the experience of participants. I am passionate about social justice and see weight stigma as a major issue in the world and one that contributes significantly to eating disorders. My own recovery has been helped immensely by the work of fat activists and Health At Every Size® (HAES®) and doing research/treating eating disorders without a major focus on weight stigma and the way in which people in larger bodies are harmed would not feel ethical to me. I have also seen from my clinical work how impactful (both positively and negatively) family relationships and family messages about weight stigma are. My passion and investment in this type of work is both benefit and potential challenge to the research. The benefit is that I have done years of my own work to unlearn anti-fat bias and am invested in this work. However, this may also be a disadvantage because I have a personal connection and attachment to this work and the outcome. For example, it would be hard for me to believe that experiencing weight stigma from family did not impact someone at all. In addition, I have a deep understanding of eating disorders, HAES®, and fat activism from my personal and professional experience and investment in the topic. While not formal research, I
already have many anecdotes from clients that help contextualize and frame my research question and hypotheses about the harms of weight stigma. The other side of this is that this will require extra work to bracket these ideas since I do have a lot of knowledge/experiences/beliefs about the topic.

In addition to exploring and naming the biases I bring to this work, I also engaged in reflexive practices by keeping a journal where I noted my thoughts and feelings throughout the research practice and engaged in peer debriefing by sharing these reflections with my dissertation chair. I also practiced bracketing during the interview process, as described below in the interview section (Husserl, 1970; Olmos-Vega et al., 2023). I also practiced member checking, which is another way of engaging in reflexive practice by acknowledging that my interpretation of the data is just one interpretation and allowing participants to collaborate on the interpretation and analysis (Olmos-Vega et al., 2023).

**Method**

**Participation Selection**

In phenomenological research, the goal is to elucidate and better understand how people experience a particular phenomenon – in this instance weight stigma – and therefore it is of utmost importance to identify and select appropriate participants for the study. The study incorporated a purposive method of sampling, which aimed to generate deeper insight and understanding into the topic and is less focused on generalizability (Braun & Clarke, 2013). As such, the sample size goal was 8-12 participants and the final research included 12 participants, as is consistent with conventions in phenomenological qualitative research. Since the goal was also to develop “rich and thick” experiences, the participants shared the same core features of being in a larger body and attempting to recover from an eating disorder. In an effort to expand
diversity in the study and in eating disorders research (as aligned with feminist values), the study prioritized participant diversity in recruitment.

Since the research question focused on the experiences of people in larger bodies recovering from an eating disorder, the primary inclusion criteria were that the participant had to be in a larger body, and that they were attempting to improve their relationship with food or their body. The inclusion criterion of someone being in a larger body is a sensitive one. This research is consistent with principles of Health at Every Size®, which is a framework that promotes weight and size acceptance and neutrality, and is grounded in social justice and feminist theory, and all of these frameworks assert that using BMI to determine meaningful information about people would be harmful and inaccurate. However, a cut off for body size for inclusion criteria needed to be determined but was difficult because the inclusion criteria of being in a larger body is based on subjective experience. Defining this inclusion criterion was complex because fatphobia is prevalent and thin privilege is not well understood, and because many people who are straight size fall may self-identify as being in a larger body even if they are not perceived or treated as such by others. Therefore, the inclusion criterion for body size was if the person is plus size and wears plus size clothing sizes or big and tall clothing or 2X or larger, as this is a more widely used measure that is less harmful than BMI. Since it was important to apply this inclusion criterion while avoiding enacting weight stigma, an explanation of the rationale and a statement about the understanding and harms of weight stigma was included with recruitment information. Additionally, since I am not in a larger body myself, I consulted with colleagues with lived experience of being in a larger body about the recruitment materials and research questions so as to ensure that weight stigma or other harm was minimized in the study itself.
Addressing the inclusion criterion to define ‘recovering from an eating disorder’ was also an important design decision. Because requiring a formal diagnosis would have excluded many people in larger bodies who struggle in their relationship with food and body but have never received a formal diagnosis (often due to systemic barriers and weight stigma), a formal diagnosis was not required. Additionally, prospective participants may not have been currently struggling with behaviors that meet criteria for an eating disorder but may have suffered in the past, and this was still valuable for the study. Rather than relying on a diagnosis, determining study eligibility involved a combination of an electronic screening questionnaire and having an initial screening call with potential participants. The electronic screening questionnaire and screening call provided the opportunity to assess whether individuals meet eligibility criteria, which was defined in terms of self-report of eating- and body-related behaviors derived from the Eating Disorder Assessment 5 (EDA-5) (Sysko et al., 2015). A threshold eating disorder diagnosis was not required for study participation, but the screening questions related to eating disorder diagnoses were used to provide information about the nature of the eating or body-related symptoms for each participant. I used questions from the EDA-5 to determine the following inclusion criteria, which indicated that participants have suffered from significant eating-related distress. To be eligible for the study, participants had to endorse one of the following: significant emotional or psychological distress relating to food and/or body, that their struggles with food/body has had an impairing influence on some aspect of their life, or endorse one behavioral symptom (restriction, binging, or purging). Particularly vulnerable populations were screened out, such as participants with active and acute suicidal ideation or active and acute psychosis. This process of participant selection and recruitment that prioritized the participants’ subjective experience of struggling with and recovering from eating- or body-related distress is
also consistent with phenomenological research in that the phenomenon was defined, but the experience of and definition of the phenomena was left up to the participants rather than being imposed by the researcher.

The goal was to collect data from around 8-12 participants, which is consistent with conventions in phenomenological qualitative research, and the final project consisted of 12 participants (Braun & Clark, 2006; Creswell & Poth, 2016). Recruitment was rolling, and I continued to recruit and interview participants throughout the research process until an adequate number of interviews were conducted and diversity and homogeneity were considered. For example, more homogeneity would indicate a need for fewer participants because saturation would be reached more quickly than with a more diverse sample. Saturation was a consideration in deciding on this number but not the sole criteria. The goal was to collect enough data to understand the phenomenon being studied, but saturation was not used as the primary criterion for determining an adequate number of interviews because the possibility for new codes and themes is endless in qualitative research (Braun & Clarke, 2021a). The decision to end recruitment and data collection at 12 participants was determined based on reaching the upper end of the initial goal, discussion with my committee, reviewing the diversity of the sample, and agreeing upon having adequate diversity for a study of this size, and beginning to see saturation in themes in the data through initial transcription and coding as consistent with the goal of phenomenology research that aims to capture a “rich and thick” experience of a particular phenomenon (Creswell & Poth, 2016).

**Demographic Information**

The participants all met the inclusion criteria of being plus size (wears clothing 2x or larger), having struggled with eating-related distress, and having attempted to recover from this
distress. Participants filled out a brief survey to answer this information, sign informed consent, and provide demographic information. The demographic information of the participants is found in Table 1. Additionally, while not included in the table because the survey did not ask for this information, three participants mentioned in the interview being neurodiverse, two mentioned identifying as queer, and one mentioned identifying as transgender.

Table 1 – Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age*</th>
<th>Gender*</th>
<th>Education</th>
<th>Employment</th>
<th>Household Income</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30-39</td>
<td>Female</td>
<td>BA</td>
<td>Full Time</td>
<td>$100,000-124,000</td>
<td>White</td>
</tr>
<tr>
<td>2</td>
<td>30-39</td>
<td>Female</td>
<td>Graduate</td>
<td>Full Time</td>
<td>$100,000-124,000</td>
<td>White</td>
</tr>
<tr>
<td>3</td>
<td>30-39</td>
<td>Non-binary</td>
<td>BA</td>
<td>Full Time</td>
<td>$25,000-49,999</td>
<td>White</td>
</tr>
<tr>
<td>4</td>
<td>30-39</td>
<td>Female</td>
<td>Graduate</td>
<td>Full Time</td>
<td>$100,000-124,000</td>
<td>White</td>
</tr>
<tr>
<td>5</td>
<td>30-39</td>
<td>Female</td>
<td>BA</td>
<td>Full Time</td>
<td>$75,000-99,999</td>
<td>Puerto Rican</td>
</tr>
<tr>
<td>6</td>
<td>30-39</td>
<td>Female</td>
<td>BA</td>
<td>Full Time</td>
<td>$50,000-74,999</td>
<td>White</td>
</tr>
<tr>
<td>7</td>
<td>30-39</td>
<td>Non-binary</td>
<td>Associate</td>
<td>Disabled</td>
<td>$25,000-49,999</td>
<td>Multiracial (Pacific Islander and African American)</td>
</tr>
<tr>
<td>8</td>
<td>21-29</td>
<td>Non-binary</td>
<td>Graduate</td>
<td>Full Time</td>
<td>$25,000-49,999</td>
<td>Asian</td>
</tr>
<tr>
<td>9</td>
<td>30-39</td>
<td>Female</td>
<td>Graduate</td>
<td>Full Time</td>
<td>$75,000-99,999</td>
<td>White</td>
</tr>
<tr>
<td>10</td>
<td>21-29</td>
<td>Non-binary</td>
<td>BA</td>
<td>Full Time</td>
<td>$50,000-74,999</td>
<td>White</td>
</tr>
<tr>
<td>11</td>
<td>30-39</td>
<td>Female</td>
<td>Some College</td>
<td>Full Time</td>
<td>$50,000-74,999</td>
<td>Multiracial</td>
</tr>
<tr>
<td>12</td>
<td>30-39</td>
<td>Female</td>
<td>Graduate</td>
<td>Full Time</td>
<td>$25,000-49,999</td>
<td>Mexican American</td>
</tr>
</tbody>
</table>

*Answer options for age were: 17 or younger, 21-29, 30-39, 40-49, 50-59, 60 or older

*Answer options for gender were: Male, Female, Transgender, Non-Binary, or option to write in.
Ethical Assurances, Recruitment, Screening, and Informed Consent Procedures

Prior to beginning the recruitment process, the study was reviewed and approved by the Antioch University Institutional Review Board. Recruitment strategies focused on contacting and disseminating study information to various national eating disorder treatment centers and reaching out to therapists and dietitians who specialized in eating disorders directly through my own contacts. I also utilized social media by reaching out to popular eating disorder recovery Instagram accounts as well as Facebook groups that focused on eating disorders and HAES® to disseminate information. I prioritized recruiting in spaces that were more likely to have access to people with diverse and marginalized identities. Recruitment materials were also written with inclusive language and explicitly stated the interest in gathering data from diverse participants. This recruitment strategies were consistent with the aim to highlight and value “everyday knowledge” and people with lived experience as opposed to “experts” (Creswell & Poth, 2016). Prior to disseminating recruitment information, adequate steps were taken to ensure permission to advertise in these various channels. Participants received a $25 Amazon gift card for participating in the study.

Initially, potential participants were asked to fill out a brief survey to gather demographic information and determine if respondents meet initial inclusion criteria. This survey also included the informed consent document, and written consent to participate as documented electronically using SurveyMonkey. After a person submitted the survey, I scheduled a screening call during which I gathered any missing demographic information and assessed the inclusion criteria described above (being in a larger body and attempting to recover from a struggle with food/body). If an individual met the criteria, I verbally reviewed essential study details as part of
obtaining informed consent, including discussion of the risks and benefits of the study. The primary risk associated with participation in this study consisted of potential psychological discomfort associated with recalling painful experiences. Individuals at elevated risk of self-harm or suicide were screened out and not included in the study, although I did not speak with anyone with acute suicidality or psychosis. The potential benefits presented to participants included a sense of psychological relief resulting from talking through difficult experiences with a supportive listener, as well as a potential sense of satisfaction with helping to increase understanding of the participant’s experiences. While on the screening call, I either put eligible and interested individuals on a waitlist for an interview or scheduled an interview quickly following the call. I prioritized interviews with people who held one or more marginalized identities in an effort to increase the diversity of the sample. Additionally, in an effort to increase diversity, recruitment materials explicitly stated that the study was inclusive and particularly interested in diverse experiences. Once an interview was scheduled, the interview began with verbally going over the informed consent document, making sure all questions and concerns were addressed before beginning the interview.

**Data Collection**

The method for collecting and recording data consisted of individual interviews with each participant. Interviews were semi-structured, in-depth interviews in order to gather data in line with the research questions and stated aim while also leaving room for the diversity and complexity of experiences of the participants and, in line with phenomenological methodology, to ensure that the data was not driven entirely by the researcher. The interviews took place via Zoom. Considerations such as accessibility, safety, comfort, and confidentiality were taken into account when determining the appropriateness of interview modality and schedule.
Interviews were recorded via the built-in recording software on Zoom and stored on the cloud through a password protected account. In addition, researcher notes were collected before and after the interview and stored on the researcher’s computer in a password protected folder.

**The Phenomenological Interview**

Prior to even beginning the interview process, phenomenological research requires careful consideration of the stance of the researcher. Husserl (1970) coined the term “bracketing”, which means to acknowledge and set aside the researcher’s assumptions and knowledge of the phenomena. According to phenomenological principles, completely setting aside our own experiences is not possible, but the goal of bracketing is being self-aware and to approach the interview with the intention of understanding how the participant experiences the phenomena and not through the researcher’s lens. Phenomenological principles acknowledge that everyone has their own experiences which affect how they interpret the world, and that the researcher should try to be aware of this in the interview process. In order to do this, I was intentional about this shift when beginning an interview and kept a researcher’s journal with reflections about my experience, thoughts, and feelings throughout the process (Dahl & Boss, 2005). Bevan (2014) identified three main components of this stance which include accepting that the participants’ experience is valid, having a reflexive critical dialogue with ourselves as researchers, and active listening. In order to address this, I also engaged in reflective exercises about my own beliefs and biases connected to the nature of this research and took notes following each interview and debriefed with my chair.

Bevan (2014) also describes three phases of phenomenological interviewing: contextualization (descriptive narrative context questions), understanding the phenomenon (descriptive), and clarifying the meaning of the phenomenon (imaginative variation questions).
All three components are fluid and significant in understanding the experience of the participant. There is room for variation and spontaneity in questions, but the interview process is structured with beginning with context questions and then trying to understand the specific phenomenon of study and then elucidating meaning. In phenomenology, the context is important, but the “facts” are less so; both in the facts that the researcher knows but puts aside (bracketing) and the facts of the participant’s experience. Instead, questions are intended to understand the meaning the participants made from the experience (Dahl & Boss, 2005). The language the participant uses is the symbol for their experience, and thus the researcher pays close attention to language and seeks to expand and explore the meaning of the words used (Dahl & Boss, 2005). I used this foundation to create my interview guide and to inform my follow up questions during the interview process.

**Semi-Structured Interview Procedures**

The interview process was semi-structured in order to both stay consistent with the intention of the research questions and to provide opportunity for participants to co-create the interview process and share relevant experiences that I, the researcher, may not have considered as is consistent with the goal of phenomenology research. The interview began with verbally going over the informed consent document, making sure all questions and concerns were addressed. After this, interviews began with time for building rapport and creating a safe space for the participant. Next, the interview transitioned into open-ended questions with notes for follow up questions that arose. There was also opportunity for spontaneous follow up questions to occur depending on the responses of the participant.

**Interview Questions**
1. I am interested in your experiences around food and/or body image and how family relationships, including parents, siblings, and partners, influence those experiences. So, whoever you consider family/your closest loved ones are who I’m thinking of when I ask about your family. Tell me about your experience with food and/or body in your family.
   a. How did your family shape your idea of your body growing up?
   b. How did your family shape your idea of food growing up?

2. Think about a time when you were really struggling with food and body. Tell me in as much detail as possible about this experience.
   a. Tell me a bit about how your family/partner responded to this.
   b. What was that like for you?
   c. You mentioned _____. Describe that in more detail.
   d. Can you give me a specific example of _____?

3. What was your experience like when you decided you wanted to improve your relationship with food and/or body?
   a. What was your experience of how your family/partner responded to this decision?

4. What has been your experience of the recovery process related to your family/partner?

5. Tell me about an experience you have had with your family while trying to improve your relationship with food and/or body.
   a. Can you describe in detail what happened?
   b. Can you describe what that felt like? What was that like for you?
   c. Tell me more about what you mean by _____ (specific word/feeling).
   d. You mentioned _____. Can you give me a specific example of that?
e. How did you interpret what happened?

f. Did/How did that affect you/your recovery?

g. Why does that experience stand out to you? What was it about the experience that was impactful?

h. How did these experiences affect your relationship with your family/partner?

6. Tell me about an experience with your family/partner that was helpful to your attempt to improve your relationship with food and/or body?

7. Is there anything else you would like to share?

Data Analysis & Interpretation

Transforming and Managing Data

The first step of analysis was to transform the raw data into usable data. Since the data were all audio recordings, I first used an AI (artificial intelligence) transcription service through Zoom and then reviewed and edited the transcripts while listening to the recording in order to correct any errors, and add notes such as emphasis, gestures, and other important non-verbal or inaudible information. The analytic process followed conventions for de-identifying information such as redacting and anonymizing names and locations. The study also followed conventions for a modified verbatim format, which increases readability and understanding of the data without sacrificing meaning. Conventions for transcribing using a modified verbatim format are included in the appendix. In TA, data analysis and collection are an ongoing and reciprocal process, and as such transcription and analysis occurred as quickly as possible following an interview and began well before all interviews had been completed. Researcher notes and summaries of the interview took place during and immediately following the interview as well. Transcripts were not labeled with any identifying information of the participants tied to the files.
To manage the data and keep it secure, both the interview recordings and transcripts were stored securely on a local computer and on the cloud, all of which were password protected and were always in the researcher’s possession or securely stored. The recordings were deleted following completion of the study. In addition, to protect participant confidentiality, names of files were designed to be confidential and did not include identifying information.

The goal of reflexive TA is to identify, analyze, and report patterns within data and also offers possibilities for interpreting this data (Braun & Clarke, 2006). In order to do this, I first became familiar with the data through the interview process and then through transcribing the data. The transcription process was slow but allowed me to become very familiar with the data. During transcription, I began to note initial ideas about patterns, codes, and themes. Once the transcripts were complete, I sent the transcript to each participant as a member check to offer them an opportunity to clarify, change, or redact any information. Of the 12 participants, 8 participants did not reply to the request, and 4 did. Of the 4 who replied, 2 approved, and 2 approved with minor changes. Once the data was transcribed and I was very familiar with the data, I then moved into coding the data. Coding consisted of a combination of deductive and inductive analysis, meaning I was grounded in theory and literature about the topic in order to be able to identify what codes and themes may be salient, but I also left room for inductive analysis and be able to interpret the data in ways that may have not been thought of by the researcher prior to engaging with the data as is consistent with my theoretical foundation of phenomenology and TA which emphasizes co-construction of meaning (Braun & Clarke, 2006). Themes and analysis were influenced by the researcher and there was a reflexive process of understanding the data and analyzing it. Reflection and writing notes were an integral part of the analysis process, and I kept a journal with my thoughts and reflection throughout data collection and analysis parts.
of the study. Data analysis also occurred as an ongoing process at the same time as data collection. As such, researcher notes and reflections were taken immediately following the interview and the transcription and initial analysis was done as soon as possible. As a form of peer debriefing, I also debriefed these reflections with my dissertation chair throughout this process which helped me engage in reflexive practices to understand how I was influencing the analysis of the data.

**Analyzing and Interpreting the Data**

The analysis process followed the steps laid out by Braun and Clark (2006) in their paper on thematic analysis and in their book *Thematic Analysis* (2021b), which goes into depth about reflexive thematic analysis. First, I became familiar with the data through transcription, reading, and noting initial ideas. Next, I used qualitative analysis software–Dedoose–to aid in the initial coding process. In my first round of coding, I took a more semantic approach and focused only on the surface level meaning of the participants’ words. The code units were also quite small, as in a few words each. After meeting with my chair, I decided to start over with coding. I chose to do this because the initial coding did not offer any significant understanding of the data and instead would have fit more with a quantitative approach and did not leave room for any analysis or interpretation (i.e., coding only the word “mom” or “diet”). In phenomenology informed reflexive TA, the goal is to capture “shared meaning” units as expressed by the participants (Braun & Clarke, 2021b). I still was able to benefit from being familiar with the data, but I deleted all codes and began fresh. When I coded the data for a second time, I focused still on semantic meaning, but codes reflected more general ideas expressed by the participants and codes read like topic summaries. For example, codes from this round included items such as “direct message about food/body” or “indirect message about food/body”. I re-coded for a third
time, and this time focused on both semantic and latent meaning and attempted to identify what was meaningful and significant about what the participant shared in the interview. I chose to re-code this way by focusing on both semantic and latent meaning and coded for larger meaning units because this is consistent with phenomenology and reflexive thematic analysis which aims to understand participants’ experiences and the meaning they make of them. By focusing on the latent meaning and beginning to think about larger themes in the data, I was able to stay close to the meaning expressed by the participants and also begin to analyze the data through my own understanding of it (or “offering a reading” of the data as Braun and Clark (2021b) write). I validated initial codes and added additional codes in a systemic way across the data set and connecting specific pieces of data (sections of the interview, quotes) to these codes. I created a codebook dictionary which includes the code, an example, and the meaning of the code that could be referenced and updated as new data was added. Then, once codes were established, the codes and data were reviewed to identify themes. Themes combine various codes and reflect a more general idea than a single code itself. Themes were continuously reviewed, adjusting as more data were analyzed and recoded, and then created a thematic map to solidify concrete themes and subthemes. Each transcript was reviewed for a fourth time until all codes were identified and matched to the existing codebook. This codebook is available for reference in the appendices. These themes were discussed with my chair and committee, and I reviewed the existing literature to further inform and analyze the themes. Once this had been done, I finalized themes and the overview of my analysis. At this point, I practiced a second round of member checking and gave participants an opportunity to review my analysis and provide feedback which is in line with the phenomenological idea that knowledge is co-constructed between participants and researcher and that my analysis of the data is just one version of many different
valid interpretations. Lastly, a written report of the themes and analysis of these themes was produced.

Since analysis and interpretation overlap, during analysis and when writing the results, I was continuously analyzing and interpreting the data. When writing the results, I used quotes when applicable from the data, and also offered my own analysis and interpretation of the data within the context of the literature and my own clinical and academic understanding of the topic. In this way, the data are not only reporting facts but also have an aspect of deeper interpretation. In interpreting the data, I approached it in line with phenomenology by staying close to the data and the meaning participants intended while also acknowledging and incorporating my own analysis and interpretation as is consistent with reflexive TA.

Data Dissemination

Data and the final research will be disseminated in a variety of ways. First and foremost, the results will be published in a dissertation and will also be submitted for publication with one or more academic journals. While the final dissertation will also be shared with the participants, in an effort to make the data more accessible, a more condensed version of the results that will be written in for lay people and a short, recorded video with a PowerPoint with the results, will be created and distributed. Also, the results will be condensed into a brief summary focused on clinical implications, which will be shared with various eating disorder treatment providers (treatment centers and clinicians), as well as submitted to various national organizations to share the data with a wider audience. Finally, these results and clinical implications/applications will be proposed to present at various conferences and talks in order to disseminate the results more broadly.

Limitations
There are inherent limitations to the study due to the design choices made. While the sample had adequate diversity and steps were taken in the design and methods to prioritize diversity, the small sample size did ultimately limit diversity. Also, due to the nature of the recruitment channels used, a large portion of higher-weight people may have been excluded. There are many people who may be struggling with their relationship with food/body and may even have a clinically diagnosable eating disorder, but because of systemic and structural barriers to treatment and support, these people would not be qualified for the study or be interested in the study. Similarly, since people already connected to the treatment world are statistically more likely to hold privileged identities (such as being cisgender women, white, heterosexual, higher SES), the sample as likely less diverse than the population of people who struggle with their relationship with food/body. Sample homogeneity limits the contributions of the data toward understanding of how people with diverse identities or multiple oppressed identities may experience weight stigma from family/partners.

My identity and presence as the researcher also impacted the study. Because I hold many privileged identities, participants may not have felt as comfortable sharing with me and therefore may not have participated in the study or share as fully as they might with someone who has lived experience in a larger body.

**Conclusion**

This study explored the experiences of people in larger bodies in recovery from an eating disorder who have experienced weight stigma from family/partners. The study design was grounded in phenomenology and consisted of semi-structure interviews with 12 participants and was analyzed using phenomenologically informed reflexive thematic analysis. Careful consideration was given to the study design in order to engage in the research in an ethical and
effective way. I aimed to have a nuanced and in depth understanding of the experiences of the participants in order to gain knowledge about the impact of weight stigma on people in larger bodies in recovery and improve eating disorder prevention and treatment.
CHAPTER IV: RESULTS

Introduction

The analysis of the data revealed rich and complex results that were difficult to summarize into just four discrete themes. While I was able to identify themes and subthemes, and all the interviews I conducted shared a similar narrative arch, at the same time each participant’s story was unique and complex. As the researcher and interviewer, it was clear to me how important this topic is and the depth of impact these experiences had on each participant. Many participants had clear and vivid memories of moments from childhood, and some became emotional when sharing these. Many participants also seemed eager to share their stories as there usually are not many safe places to discuss these topics. Participants had abundant experiences to share, and throughout the interviews I found myself moved and at times emotional by witnessing their stories. This depth is difficult to capture in the written word, but I wish to convey to all who read this to remember that each quote is from a real person whose life has been significantly shaped by these experiences of weight stigma. Almost all participants expressed the hope that by sharing their story, some change will occur and someone else will not have to suffer in the same ways they did. Through the phenomenology-informed reflexive analysis process outlined above, the analysis resulted in four subthemes with three to five subthemes each.

Themes

The themes resulting from this research, deriving from the research questions, all centered around the experiences of weight stigma and eating disorders in the context of relationships. My analysis process resulted in four primary themes, with each theme having three to five subthemes. Each primary theme highlights an important dimension of experience that
most participants expressed in the interview and that seemed significant and salient. The subthemes explored ideas that many participants shared and that provided depth and nuance to the primary theme. It is important to note that each theme and subtheme were interconnected. The themes of relationships, weight, and eating disorders run through each theme, and each theme explained one aspect of the impact of weight stigma in relationships. The order of themes was chosen to prioritize a logical flow of the results, but otherwise are not in any particular order of importance or salience. For ease of reporting results, each exemplary quote is used to illustrate a particular theme, but in reality, exemplary quotes often contain aspects of multiple themes and subthemes. The themes and subthemes are represented below in written and graphic formats. In the written representation of themes, I have also included the number of participants that endorsed each theme and subtheme.
Figure 1 – Graphic Representation of Theme
Overview of Themes:

Theme 1: It Matters That It Comes from Family

- **Subtheme 1**: Pervasive Messages and Lasting Impact
- **Subtheme 2**: Children are Vulnerable
- **Subtheme 3**: Direct and Indirect Messages
- **Subtheme 4**: Messages Communicate Ideas about Identity, Value, and Worth
- **Subtheme 5**: Family Relationships as a Vector for Fatphobia

Theme 2: It’s Different When You’re Fat

- **Subtheme 1**: Awareness of and Focus on Body Size
- **Subtheme 2**: Less Understanding and Less Support
- **Subtheme 3**: The Intersection of Body Size and Eating Disorders

Theme 3: Focus on Food and Weight Harms Relationships

- **Subtheme 1**: Weight Stigma Results in Distance and Isolation
- **Subtheme 2**: The Need For Boundaries
- **Subtheme 3**: Ending Romantic Relationships
- **Subtheme 4**: Ending Family Relationships

Theme 4: Relationships Heal

- **Subtheme 1**: Explicit Acceptance of Body
- **Subtheme 2**: Challenging Messages Learned from Family
- **Subtheme 3**: Fat Positive Community
- **Subtheme 4**: HAES® Eating Disorder Treatment
Theme 1: It Matters That It Comes from Family

The first theme “It Matters That It Comes from Family” represents the idea that the fact that family (as opposed to other sources such as peers, medical providers, other adults, etc.) was a primary mechanism for messages about food and body is significant. There are a number of reasons that participants reported the particular impact of these messages coming from family. The subthemes and excerpts from participants highlight and explicate these reasons.

Subtheme 1: Pervasive Messages and Lasting Impact

Almost every participant reported that they received pervasive messages about food, weight, and bodies. These messages were most commonly from family, as with family is where the majority of the participants’ time spent when they were young. Because of the messages coming from family, participants received these messages from a young age. Many participants noted the young age they started hearing these messages, and some reported specific moments and memories. Participants described hearing these messages constantly and tried to make sense of these messages at a young age and described how deeply impacted their relationship with both food and body. Participant 3 described the experience of learning from their family what it meant to be fat:

“I was never taught how to love myself, or how to have a good self-esteem, because the only thing I ever heard my mom say about herself was something negative. I think I just started kind of mimicking that, not fully understanding it at the time, maybe around ten… I don't have a solid memory but have a vague memory of calling myself fat, but not knowing what that really meant, or what the implications of it were. But just kind of mimicking that behavior. It definitely fed into my entire being. Which lots of therapy has taught me how to disassociate from that.” (Participant 3).
Similarly, another participant described their experience of learning what fat means, and how this was connected to messages from their mom and their mom’s own struggle with food and body:

“And my mom did internalize that…she still had a lot of issues around her body. And when I was born obviously that was passed on to me. I remember, even when I was four years old… I already knew what's fat at four years old, and it wasn't something I could verbalize, but it was just a gut feeling that I knew” (Participant 8).

Many participants described how these early childhood experiences have had a lasting impact on their relationship with food and body, so much so that many still struggle to this day. Participants described internalizing these messages deeply, and a few noted how they almost hear the voice from family in their head. Participant 7 described:

“Yes, it's right there. I think about it every time I go to get something for myself, I can hear those people saying something. Even now it's… my husband doesn't necessarily mean to say something, but he'll say it, and it triggers that trauma, and then it's “Well, now I can't eat.” And I'm punishing myself by not letting myself eat, and I still have to work through that all the time. It's such a big thing, because I still struggle with my eating and trying to just get to a point where I don't feel any shame about what I’m eating, and when I’m eating it… And that's so crazy to me because no one deserves that. But it's just something I have to struggle with, and a lot of people don't understand it. (Participant 7).

This participant also explicitly describes the importance of the role that parents play in communicating messages about food and body to children and the importance of parents understanding the impact of these messages. They said:
“I think that's a big thing is parents aren't really taught how to parent. You just are thrust into it, and there needs to be more, especially when it comes to these things with food and stuff that affects our mental health, because, unfortunately, food is going to affect your mental health. And when it's they're all tied together like that, so you have to be careful. And I know that to them, it was just a Tuesday. But to me, those things sat in my heart forever. And so, I think, being more aware of how we say things, and all this stuff would have just been a lot better for a lot of people who were struggling with eating disorders.” (Participant 7).

Similarly, participant 12 described this lasting impact, and how she still battles these internalized messages. Participant 12 also describes how these messages directly impact her recovery from food/body distress and makes it harder:

“Absolutely. And to this day, I mean I'm thirty years old now, it’s still a constant issue. and I still a struggle with it internally, of course, with my own thing about it. But even externally I try to be as body positive and accepting as I can. But I know there's some internalized fatphobia that's just been burned inside of me. So that's hard because that's obviously just an internal battle…” (Participant 12).

These excerpts illustrate how constant and pervasive the messaging about food and body is from family, and how because of the pervasive nature of it the impact is lasting. Even when participants reported that they were doing better in their recovery, these experiences and internalized message still impacted them.

Subtheme 2: Children are Vulnerable

Another layer of the importance of the messages coming from family is that children are vulnerable, emotionally, and practically. Children spend the most time with family, and family
members are the ones in charge of the practical aspects of food as well as communicating messages about food and body. Children do not have access to their own food and usually cannot recognize that their family’s relationship with food and the messages they are receiving may be harmful. They are stuck. Participant 7 describes the harmful effects of the focus on food and body and how this resulted in controlling their food intake. This resulted in them needing to try to access food in other ways, which also contributed to intense shame around eating:

“It hasn't been a great experience, unfortunately. I grew up in a family that really prioritized thinness, especially from the matriarch of our family. So, my grandmother was really, she was really fatphobic. From a young age I just remember her always nit picking at my eating habits. It went from just quiet comments to outright asking in front of people, being embarrassing, watching how much I’m eating, how much I’m getting. To the point where I would not eat when I came over to her house, and unfortunately, I was over at their house a lot, so I just learned to not be hungry and to push it down, especially at her house…And then with not only my grandmother, but my father was also pretty abusive, and me being fat was one of the abuse topics, unfortunately. So eating was a struggle anywhere. It got to the point where, even in childhood, I had an instance in school where I was stealing snacks from kids’ bags. It was because I had an unhealthy relationship with food, I constantly felt like I had to steal food in order to eat anything. Because eating food when it was appropriate was a problem. So, I just learned to hide it, and it became a guilty thing. I always felt guilty and still struggle with feeling guilty about what I need and how much I'm eating, when I’m eating, all of these things so it's just been a lifelong battle.” (Participant 7).
Participant 12 also described the impact of being a child and having a parent be in charge of food. She described being put on a diet, and how finding other ways to meet her food needs resulted in disordered behaviors and shame:

“And actually, I remember that being a thing even when I was in high school, because my mom, was always putting me on diets, and I remember being on, I think, on weight watchers with her for the ten thousand time… I remember thinking, “Oh my gosh, If I eat when she's not here she's not gonna know. And then I won't be hungry, and then it'll just look I'm eating very little bit,” and I remember feeling like “Oh, wow! I can get away with a lot!” And of course, I went crazy, I remember going to Subway and getting two-foot longs, and not even tasting them, just downing them, and then be like “okay, I feel so much better,” …I’ve never admitted it [to her] to this day (Participant 12).

Participant 2 also described the shame that resulted in needing to hide and sneak food as a result of parents controlling food. She notes an important aspect that for children, food may be the only way they know how to cope, and it can be harmful to have this coping mechanism shamed or taken away from them or be shamed for using it. She said:

“Just real shame. Like “Oh, I shouldn't be doing that.” I used food as a coping mechanism. And so, it was basically telling me not to cope. And as a kid, you can't comprehend all that. So, it was a lot of shame. “Oh, I shouldn't be doing this” or I'm feeling punished. And I was one of those kids who never wanted to get in trouble. I never wanted to get yelled at, and so of course I stopped doing or stopped eating. And then that promoted a lot of the sneaking around and then bingeing on food too. But in secret” (Participant 2).
Children are vulnerable both emotionally and practically. These excerpts describe how the participants as children did not always understand what was going on and tried to make sense of this. Parents having control over what children eat and the access they have to food also increased this vulnerability and shame and exacerbated the problem.

**Subtheme 3: Direct and Indirect Messages**

In addition to the messages being pervasive, participants described a variety of types of messages from family. The messages from family were direct and indirect, sometimes mostly focused on body and weight, or other times mostly focused on food. Regardless of the style or content, the messages were harmful. Participant 2 describes direct messages she received about food, weight, and her body:

“No, it went into food, especially when the doctors said, “You know [participant name] is overweight, or she needs to lose weight” and my family would tell me: “Okay, you need to stop, you need to restrict.” Or “No, we can’t do that, or okay no seconds.” Just noting and telling me what I could and could not do. Or this food is off limits. So, it was definitely… if the goal was weight loss, then they definitely made a point. And there was sometimes kind of innocent name calling, I remember hearing “Don't be a piggy. Don't be a piglet.” Those kinds of things. I don't know if they were trying to be super hurtful, but I think it was like “Hey, you're being a piggy, stop eating” kind of thing. It was all about food and weight. “You're not going to fit in that prom dress if you keep eating this.” Those kind of messages. So, it was food and body. Most of growing up.”

(Participant 2)

Other participants described more indirect messages about food/body, but the impact was the same. Participant 5 reported never receiving a direct message about her weight but explained that
she still knew what her family thought about her body and internalized beliefs about this. She says:

“As far as my body, it seems they were a little sad that I was bigger, but they never really said like “Oh, this looks terrible.” A lot of the times it'd be “well you should wear this, because this makes you look slimmer. Make sure your posture is really straight, so that you look smaller. Don't wear that because it’s too tight on you.” That part has lasted until now… (Participant 5)

Similarly, Participant 1 describes how indirect messages that are focused on other people or the parent themselves are still harmful and communicate the same messages about food and bodies. She describes:

“I have a really hard time when people who are thin call themselves fat or judge their own bodies. I’ve tried to explain this to my mom, and even to my husband. When people talk poorly about their own bodies in front of me, it’s directly affecting me. Because I’m like “If you think that way about your body, then what do you think about my body?” If you’re like “I'm fat and disgusting” and I can objectively look at you and you are thinner than me, then you're calling me fat and disgusting. And that's really hurtful. And you may think that you're just being self-depreciating. But you're actively hurting me. And trying to get that messaging across to people, trying to tell people: you need to be careful about the way you talk to you about yourself around other people because it's hurtful. And people think that they can say whatever they want about themselves. But that's just not the way it works in the world, especially to your children and to people who are hearing that. So, hearing my mom talk about her body, or talk about it in that way, is calling me names.” (Participant 1).
These messages show up in many different ways. Another participant reported how positive messages about weight loss also communicated the same message and was harmful. They struggled with orthorexia and described how the positive feedback impacted them. Participant 3 shared:

“Mostly it was just positive feedback. None of them saw an issue with it, and I think that's what makes orthorexia is so complicated, is that a lot of people just see that as “Oh, they're so disciplined and eating healthy” … they don't see “healthy eating” as an eating disorder or “clean eating” as an eating disorder. But it very much is when you start factoring in the emotional and mental state in it. So, everyone was inspired by me. They were like, “You have discipline, you're running. You've lost all this weight. You look so great. You seem to feel good,” and all these other kind of things…. I thought, clearly nothing’s wrong because I lost weight, and that was the solution to all my problems.”

(Participant 3).

Every single participant reported receiving indirect or direct messages about food and body, and whether it is indirect, direct, about food, or about body, it is harmful. Most participants described receiving all types of messages, but even when the messages were masked or seemingly “positive,” the impact was still the same.

**Subtheme 4: Messages Communicate Ideas about Identity, Value, and Worth**

In trying to understand what makes these messages from family especially harmful, participants described that the messages about weight and food communicate deeper messages about identity, value, and worth. These ideas often come from family and are shaped from a young age. As adults, participants were able to look back at these experiences and describe the
deeper messages they received from them. One participant described how the focus on food and weight communicated the importance of thinness:

“My mom was always encouraging me to diet. I would get such praise and such approval for my mom or people like, “you're finally taking care of your health. You're finally trying to do better!” People, my co-workers they would say things like “Oh, you're looking so skinny,” things like that. So, people, when you're in those diet things any mention of it is the most positive things. It could be like, well, I just got a promotion at work, and that's nothing compared to that. Even now, if you're like “Oh, I lost twenty pounds,” that reinforcement of “nothing is more important than being thin”. (Participant 1).

Another participant described the messages they internalized about weight and thinness, and how thinness was sold as the way to succeed in life. She says:

“And if you don't [lose weight], then you are failing at life. You are never going to be happy. You're never going to find a partner. You're never going to succeed. You're never going to get a full life experience. Yeah, lots of that “this is the way to have a good life is to be thin. Then you can succeed in life.” (Participant 1).

The messages about food and body also communicated ideas about acceptability and worth as a person. Participant 6 recalls:

“I think the thing that’s stuck with me the most, or that’s been hardest to overcome… I think I was 13-ish, and my mom explicitly said to me, “People don't like other people who are fat.” And that was the one time that I remember explicitly those words were used. But that was often the sort of message I got, and that's the thing that I still think about when meeting someone new, or going into any situation I think, “Are these people
going to judge me because of my body size. Are they going to not like me automatically because of the way I look?... I mean I’ve had a number of periods like that in my life [where I was really struggling]. But I feel like one of the big parts of that was isolation. Feeling like I was isolated, and part of it I think was related to this anxiety around, “Well, how am I going to make any friends that people won't like me because I’m fat” It’s all tangled up. I definitely have a genetic predisposition to like depression, but also a big part of those really challenging hard feelings were tied up in body image, and feeling like, “My body shouldn't exist. My body shouldn't be here.” (Participant 6).

Many participants described how these messages directly affected their self-esteem and self-worth. Participant 10 describes:

“But yeah, so those ate away at my self-esteem a lot, and it reached a point, before I was in therapy knowing about my neurodivergence, everything was about “Why is your self-esteem so low?” It's like, maybe because people have been telling me forever that I am disgusting, not feminine enough, not pretty enough, not attractive enough. And when we talk about low points, I hit a point in college where, apparently in my photos I never looked fat as I was, and I had multiple men show up for dates and pulled up, saw me, lied about seeing me, turned around and left, and completely blocked me. Never spoke to me ever again. All of that. And I couldn't think of anything else that they could have clocked from that that close of a distance to say like…there was nothing else about how I looked.” (Participant 10).

Not only are the messages that participants received pervasive and harmful regardless of the style or content, but the messages also communicated a deeper meaning about worth and acceptability which is another layer to understanding why the messages are so harmful and lasting.
Subtheme 5: Family Relationships as a Vector for Fatphobia

The final subtheme of this theme describes the way in which family is a vector for fatphobia. Participants described how they did receive these messages from others, as we all do, but that family reinforced and heightened these messages. Participant 9 recalled learning about medical fatphobia she experienced, and how her mom perpetuated and reinforced this:

“I have been overweight for almost as long as I can remember…. I would say that there is a good amount of history in my family of dieting for me and being told I needed to lose weight and comments about my body, trying to hide my body, things like that. My mom brought me to weight watchers when I was twelve, I had to get a doctor's note in order to go. She asked about liquid diets and bariatric surgery twenty years ago, when I was sixteen. So that was a big deal, and I didn't even know about that until I got my records from my pediatrician, when I moved away from home for college, when I moved to [U.S. State] for grad school. I was reading through my doctor's notes, and that's when I learned that. But it was definitely not a hidden thing in my family for there to be comments about my body, and attempts to restrict what I was eating...” (Participant 9)

Another participant recalls how they were teased by peers at school, and how her mom reinforced the message that there was something wrong with her body and that she needed to change it. She said:

“There’s a lot. I remember starting to notice that I was bigger than other people around maybe fourth or fifth grade. I think I was always a chubby kid, but it wasn't like a big difference until puberty, and then I started filling in. I remember being in school, and everybody was like lifting up their shirts, not to show their breast, but their bellies. And I remember I did it, and someone went “Ew!” I really remember that moment, I remember
what I was wearing. I was in fifth grade. I remember this moment, and I was like “Oh my god, my body is different than everyone else's body.” And then I think I probably told my mom and she probably spiraled, and that probably was like - instead of being like “you're beautiful, you're great,” she was like, “Let's get this weight off of you.” I remember going to nutritionists, trying to diagnose what's wrong with me and trying to find the solution. I remember I got invited to a pool party, but I was so afraid of being in a bathing suit. And my mom helped me. My mom helped me make a plan where I would exercise every morning to try to lose weight for this pool party. We had a calendar when the pool party was, and how many days, and I would cross off how many days until then. I would wake up before school and run on a treadmill. I was like in fifth or sixth grade, it’s crazy. It’s sad, but it's mostly just like angering to think about.” (Participant 1).

Participant 4 recalls how diet culture messaging in media and society influenced her, and how harmful it was for her mom to support this:

“[Puberty is] just not something we're educated on, and I went from being in this child's body, to I felt like I was in a woman's body and feeling like I was fat. I remember listening to the radio one morning, and the radio DJ as doing a commercial for like a dietary supplement. And I mentioned to my mom that I wanted to try it, and I think I only tried it one day, so it wasn't anything consistent, but just the sheer fact that I expressed an interest, that that ad spoke to me in some way, and that my mother allowed me to try that. Yeah, there's something very wrong with it, definitely.” (Participant 4)

Participants received fatphobic messages from outside the family, but it seems the families were still part of the harm because they replicated and reinforced these messages.
Theme 2: It’s Different When You’re Fat

A second theme in the results is “It’s Different When You’re Fat.” This theme encapsulates the idea that while many of the experiences that participants described may have happened and been harmful to anybody, there is something different and uniquely harmful about the intersection of being fat and having these experiences. This theme showed up in that participants described being very aware of body size at a very young age and how this impacted their relationship with food/body. Almost all of the participants were fat as children and noted this as being important to their experience. Many participants reported that being fat, both as an adult and child, made their relationship with others, and with food and body more challenging.

Subtheme 1: Awareness of and Focus on Body Size

Participants reported that being fat as a child made them aware of body size and the meaning people make of it at a very young age. Almost every participant noted their body size as a young child, or when they started to become aware they were “bigger”. Participants often described this awareness and trying to make sense of these messages. This focus was, in large part, because of their body size, as opposed to if they had been thinner. Participant 6 describes her awareness of body size form a young age:

“Yeah. It was a little bit challenging growing up, because from the time I was like a year-old I’ve been a bigger baby, a chubby baby, like whatever is the right term, and so starting around age 2, my mom, in particular, was very focused on my weight and my size. Some of my earliest memories are memories of being told that I was fat, or I was too big, or I was… So, I had a lot of that with both of my parents, with my mom and my dad. They were very worried about body my whole childhood and adolescence. And they encouraged dieting from a young age and exercise… I'm still definitely working on the…"
who you are as a fat person, and as a fat person that is bad. That sort of thing is still part of me.” (Participant 6).

Another participant, Participant 11, being aware of her body and that being fat was bad from a young age, and that the focus on her body was related to her body being bigger. She says:

“For a long time, I thought like fat was bad, being fat was bad, it makes you less lovable. My mother… I was put on my first diet when I was probably five years old, four or five years old, when my mom wanted to try Richard Simmons’s deal meal for the first time, or there was a problem with my weight. It's a lot of times, too, we were poor. We didn't really eat the most nutritious foods as well. I was very aware of body and weight from a very young age and having a negative perception of my body from a very young age.” (Participant 11).

Most participants described being aware of body size at a young age, and therefore also aware of the negative messages associated with body size as well. Even if participants weren’t able to completely make sense of the focus on bodies, they were aware that it was important, and it was something to be concerned about.

**Subtheme 2: Less Understanding and Less Support**

In addition to being aware of and having lots of focus on weight and body size due to being fat as a child, participants also described the impact this had on them. Participants reported getting less understanding and support from others as a result of being fat both as a child and for some as adults. Participant 9 describes the challenge of navigating diet culture messaging while being fat, and how because of her size these harmful messages are reinforced by others which gets in the way of others being able to see her struggle. She describes:
“It definitely caused a really harmful relationship between my brain and my body…for the most part for a really long time I felt just trapped in my body. I feel like I’m constantly judged by everyone in public. I don't like going in public spaces a lot. I mean, I do it because I don't want to be a hermit, but I oftentimes choose not to, because I just don't want to open myself up to it. I’ve had enough awful things said to me, or dirty looks just from general public, who have no idea who I am as a person, or what I have going on or not. It's hard to love your body. It's very hard to love your body when you're in a large body. Not even just a large body, but a very large body. Yeah, it's just been really hard.” (Participant 9).

This participant also describes how being fat makes it more challenging to talk to others about food/body-related issues because people disregard and dismiss her because of her body size. She explains:

“I try to do the best that I can, and mind my business, and try to educate people where I can. But I feel in a lot of settings nobody is going to listen to the fat person talk about good eating habits, being good to your body, being kind to your body, because I’m not kind to my body, and I never really have been, and that's evident by the size of my body. But I’m trying to not actively hate my body every day and not punish my body every day. But it's really hard, because I don't feel like people will ever listen to me talk and about anything positive related to food or eating, or treatment of your body. Because why would they? And experience has shown that they don't, they just scoff, or disregard or change the topic because it makes them uncomfortable, I think. And they're not going to say, “I’m not gonna listen to you about that.”” (Participant 9).
Similarly, another participant, Participant 7, explains how they have received a lack of understanding and increased judgement from others because of their body size. They also share how being fat intersects with being disabled, and how this has impacted them in terms of getting support and treatment. They say:

(After becoming emotional) “I’m fine, it's a hard topic. My body has always never felt like my own. I’m constantly aware of everyone's expectations for my own body. And it doesn't help that now I’m also disabled, And so that's especially hard, because when people see me, they don't see disabled. They see lazy, oh you’re fat. So, you’re not disabled, you’re fat. But I am disabled, and I got fat because I’m disabled. Those illnesses were there already, and they were growing, but nobody knew. It took so long for me to get diagnoses. But by the time that I did, even doctors were like we should have known sooner. Had we known sooner things could be different. And so, trying to explain to people, you only see what's on the outside. And half the time people aren’t really willing to give it a second glance when you're overweight. They just don't care. You're overweight, you're a burden and that's it. That's it. They don't want to see anything else.”

(Participant 7).

Participants described that being in a larger body both as a child and as an adult made them less able to seek or receive support, and that their struggles were amplified or prolonged because of this. While participants didn’t explicitly say this, the implication is that things might have been different had they been thin.

**Subtheme 3: The Intersection of Body Size and Eating Disorders**

In addition, the intersection of eating disorders and being fat was a significant topic that many participants discussed. Participants described experiencing intense shame around
struggling with an eating disorder because of their body size, and that due to their size they received less understanding and compassion than thin people who struggle with eating-related distress. Participant 10 describes this, and specifically their experience with binge eating disorder which is (incorrectly) but often associated with larger body size. They shared that it took them a long time to get a formal evaluation done and they had to discover for themselves that they were struggling with an eating disorder. They say:

“…I never went to get evaluated. Because obviously, there is one degrading aspect of being fat with an eating disorder when you are restricting, and they're saying, “Well, no, you don't have this because your body is still too big, so of course there's no way you could be restricting,” versus the degrading aspect of trying to go into a doctor's office and go “Hey, I'm fat because I keep eating way more than I need to be eating, and I don't know what the fuck's wrong with that,” because we're just gonna immediately turn it around on you as a moral issue. So, I never said anything to anyone. Because it's horrifying, it seems so embarrassing and so terrible to admit out loud, especially when you grow up learning that fat is the worst thing you could be, and to have any that you'd, quote, “did that to yourself” is just like the nail in the coffin for people.” (Participant 10).

Participant 7 also described how being bigger made it more challenging for people to see and understand that they were struggling with food. This participant struggled with restriction, and yet the outcome in terms of lack of understanding is the same. They say:

“And I think a lot of people when they see me, because I’m bigger, they’re like, “How can you have an eating disorder? That means that you don't eat, because obviously you do eat.” But if you sat at home with me, you'd be genuinely concerned, because the same way eating a lot of food makes you gain weight, the lack of food also will make you gain
weight. I don’t think people really look at that. And so, I think a lot of people struggle to see that boundary. And then, when they meet someone like me, a lot of people are like “no, that doesn't…That's not…” But yeah, when you don't eat, your body is going to save everything you do eat. Everything I do eat is just saved for later, because who knows when I'm going to eat again? My body is literally in fight or flight mode constantly.” (Participant 7).

While only a few participants mentioned the intersection between eating disorders and body size explicitly, the ways in which body size and lack of support and understanding harmed them is significant. Again, there is an implication that being in a smaller body likely would have garnered more support from others and different interventions.

**Theme 3: Weight Stigma Harms Relationships**

It is abundantly clear from the results how harmful the focus on food and body from family is to people, and the many different ways it impacts people. Interestingly, the results showed that the inverse is also true; just as the focus on food/body harms individuals, it also harms relationships. When families perpetrate and perpetuate weight stigma, this harms the family relationships.

**Subtheme 1: Weight Stigma Results in Distance and Isolation**

Almost all participants described that having these experiences with family harmed the relationships resulted in distance and isolation. Participants experienced harm and a lack of support from family around issues related to food and body which made them shut down and not talk about these issues. This resulted in less closeness with family, even if participants had a close relationship around other topics. Participant 6 describes how her parents were able to
support in other types of crises but failed to do so around this topic which caused her to not being able to rely on them for support. She explains:

   “My parents are pretty good in a crisis. They were supportive in the ways that they were able to. I feel like, I still feel this way that I can't… throwback to, because as a teenager, I also struggled with depression and suicidal thought and that sort of thing…

Here, the participant went on to share an emotional memory of trying to share her struggles around body shame with her parents, and her parents not understanding and inadvertently reinforcing this shame. She continued:

   “Anyway, I think the point of that story is my parents can be really supportive in crisis. But I still do this day can’t talk to them about body stuff. That’s not a safe topic.”

   (Participant 6).

Another participant described needing to have distance from her family because her parents were not able to understand or be supportive around this issue. She says:

   “Yeah, family, not so much. Okay, my mom definitely got better. It was still a struggle. I never really talked about my eating disorder with her…She just never got it… She never got it. My dad, I don't really talk about it with him at all. He'll ask me every once in a while, “How's your eating, going?” And I’m just like, Well, I’m still in therapy. Still seeing a dietitian. That's all I'm really willing to say about it, and he's like okay. So, he respects my limits around it now, I think, which is better, because he knows when he tries to talk about it, it doesn't go well. If it's something I bring up and say, I would like to talk with this about you, it goes a little bit better, but there have rarely been those things, because he just doesn't get it.” (Participant 9).
Participant 1 also described the harm that the focus on food/body has done to her family relationships. She described having an otherwise supportive and close relationship with her mom, but that she still struggles when these topics come up. She explains how it still hurts to this day, even though she has an overall close relationship with family and family has respected some boundaries. She says:

“I mean it was painful, and there was like a pang, there’s always a pang of like “oof”. I feel it in my chest when that kind of stuff happens, it kind of shuts you down. Even just when they have conversations amongst themselves, even if it's not related to me… Or talking about that kind of stuff, losing weight for things. It always just kind of makes me feel really shitty. I kind of just shut down. I'm very talkative, and I have a lot of things to say in family conversations, and usually I just back out of those, because there's nothing… I’ve never been able to say something that makes them or me feel better… The pain I feel from them, from them by discussing it, just opens me up to more pain rather than just keeping my mouth shut and like processing it separately. It really hurts. It hurts to be reminded constantly of like the damage that has been done to me, even if I’m not letting the damage continue, it’s kind of just scraping away at that little younger self that I’m protective of. And when I hear that language that's what hurts, reminding myself what it how it felt when I was younger.” (Participant 1).

Another participant, participant 4, echoed the struggle of needing to distance from family who continue to perpetuate weight stigma, and how this is intersects with other issues as well. For this participant, family perpetuating weight stigma is compounded by them not understanding the impact of trauma or other mental health-related issues, all of which resulted in her shutting down and having a limited relationship with these family members. She says:
“And since I’ve found [Intuitive Eating], I’ve tried to share some of that with my family, namely my sister, who is still heavily feeling shame in diet culture. And I’ve tried to explain my perspective on my diet, and how I fall into restrictive patterns, and how dieting is just not something for me. And there's just so much to that complexity of it, and I just feel like none of it gets grasped. And when I say, I don't you want to hear about your diet, and I don't care about… that you heard about your neighbor doing whatever and she's had success with it, or whatever. I don't care about that, because these things are triggering, but these things seem to get lost among my family members. They seem not to understand that those things are bothersome to me…It's just really frustrating when you are aware of what things come up and what things are going to stick, and you reach out and say, “This is what I need from you,” and then it just consistently gets ignored. So, you just kind of have to learn how to maneuver around it and navigate, and it’s exhausting.” (Participant 4).

Participant 2 describes a similar dynamic with her family, and specifically how the focus on food/body has prevented her from sharing about her eating disorder journey at all with them. She connects her overall happiness to other life changes such as getting married but explains how this is only part of the story. She isn’t able to share her full self with her family because of the history of weight stigma. She says:

“It's made me more aware of the messages, of what they say, when they say it. It sticks out like a sore thumb now, any diet talk. I try to shut it down, or I just walk out. I think my family equates my happiness with being married instead of being in recovery. I'm like, yes, a lot of that is the fact that I’m married. However, there is more to the story. It’s not just that I got married, but that I’m in eating disorder recovery and they are unaware.
But I think that they equate that a lot with… you finally found somebody! And To answer your question, they've seen a difference. They just don't know why. They don't know the full picture.’’ (Participant 2)

Participants described a myriad of ways that experiencing weight stigma in their relationships harmed these relationships and put distance between themselves and family members. For some participants, this occurred early on because they knew family were not supportive around these issues, whereas for others, this happened after many attempts of trying to get the support from their family.

**Subtheme 2: The Need for Boundaries**

For many participants, the harm that came from their family’s focus on food and body eventually led them to need to set boundaries in these relationships. Boundaries are clear lines that people communicate with others about their needs in relationship, and what type of behavior they will or will not accept. While painful, participants described how this separation from family and setting of boundaries allowed them to heal. Often, these boundaries happened after participants attempted to share and explain with family, and when family didn’t understand, participants had to set boundaries in order to protect themselves. The participants who were able to do this reported how important this was for them. Participant 1 describes:

“With my mom, I've had to really set that clear boundary of: I don't want to talk about weight. I don't want to talk about weight loss. So, she's been good. My mom's wonderful. For all her ways that she fucked me up, she's really good at like listening and trying to improve now. Now I've explained. I've had these conversations with her about the ways that it's affected me, and why this method is working for me, and why I've been consistent with it for the first time in my whole life. And so, she’s been really good…She
isn't talking about my body, which is really good. And she’s been doing a mostly better job about not talking about her own body. I'll catch her sometimes. She was like “I went on vacation, and I only gained two pounds!” And I was like “Mom, it's probably water weight…” Like oh my god ugh! Yeah, that's where we're at now is just having really clear boundaries. And knowing what I need, and what I don’t need in my life.”

(Participant 1).

Another participant, Participant 6, described how being able to differentiate and separate her own feelings about food/body from that of her parents has been helpful. She explains how the comments are still harmful and impact her deeply, but she is better able to let the messages go and focus on her own recovery. She explains:

“Yeah, I mean, I think a lot of stuff I've gotten better mostly. I let a lot of stuff go. Essentially, I tell myself, which I do have to stop and tell myself something about it. But sort of like, “Okay, that's their own stuff that they're doing. They're trying to work on their own things that are going on.” I would say, eighty or so percent of the time like that works. I'm able to say, “Okay, they're dealing with their own stuff, it’s not really about me. It's really about what's going on with them.” There’s still sometimes where something somehow hits a little home a little bit more or a little bit harder, and then I find that when that happens my first thought is, “Well, I just shouldn’t eat. I just shouldn’t eat anymore.” And I used to just go “Okay, well, that's what I’m going to do. I'm just not going to eat.” And then, of course, that doesn't work, and then I binge. And so now I still have that thought, or I might even have like an hour or something where I'm like “Okay, that's my new plan. I'm not going to eat.” And then usually at some point, either I'm able to work through it myself or I'm able to talk to [partner] or I'm able to look back at some

Participant 9 also shared how important and helpful boundaries have been in her recovery, but how it still impacts the relationship and harms her. She says:

“And the more I learned and after I started treatment for an eating disorder, I got to the point where I was like I'm not doing this anymore. Those are things that you're gonna say? I'm out. I'm not engaging in these conversations. I'm not allowing these conversations. And that was that. And as soon as I stopped tolerating any form of those comments, it definitely improved. I think there still were comments made, but I don't think that she understood what she was actually saying…” (Participant 9).

A few participants also noted how they were able to set boundaries and accept that their family continues to perpetuate harm and also harm the relationship, but that they felt motivated to be a better role model for others. Participant 1 says:

“I don't think they'll ever change. I don't. They don't care enough. They don't see that there's something wrong. And so therefore they can't change. So, I really just focus on like the way that I let them affect me, and the way that I can show up for my niece and nephew, who are still young and moldable. And trying to be an alternative example of what like a healthy body looks like and what a healthy person looks like. That’s where I put my focus these days.” (Participant 1).

When participants were not able to get support from family or continued to be actively harmed by their family members, many were able to set boundaries and purposefully create distance in order to protect themselves. While healthy boundaries are part of all relationships, this theme highlights that participants had to do this in response to harmful weight stigma experiences.
**Subtheme 3: Ending Romantic Relationships**

All interview questions were framed as having to do with family or intimate partners, and it was clarified that I as the researcher was interested whoever the participant considered “close family.” It is interesting to note that most participants talked about family of origin relationships, but handful of participants also shared about experiences with partners. A few participants described how weight stigma from intimate partners impacted them, and all participants had since ended these relationships in part due to the weight stigma they experienced. This is consistent with subtheme 2, the need for boundaries, as ending a relationship if the person isn’t open to change is a type of boundary. Participant 2 described how weight stigma was part of a past romantic relationship, and how ending the relationship was important for her healing. She says:

“I never felt good enough. I was always trying to get his approval. I was always trying to look good, be good, do the right things, say the right things. It was very controlling, very manipulative, but a lot of it was focused on food and body. Looking back, I think that was just a projection on him. I can say that now. But back then it was just a constant “I’m just worthless.” My ego was like this big (makes a small pinching motion). It took me years of coping, of detaching myself from him to get better. I’m in a very loving, healthy relationship now, and we eat all the foods together, and it’s great. And he loves my body the way it is. So, it turned around. But it was just a constant like (big sigh). Defeat.”

(Participant 2).

Participant 12 also described ending multiple relationships because of weight stigma, and how if the topic did come up in the relationship it was a sign for her that the relationship was no longer supportive. She shared:
“But past significant others, I know that it was an issue where it was brought up, and it was kind of like “You've gained some weight since we’ve been together, and should we start working out and this and that?” And then I remember being really angry about it because they had gained a lot of weight, and I never said anything about, and I wasn't ever trying to change it. But I was like, okay. But that was usually always a signal that I needed to end the relationship, anyway. So, it worked out.” (Participant 12).

Similarly, participant 3 described how their relationship changed when they began recovery from an eating disorder. In recovery, the participant started pushing back on the focus on food and body and this was part of what led to the ending of the relationship. They said:

“And interestingly enough, the boyfriend at the time I was with for ten years. We broke up as a part of this. It wasn’t the main reason. There are clearly other issues. But this was a big part of it, where we just kind of had a mutual separating, because he suddenly became super obsessed with eating to diet and wanting to lose weight and all this other kind of stuff. And then he was concerned about me having gained weight back…. So, I definitely think that probably broke my relationship with him.” (Participant 3).

While only a few participants reported ending romantic relationships due to weight stigma, these are poignant examples of the ultimate harm that weight stigma can do to relationships.

**Subtheme 4: Ending Family Relationships**

While all participants described how weight stigma harmed their family relationships in some way, a few participants reported that the focus on food and body resulted in more significant separation, isolation, and even in one case estrangement from family. This seemed to occur when participants tried hard to set boundaries and change the relationship, but weren’t able to, so their only choice was to completely separate. Participant 8 shared:
“Yeah, I think it’s mixed. I’m trans, I use they/them pronouns. It’s a different reason [for the estrangement] for different members of my family…I think with my mom, she and I had that sticking point, and that contributed because my mom was a lot more vitriolic than my dad, as far as how she enforced her views of body image, so that definitely contributed some, because I would set this boundaries and say, “Okay, this is what I’m comfortable with. Please don’t talk about this or that” and then she would just completely ignore it. So, unfortunately that was a lot more of a factor [in the estrangement] from my mom than my dad.” (Participant 8).

Another participant also described how they experienced a lot of harm from a family member, and while weight stigma was not the only reason, it was a large part of the decision to separate from family. They said:

“This would probably be, not this year, but last year was probably one of the hardest times…I don't have a great relationship with my family, obviously, and I had gotten to the point where I was tired of being pushed to the side family wise, and nobody listening to my hurt and everything. And I voiced my opinions. I told my grandma about how she made me feel, and all these things about how they had created these eating issues, and instead of it going the way I had hoped… and we always kind of hope, even though we know the person, we always hope that they’ll just be different. And she wasn't. She said, “If you think I’m cruel, I could get crueler.” And to me, just for her to be that, and just be like, “I can tell you why your self-esteem is low,” and to just know that in her head... I could tell in my heart that she had nasty things that she had been waiting to say without her having to say it. And I remember, after blocking them, I just decided I can't do it anymore. I blocked them, and I had taken a shower, and I was just looking at my body.
And I just thought “what's wrong with it?” Because when I look at it, yeah, it's not thin, I’ve got lumps, I got bumps. I got all kinds of stuff. But I've almost died, and it's saved me. It's the only one I have. And why wouldn't you want to just teach the people you love to love their body?” (Participant 7).

These theme highlights that all participants had to create some distance and separation due to the harms of weight stigma, but that for some it resulted in completely ending the relationship. While this was necessary for these participants, it is a painful reminder of the inverse harm that weight stigma can do to relationships in addition to the individual experiencing it.

**Theme 4: Relationships Heal**

While participants reported lasting and pervasive harm done by experiencing weight stigma in relationships, participants also described supportive relationships as a significant part of their recovery. The most healing thing participants described were separation from harmful relationships and finding other supportive relationships that countered the messages they internalized from family and offered an opportunity for an adoption of a new value system. These relationships include treatment professionals, fat positive community, supportive friends, and romantic relationships where participants explicitly got the message that their worth was not in their body/appearance/weight.

**Subtheme 1: Explicit Acceptance of Body**

Participants described supportive relationships with romantic partners as having a significant positive impact on their recovery. Participant 4 shares the importance of having support from her spouse and explicitly supporting her recovery:

“…My spouse is really supportive of what I'm doing. I think he really understands what all has occurred up until this point, and the amount of shame it's put me through, and just
like those raw emotions that have happened. And having that kind of support at home has been really necessary.” (Participant 4)

Another participant reports the importance of the support from her spouse and describes specifically how his explicitly acceptance of her body was a significant piece of being able to change her own relationship with her body. She shares:

“So, when I met my husband… I was twenty-five. Now we’ve been together for ten years. I didn't like to believe in the beginning because it started the same kind of way. It was more casual, and it took me a while to be able to let in the way that he felt about me and feel it. And really feel beautiful. He would say, “You're the most beautiful woman I've ever met.” And it didn’t mean anything. Now, I can feel it. I let it in now. Sorry I’m going to cry. I know he means it, and it feels really good, and it's really helped me. To be in this this new phase of my life where I believe it to myself too. It just took cracking that little shell and understanding that really kind of set that off for me. So yeah, I don't know there's like a specific example. So much as like it took every single friggin’ day. It took a long time. It's a lot of damage to be undone.” (Participant 1).

Similarly, participant 3 shares how experiencing explicit acceptance of their body and their partner finding them attractive and desirable has been one of the most important things in recovery. They say:

“But I think the conversations I've had with him and learning more about the way his brain works…And with my surgery last week, I don’t think we had any conversations about food or body or anything, but it was just seeing how much he loved and care for me during that process. And just validating that my size does not matter to him at all. We’ve had multiple conversations where he has said: I love you the person and you could gain
weight, lose weight, it doesn’t matter. He doesn’t see that; he doesn't see the weight…So, I think just having those conversations, and having such a healthy perspective compared to what I’ve been dealing with for the last decade, was probably one of the most important things to happen. Even if we break up, it’s been very important to have that alternative perspective in my life, coming from a cisgender male.” (Participant 3).

Participant 10 also reflected on the importance of support in a romantic relationship and highlights the difference of trying to recover on their own versus having support. They shared:

“But then, after that I did not get into an actual relationship…It took me five years before, I had to graduate college before I could find someone that was actually into me. And thankfully, this one's been amazing, and it stuck, like we're good, everything's great there. It turned around for me. But it took five years of all of that up and down, and when I didn't really have anyone to back me up on it, I was just trying to fight my own internalized issues. It just took me so much longer to push through it all.” (Participant 10).

These excerpts highlight that explicit or direct acceptance of body, and larger bodies in particular, were an important part of many people’s recovery. These examples also highlight that repeatedly and consistently hearing this explicit acceptance is key; it takes more than just a positive comment here or there.

**Subtheme 2: Challenging Messages Learned from Family**

When attempting to explore what exactly it was about supportive relationships that were helpful, many participants noted how in safe and supportive relationships they were able to challenge and counter the harmful messages they internalized from their families. Participant 7
describes how helpful it has been to have their spouse not focus on their body and instead communicate that they want them to be happy and nourished. They say:

“When it comes to him, with my husband, he's never looked at my body, and when he touches me, or he's hugging me, it’s genuine. I can tell that he's never, there's never been any fatphobic comments from him. Nothing like that. He’s genuine in the way that he loves me, and his love for food has also sparked my love for food. He loves to eat, and I enjoy baking and cooking for him. Just having him always be appreciative when I do cook for him, and telling me how much he loves it, and then not making me feel bad when I’m eating it. He's quick to be like, “Do you want more? Let me get you some more food. If you’re hungry, you should eat.” That’s his motto: If you’re hungry, you should eat. And he always tells me that it doesn't matter what time it is. If I’m hungry, he wants to make sure I eat, and he'll go find me some food.” (Participant 7).

Similarly, Participant 6 explained how having a safe person to work through the internalized messages has been an important part of their healing. They note that they try to challenge these messages on their own, but that it is more helpful with support. They say:

“Yeah, I mean they’ll listen to what I’m saying. Sometimes they’ll challenge some of the thoughts that I’m having. In a very kind way, like “So you're saying this, you're saying no one likes you because you are fat, or whatever. I know that it feels that way. But can we think about all of the people we know who do like you.” And sometimes I’m like “no, don’t tell me about that.” But usually I’m like I get it, that sort of like rational voice, that can be really helpful. So, like listening to what I’m going through, that kind, challenging thing, and oftentimes just like repeating, not exactly affirmations, repeating that sort of stuff like, “Your worth isn't measured by your size. You can be fat, or in a bigger body,
or whatever, and you can still be beautiful, you can still be accepted.” Just reminding me of these things that I believe to be true but being there as the external voice to help remind me.” (Participant 6).

Participant 11 shared a similar sentiment, and the importance of having partners who provided a different experience than the one she had with family. She explained how having relationships with people who care about her well-being and see her as human and as more than just her body has been helpful. She says:

“Oh, yeah. I don't know, just dealing with, when someone notices like, “You haven't eaten all day. Are you okay?” When you're with people that you don't know well you don't really eat, or again, when you have a really messed up relationship with food, you can go days without eating especially when you're in that bad head space, and then go on a crazy binge. And people who are like “You're not eating, are you okay? Maybe you should… Are you sure you're not hungry?” So, I’ve started to have partners that actually do that and realize that, okay, you're a human with normal human needs. That was a big thing for me. You have people who care about you and feel like there are people who don't feel like because you're fat you don't need to eat, kind of thing. So that was a big that was a big thing to realize. There are people who are okay if you're out walking, and you need to take a rest break. They're checking in on you instead of being like “Oh, my God, you're so out of shape, you're so slow.” Seeing that you’re fat and not it being a deterrent.” (Participant 11)

In addition to explicit acceptance of one’s body, being able to hear messages that challenge the messages participants learned from their families and have a safe space to explicitly challenge
these messages was a crucial aspect of recovery. It helped tremendously to have other people challenge these messages rather than the participant having to do it alone.

**Subtheme 3: Fat Positive Community**

Many participants also noted the importance of finding fat positive community more generally. Participants often struggled to find this community, but some had been able to find supportive spaces in person or online. Having a community of support, and having other people who have similar experiences, and a safe place to talk about the experience of being fat was validating. Participant 11 described her experience of finding fat community and being able to challenge her internalized fatphobia. She says:

“When I was really healing my relationship with my body in general, it wasn't until probably I was almost thirty when I was like “Oh, crap, being fat isn’t a bad thing!” I got involved with people who are in the fat positive community. And you’re like “Oh crap,” there’s so much behind, people who… with fatphobia and things like that, and how much of racism and classism and everything behind it, and how I deserve to exist. And in the community, it helped me more than just regular therapy did, having fat friends and things like that, just being able, not being afraid to eat what you want, getting involved in that was really such a healing experience for me, and allowed me to really be like, “Okay, it's okay to have a good relationship with your body, you don't have to feel a bad person. It's not so moralized.” Especially being always on the higher end of the fat spectrum and feeling like, you always feel you're somebody's… I don't want to say horror story, but at the same time, you do get demonized by people being a superfat. Just overall finding a community really helped my body relationship. It just brought everything together, and
really what I needed to heal, rather than what even professional thought I needed to heal.”

(Participant 11).

A few people mentioned this when they were not able to find community face to face, but that finding online community or even social media that is fat positive has been helpful. Participant 8 shared:

“I think the internet. I guess I’ll break it into two parts, in real life and internet components. In real life just dating other fat people, having sex with other fat people that is that people are so affirming. Because I’m like, “well, if I find you attractive, and we look the same, then maybe I don’t look so bad.” It's been very nice to have that, I think that has been very healing. Even my best friend who I talked about, I've seen how his body has changed over time, but I don't feel any different about him. Just because you got fat doesn't mean I’m not gonna like you anymore. But when I feel that this when I have that internalized “okay, if I see a friend who I haven't seen in three years, and they found out that I got a bit fatter then somehow they won’t like me anymore.” Which when I say it out loud, that sounds so ridiculous, but it's just something that I internalize. So that's been helpful in the real-life aspect.” (Participant 8).

Finding explicitly accepting and fat positive community was key to many participants’ recovery for similar reasons as challenging messages learned from family and finding new relationships to create new meaning about food and bodies. This community could be in person or virtual, but what was significant for participants was having other people with shared experiences who were also fat positive.
Subtheme 4: HAES® Eating Disorder Treatment

Lastly, many participants shared that some sort of formal eating disorder treatment that was Health At Every Size aligned has been an important part of their recovery. Learning about the principles of HAES® or Intuitive Eating, challenging fatphobia, and having the support of therapists and dietitians who practice from these lenses were all aspects of treatment that participants reported as helpful. Participant 10 describes how their therapist helped them to challenge the messages learned from family:

“Yeah, absolutely. I think a huge part of that, first of all is finding a good therapist. Someone to actually get with you, because my therapist herself is not a fat woman, but she is one of the most supportive people, and probably the best choice that I have made in terms of my mental health journey. Having someone that just completely, objectively… who’s there to be like, no, no, no, no, we're not having these thoughts about food. Not in a way that like “stop right now,” but just being like a question that thought, don't just have thought, and letting me talk about those things, and generally understanding what I mean, because she is well researched on topics that don't affect her. Good therapy probably the best foundation I could ever recommend for anyone.” (Participant 10).

Participant 2 also shared about her experience with therapy and Intuitive Eating, and how working to accept her body instead of changing it was helpful. She says:

“And during that time, I was in therapy with an Intuitive Eating counselor, and she helped me get into recovery from binging and purging. I haven't binged and purged in years at this point. Intuitive Eating helped me so much to just put the sword down. I'm just tired of fighting it, and just freedom, and just to be. It's been altering and life changing for sure.” (Participant 2).
Some participants also shared that treatment providers were sometimes the only safe or fat positive place they could talk about their struggles because they didn’t have anyone in their family or day to day life. Participant 9 says:

“I've tried to find that at least professionals that I can identify with, and that I’m comfortable talking about these problems with that at the very least, if there is no one else in my life who understands, there is someone that I can share that with, and there’s a safe space for me to go to talk about it. That's been super helpful.” (Participant 9).

Formal eating disorder treatment that was Health At Every Size and explicitly fat positive was also a crucial part of recovery for many participants. For the participants who spoke about treatment providers, many mentioned that having this support was one of the most helpful aspects of their recovery. Participants who spoke about providers were able to articulate that what was significant about these experiences were that these relationships provided a safe and affirming place to counteract the messages learned from family as a child.

**Conclusion**

The analysis of the data resulted in four themes: It Matters That It Comes From Family, It’s Different When You’re Fat, Weight Stigma Harms Relationships, and Relationships Heal. Among these themes include 16 subthemes which provide nuance and depth to the primary themes. There were both common and distinct elements of each participant’s story. The results provide insight into the implications of weight stigma in the context of family relationships, and how this impacts both individuals and their larger family systems. These impacts are significant and lasting, with all participants expressing that these issues still affect them to this day.
CHAPTER V: DISCUSSION

Introduction

As a whole, the results both echo and provide nuance to the existing literature on the topic of weight stigma, eating disorders, and relationships. In reviewing the results, much of the participants’ experiences are in line with what existing research has shown about the harms of weight stigma. However, there is little research that explores the systemic impact of weight stigma on relationships and families, and what it is about relationships that can be supportive in recovery. This study has the opportunity to provide a much-needed foundation for beginning to understand this issue and to inform further research on this issue. This is also evident in the ways that extant literature is apparent (or not) in this chapter. Existing research abounds with evidence and examples of the harm of weight stigma on individuals, and this is reflected in the ample literature referenced in theme 1, It Matters That It Comes From Family. In the discussion of themes 2-4, I incorporated the little relevant literature that is available, but this section also reflects much more of my own interpretation and clinical understanding of these issues because research related to these themes is lacking. As a whole, this study supports and gives nuance to issues that have been studied in existing literature and begins to fill in gaps in the literature around the intersection of fatphobia and relationships. The way the study was conducted and presented aligns with the phenomenology belief and feminist goal of valuing everyday knowledge, allowing for complexity and nuance, and amplifying marginalized voices and experiences.

Discussion of Theme 1: It Matters That It Comes from Family

This theme represents the importance of family as the mechanism for messages about food/body given the influence of family on child’s development and communicating messages
about identity, value, and worth. It is interesting to note that while the interview questions inquired various experiences around food/body and not just family experiences, most participants spent the majority of their time talking about significant family of origin issues as children and some as adults. This seems significant to me because in my interview guide, I framed questions as “whoever you consider family, including parents, siblings, partners, friends etc.” I also had questions equally split between the development of struggle with food/body and the unfolding of recovery, and yet most people focused on development and the harm that family in early life caused. This is more process-based evidence that these experiences are so harmful and impactful that even years later, once the person has engaged in healing their relationship with food/body, these experiences still stand out as the most salient. The impact was also clear in the interviews, which is difficult to convey in this paper. I could feel the depth of the pain in the interviews and even in participants who were able to describe their experiences calmly. When re-reading the transcripts, I became emotional about the depth of the impact participants described.

Subtheme 1: Pervasive Messages and Lasting Impact

This subtheme focused on the idea that every single participant described in some way that the messages about food and body were pervasive in their family of origin growing up, and that it has had a deep and lasting impact. This is consistent with existing literature that focuses on the impact of weight stigma. For example, Vartanian et al. (2014) and Puhl, Moss-Racusin, Schwartz and Brownell (2008) found that people experience the majority of weight stigma from family and “close relationship partners” and that these experiences are significant and painful. Similarly, Eisenberg et al. (2012) found that children most commonly experience weights stigma from family and peers. The current study not only bolsters this, but it also begins to answer the question of why it is most significant and painful when it comes from family. Similarly, Magson
and Rappee (2022) also found that stigma from parents was most damaging to adolescents, which also supports the results of this study in that childhood and adolescence are an important time for these messages. Kluck (2010) found similar results and reiterates that a family culture focused on weight and appearance correlates with body image dissatisfaction and disordered eating. “Culture” is an apt word to describe the pervasiveness of the messages. This pervasive culture is different than a one-off comment about weight. While participants sometimes remembered a specific harmful interaction, most participants described their experience around food/body as something that was just part of their family almost all the time. Existing longitudinal research also replicates the lasting impact of food/body focused messages as children long into adulthood (Kotler et al., 2001).

Another interesting aspect of these results is the way in which the impact was lasting which indicates that the participants internalized the messages from their family and struggled to externalize them even as adults. This is also consistent with the research on weight stigma. Literature shows that level of internalized weight stigma is a large part of the harmful effects of it (Hayward et al., 2018; Himmelstein & Puhl, 2019; Meadows & Calogero, 2018; Pearl & Puhl, 2016). Because of this, existing literature has suggested targeting internalized weight stigma and aiding people in coping with weight stigma. But similar to general family therapy and systems theories, interventions aimed at helping children cope while they are still in a harmful system or environment can only do so much. For example, internalized weight stigma has a specific feature of blaming oneself for ones’ appearance or size (Meadows & Calogero, 2018). This dissertation study shows that that is the exact messages that participants received from their families: It is your fault you look this way, and you are a failure for not changing it. How can we expect young children to not internalize the messages that come directly from or are reinforced from parents?
And how can we expect children cope without the help of their parents? This study highlights the importance of looking at the issue of weight relationally and systemically, rather than just individually. Also consistent with the results of this study is existing research that shows that much of this need to control children’s eating comes from parents’ own challenges in their relationship with food and body (Webb & Haycraft, 2019). Many participants were able to reflect on their experiences as children and can recognize as adults that the focus on food and body was related to their parents’ own struggles with food and body.

**Subtheme 2: Children are Vulnerable**

The messages people receive from family are significant and lasting in large part because childhood is an incredibly vulnerable time. Childhood is when we learn important information about ourselves, others, and the world, and it shapes our outlook on the world significantly. The primary way that we learn about these things is through relationships, an idea that is supported by many theories including attachment theory and relational cultural therapy (Ainsworth & Bowlby, 1991; Jordan, 2017). Research supports the vulnerability and malleability of childhood, as well as throughout adolescence. Magson and Rapee (2022) note that adolescence is a particularly vulnerable time for development and when “one’s sense of self is most fragile”, and therefore experiences of weight stigma may be most harmful and lasting when they occur during this time. Children develop a strong sense of self and are able to resilient when they have safe and nurturing relationships with caregivers. As this research shows, experiencing weight stigma disrupts this relationship and can create an environment that is no longer safe and supportive. The experience of reflecting on childhood as an adult also highlights this vulnerability as it can be an acutely painful thing to realize the ways that as a child, we were vulnerable and may have been harmed, and could not do anything about it until adulthood.
Additionally, the practical elements of the vulnerability of childhood were highlighted in this study as well. Most significantly, parents control children’s access to food. Ideally, this is done in an emotionally healthy (non-restrictive) way such as providing sufficient food for children, modeling Intuitive Eating, and modeling a structure of eating adequately throughout the day (Satter, 1990). However, when parents struggle with their own issues related to food and/or body or have concerns about their child’s body, parents often restrict food. Many participants reported this. Participants described explicitly having their food restricted and not having access to all the food they wanted or certain types of foods, and/or described experiencing judgement and shame for desiring certain foods or the quantity of food their body required. For many participants, this heightened their distress around their relationship with food and/or body and pushed them to eat in secret or feel out of control around food once they had increased access to food like while at school or when they were teenagers and had some money and increased access to food. This dynamic is harmful both practically and emotionally and replicates a common eating disorder behavior which is the restrict-binge cycle. In eating disorder treatment, the main focus to disrupt this cycle is to stop the restriction (increase food intake and access to all foods), and the binging will subside. Another important treatment is to target the shame around bingeing and feeling out of control around food. In the case of the participants in this study, these disordered behaviors were triggered and/or reinforced by the family’s judgement and control of food. Because caregivers and families have so much control over children’s experience of food, the impact on participants and their subsequent relationship with food and/or body is profound. The participants in this study would not have been able to recover from their eating/body-related distress in the environment they existed in as children.

**Subtheme 3: Direct and Indirect Messages**
This study showed that many different types of messages about food and body are harmful, regardless of whether these negative messages were direct or indirect. For some participants, the messages were more indirect and coded; for others they were extremely direct. Some participants described more of a focus on bodies and weight, and others felt the focus was primarily on food. Regardless of the style, it was harmful. Participants explained that these experiences impacted their relationship with food, their relationship with their body, self-esteem, and self-worth. This is consistent with existing research that weight stigma—both internalized and experienced—has many negative effects, including increased levels of internalized weight stigma, increased negative body image and body image dissatisfaction, depression and anxiety, low self-esteem, and eating pathology, and weight and shape concerns (Gowers & Shore, 2001; Major et al., 2012; Meadows & Calogero, 2018; Myers & Rosen, 1999; Puhl & Heuer, 2009). In a longitudinal study, Hunger and Tomiyama (2014) found that being labeled as “overweight” or “obese” resulted in weight gain later on independent of baseline BMI. This reinforces that any focus on children’s weight is harmful, and even less overt weight stigma (than something like bullying) such as just being labeled as overweight or obese has harmful impacts on children. This is consistent with my research that people reported “knowing” their weight was a problem, even if parents were not as explicit about it, and that these experiences continued to impact people years later. It’s important to note that even if parents think they are only commenting on food and not body size, the implication is still there, and this implied message still has an impact on children. Children know what parents mean. This is consistent with research that shows there is no “positive” or safe way to talk about weight loss or restricting food with children and adolescents (Puhl & Himmelstein, 2018). Any type of discussion around food/body that
communicates that there is something wrong with the person or that they should change their body or the way they engage with food has the potential to do harm, as these results show.

**Subtheme 4: Messages Communicate Ideas about Identity, Value, and Worth**

It was clear in the results of this study that another explanation for why the messages were so impactful and lasting was that the messages communicated deeper ideas about identity, value, and worth. They are deeply personal and are connected to crucial areas of life such as acceptability, being lovable, and future success. The flip side of this is deep and intense shame, which many participants reported experiencing when they inevitably could not reach the thin ideal. Existing research supports the idea that focus on eating/food also communicates a message about work, value, and shame (Oliveira, Pires, & Ferreira, 2018). Oliveira, Pires, and Ferreira, (2018) found that external shame was a mediator between parental messages about eating and future body image/disordered eating. The study found that parental messages about food/body “can activate feelings of inadequacy or the perception that the self fails or presents a defect” (p.477). The paper then goes on to suggest that these feelings of inadequacy can continue after the explicit messages are gone, and that restriction is used as a strategy to cope with these feelings and gain acceptability and approval from others. Again, this is in line with my results which show that the message about controlling/changing body is about trying to become accepted and appreciated by others, which is why it is so harmful. We can more easily challenge or let go of beliefs that are more separate from ourselves than ones that are about identity, relationships, and emotional safety. In line with subtheme 3: Indirect and Direct Messages, most participants absorbed the deeper messages about identity, value, and worth regardless of the way that these messages were communicated. While some participants remembered explicit statements (such as “People don’t like other people who are fat,” Participant 6), others still
picked up on this message in more subtle ways. As long as families hold the belief that body size is connected to value and worth, children will learn this message.

Subtheme 5: Family Relationships as a Vector for Fatphobia

As a systemic and feminist clinician, it was not surprising to see the data reflect the idea that family is a vector for fatphobia from larger systems. Some existing research has looked at this phenomena, and a socio-ecological model of mental health and well-being supports this (Michaels et al., 2022). When specifically considering weight stigma, research has found that family communication can be a way that the family communicates societal attitudes and behaviors, and in this context communicates messages of weight stigma (Fitzpatrick & Ritchie, 1994). There is also a missed opportunity for parents to intervene in the experience of fatphobia with children. Since families can be a vector for reinforcing fatphobia, families potentially could also act as a buffer for this fatphobia and provide a different experience for children who receive weight stigma from others. I will touch on this in the future research section with further exploration of this potential and research recommendations.

Theme 2: It’s Different When You’re Fat

Participants described being very aware of body size at a very young age and how this impacted their relationship with food/body. Being fat, both as an adult and child, made their relationship with food, body, and others harder. Participants described this in various ways, sometimes reporting an explicit awareness that being fat was bad whereas others knew this implicitly and felt that as a young child there was something “wrong” with their body. This theme is significant in our understanding of how people in larger bodies experience the world differently; everyone in our society learns that being fat is “bad,” but children in larger bodies
learn that their bodies are “bad.” Participants reflected on this experience of being in a larger body and how this affected them in their relationship with food and body.

**Subtheme 1: Awareness of and Focus on Body Size**

Participants described experiencing a large focus on and awareness of their body size both from others and themselves. While each person only has their own individual experience to go off of, this is supported by existing research. Being fat makes the experience of focus on food/body more common and more pervasive; unsurprisingly, higher weight individuals experience more weight talk and weight-related teasing (Eisenberg et al., 2012). Similarly, Rogers et al. (2019) explored the influence of parental messages about eating on body image and found that restrictive messages around food corresponded with larger BMI (i.e., if the child is larger there were more messages around food and higher levels of anti-fat attitudes and body shame). While there is little research on this topic, it is clear and logical that there is a difference between growing up thin and learning that fat bodies are bad and growing up fat and learning that your body is bad.

It is also important to note that even among children and adults in larger bodies, a size spectrum exists. While there is no research looking at this issue, I hypothesize that the larger the child is, the more focus and attention they would receive from parents and others about their body size, and that this then may have impacted people’s experiences differently.

**Subtheme 2: Less Understanding and Less Support**

This subtheme reflects the idea that being fat as a child resulted in less understanding and less support from others. This is well-documented and supported by existing research. Anti-fat bias is pervasive in all healthcare professions and an astounding number of people hold negative beliefs about people in larger bodies (Puhl and Huer, 2009; Puhl et al., 2014; Veillette et al.,
Participants in this study reported feeling less believed, less understood, dismissed, and minimized when it came to all kinds of medical and health issues, not just eating disorder-related issues. Participants also described how this resulted in more isolation because participants knew others would not understand and they would not be able to get support. This is a lesser-known effect of weight stigma, but one that according to this research may have a detrimental and lasting influence on people.

**Subtheme 3: The Intersection of Body Size and Eating Disorders**

Participants also described the explicit intersection of body size and eating disorders. Participants reported difficulty internally with shame related to struggling with an eating disorder and being in a larger body, and difficulty sharing with and getting support from others due to their body size. This is also well-documented in the literature around larger bodies and eating disorders (Sawyer et al., 2016). For example, research supports that people in larger bodies are less likely to be diagnosed with an eating disorder, it takes longer for them to get diagnosed, and that treatment providers struggled to convince parents of the severity of ED symptoms when the person was in a larger body (Kimber et al., 2019; Puhl et al., 2014; Veillette et al., 2018).

Similarly, Harrop (2019) described their experience with weight stigma in eating disorder treatment for A-AN, and the impacts of this stigma are parallel with my results. Harrop identifies various negative effects of these interactions including increased denial of their eating disorder, the therapist modeling eating disorder behaviors, disrupted the therapeutic alliance, enacted body shame, and reinforced feelings of lack of self-worth. These experiences are very similar to what participant’s described experiencing from parents and medical providers around their struggle with an eating disorder. This is especially significant because it is well documented that early intervention in treating eating disorders is an important indicator of future recovery. When eating
disorders are left untreated, symptoms tend to become more severe and more resistant to treatment (Treasure & Russell, 2011). Therefore, weight stigma has ripple effects of harm on people in larger bodies.

**Theme 3: Focus on Food and Weight Harms Relationships**

The effect of weight stigma is also bi-directional. It is clear that relationships that include weight stigma harms individuals, but when families perpetuate weight stigma it also harms the family relationships. There is little existing research on this issue, which is a major gap in the literature. Later on, I provide some suggestions for future research on this topic.

**Subtheme 1: Weight Stigma Results in Distance and Isolation & Subtheme 2: The Need For Boundaries**

Participants described how experiencing weight stigma from family made those relationships no longer safe places for support, especially around this topic. This harms the relationship, which harms the larger system. This also sets up a terrible cycle for the individual; weight stigma creates isolation, and isolation is a key feature of eating disorders which makes the eating disorder worse. This then creates more isolation, and then the eating disorder continues to get worse, and the cycle continues. Eating disorders already create disconnection and involve a lot of shame and isolation. Adding weight stigma to this, and family reinforcing that the person’s weight is a problem, just compounds this. Eating disorder development disconnects people from their support systems, and therefore reestablishing that connection, emphasizing one’s voice, and empowerment are keys to recovery (Wacker, 2018a). However, people cannot reestablish that connection when the relationships are harmful. Therefore, boundaries are needed, which improves recovery but continues to result in relationships that are less close and less supportive.
Subtheme 3: Ending Romantic Relationships

There is less existing research about the impact of harmful romantic relationships on eating disorder development and recovery, but I have seen through my clinical experience and from the results of this study that having supportive relationships to be a crucial part of recovery, and that the lack of supportive relationships is harmful to recovery. Existing research is limited in the area of understanding romantic relationships and eating disorder treatment, but a few anecdotal studies exist. In this existing literature, studies highlight that eating disorder symptoms may be connected to not feeling accepted by partners, and that minimizing the disorder, isolation, and hearing hurtful comments about weight negatively impacts recovery (Reyes-Rodriguez et al., 2019; Linville et al., 2012). In this present study, participants were clear on how being in harmful romantic relationships was harmful to their relationship with food and/or body. Romantic relationships are the closest family relationships that we get to choose as adults, and attachment theory suggests that most people’s attachment figures shift from parents to romantic partners in adulthood (Ainsworth & Bowlby, 1991). In line with attachment theory and RCT, we develop our sense of self in relationship, and this is an ongoing process throughout adulthood (Ainsworth & Bowlby, 1991; Jordan, 2017). Therefore, romantic relationships are an essential part of recovery from eating disorders and the lack of support is essential as well. One primary difference between family of origin relationships and adult romantic relationships is that as adults we get to choose who we partner with. This study clearly shows that being able to end unsupportive or harmful relationships is a potentially important part of eating disorder recovery. For the participants in this study, ending these harmful relationships was important and people were confident in their decision. However, ending any relationship is usually painful and takes a
toll on people. The fact that weight stigma was part of the reason for ending the relationship highlights the damage to relationships that weight stigma can do if left unchecked.

**Subtheme 4: Ending Family Relationships**

It is clear from the literature and this study that people experience weight stigma from family and partners, and that these experiences are often harmful (Calogero et al., 2016; Hayward et al., 2018; Puhl & Suh, 2015). However, there is very little research on what happens next and how people navigate these experiences of stigma. Most of the research on coping with weight stigma has focused on reducing internalized levels of weight stigma, and very little has looked relationally or systemically on how to navigate ongoing weight stigma from close relationships (Hayward et al., 2018; Himmelstein & Puhl, 2019; Meadows & Calogero, 2018; Pearl & Puhl, 2016). Thus, there is very little literature to support this, but this study sheds some light on how people have handled these relationships. Many participants first tried to talk to family and partners about the harm they had caused or tried to set boundaries around food and weight comments. For some people, this worked, and they were able to maintain a relationship and protect their recovery. When this did not work, a few participants had to make the difficult choice to completely end the relationship in order to protect themselves. Ending a relationship with a family member is a difficult and painful choice, and one that usually takes a toll on people. While the participants in this study noted that weight stigma was not the only factor in their decision to end relationships, it was a significant one. This emphasizes the harm that weight stigma can do to family relationships and the importance of including an understanding of this relationship and systemic effect when working with people and families with eating disorders. Families need to know the harm they are causing to their child and also to themselves by enacting weight stigma in these relationships.
Theme 4: Relationships Heal

The most healing thing participants described were other supportive relationships. This is consistent with existing research that highlights the importance of relationships, but this study adds depth to the understanding of what was helpful about these different relationships. The emphasis on the importance of the relationships is also consistent with anecdotal research shows that people identify social support as a significant factor in their recovery from an eating disorder, and specify both practical and emotional supports as helpful (Linville et al., 2012; Reyes-Rodriguez et al., 2019). Family support is often a missed opportunity for support in recovery. Many people do not have adequate support from family, and even fewer have the type of support that participants in this study mentioned such as being explicitly accepting of their bodies and weight inclusive. Some research has looked at sources of support in eating disorder recovery and identified a few specific factors that are helpful in recovery such as connection to others and emotional support (Linville et al., 2012; Quiles Marcos et al., 2013). However, there is little research that explicates what exactly about social support is helpful in recovery. Additionally, there is virtually no research on how having relationships that understand and counteract weight stigma impacts people in recovery. Since weight stigma is clearly harmful and influences the development of eating disorders, it would logically follow that relationships that combat and counteract this are essential to recovery. This study begins to shed light on what is helpful about relationships in recovery and incorporates an explicit understanding of how weight stigma and counteracting this intersects with supportive relationships.

Subtheme 1: Explicit Acceptance of Body

Participants described safe, supportive relationships in which they received explicit acceptance of their bodies and the message that they were loved and appreciated as they are.
While there has been little research done to explore the connection between attachment and weight stigma, some research is beginning to support this connection. Laporta-Herrero et al. (2022) found that children with secure attachment (which includes attunement and responsiveness) from caregivers are more likely to develop an overall sense of trust and confidence in their bodies. This also fits with my understanding of eating disorders and body image concerns as connected to attachment needs and fears. The fact that experiencing weight stigma from trusted loved ones is especially harmful is consistent with research on attachment theory which posits the importance of having safe, secure relationships (Ainsworth & Bowlby, 1991). Relationships that perpetuate weight stigma are no longer safe and finding safe relationships that do not perpetuate this harm is crucial to recovery. For most adults, romantic relationships are where we have the opportunity to create secure attachment bonds. Experiencing a relationship that is explicitly an unconditionally accepting of one’s body seems to be an essential part of having a safe relationship and supporting someone’s recovery.

Subtheme 2: Challenging Messages Learned from Family

While the evidence for the need for social support in recovery is there, there is more research needed to identify what specifically about relationships is healing in recovery. Despite research consistently reporting that relationships are important for recovery, there is very little research that explores what exactly about supportive relationships is helpful. This future research would be crucial to our understanding of the relational factors that contribute to ED recovery and ways to incorporate these elements into treatment for people who do not have this support. This study begins to do this by identifying that a key feature of supportive relationships is having a safe space to challenge and externalize messages that participants had previously internalized from family. Participants described struggling with having internalized these messages learned
from family, and also hearing them replicated in the outside world. Having safe relationships that helped participants challenge and internalize a new healthier message about weight and bodies seemed to be an important aspect of recovery. This also aligns with some eating disorder treatment interventions. A common eating disorder treatment intervention is challenging internalized weight stigma or an internalized “eating disorder voice.” Currently, most treatment does this by supporting the person in doing this in their own head or with a therapist. Being able to do this with a supportive person who is in the person’s daily life seems to be an important opportunity for improved eating disorder treatment and an increased potential for recovery rather than doing this alone. This is also consistent with RCT and feminist approaches to eating disorders that posit that we continue to develop through and in relationships, not alone or in isolation (Jordan, 2017; Piran, 2010).

**Subtheme 3: Fat Positive Community**

Many participants were not really able to heal from these internalized messages until they could choose their own community. There is little research looking at the role of a larger community, and specifically fat positive community, in eating disorder recovery although this is a common suggestion in eating disorder treatment. While children do not have access to other community, and we do not get to choose our family, we do have more choice in creating a supportive and safe community. Fat positive community seems to be another opportunity for having safe, supportive relationships that can challenge previous messages internalized from family as discussed above. Many participants also described how having this community and being able to challenge the internalized negative messages by seeing other people who had similar bodies to them was helpful. While there is little research on this, this is another common process that occurs in eating disorder treatment. From my clinical anecdotal experience, many
people go through the process of first being able to accept and feel non-judgmental about other people’s bodies before being able to do this for themselves. For example, it is often easier to challenge the message that body size is related to acceptance by reflecting on the fact that the client loves their friends and family regardless of body size, and then subsequently is able to integrate this idea about themselves. Having a safe community with representation of diverse bodies also helps to challenge beliefs about what is possible as a person in a larger body. There is also an opportunity to include this type of community in recommendations for eating disorder treatment at all levels of care in a more formal way.

**Subtheme 4: HAES® Eating Disorder Treatment**

It is clear that access to eating disorder treatment was important; participants who had some form of formal treatment for their ED seemed to be able to better articulate their experience and feelings and seemed to be farther along in their recovery. This seems logical, but this study also added to the understanding of what it is about treatment that is helpful, particularly for people in larger bodies. Participants reported some specific aspects of treatment that were helpful to them, but most reflected on the support they received in these relationships. This is consistent with the feminist-relational model of eating disorders which identifies core aspects of the treatment of eating disorders as connection, social support, voice, empowerment, and feminist identity. The feminist-relational framework suggests that connection, relationships, and support are crucial factors in the development of ED (Piran, 2010; Trepal et al., 2012; Wacker, 2018a, 2018b).

Feminist scholars who look at the intersection of feminism and eating disorders highlight that not enough attention is given to the larger systems (societal and relational) when it comes to our understanding of ED development and research. In addition, research shows that current
eating disorder treatment is often fatphobic and does not address the needs of people with marginalized identities (Harrop, 2019). In my opinion, this is related to the biases we still have about eating disorders. If we see eating disorders as a thin white women’s disease, then it is easier to focus on the intrapsychic elements of eating disorders. People with these identities have immense amounts of privilege, and their bodies generally align with the “thin ideal.” Therefore, it is easy to suggest interventions that focus on how their perception of their bodies are mismatched with reality. I recall learning about an eating disorder intervention called “body tracing” that used to be commonplace in treatment where the person stood with their back facing a sheet of butcher paper and someone traced the outline of their body. Next, the person was supposed to look at this silhouette and the aim was to challenge the image they had of themselves internally. Essentially, the message was “See, the eating disorder is lying to you. You aren’t actually fat, therefore it’s okay to eat.” Now, this intervention is (hopefully) acknowledged as fatphobic. Many people with eating disorders are fat, and they do get the message reinforced from family, peers, medical providers, and society that their body is wrong and that they do need to change it. Other intersectional identities such as race, gender, and sexuality also can elicit messages from society and others that their body is wrong, and it is dangerous to exist in the world in their body. This is the reality of the world we live in, not a cognitive distortion. In considering this shift, our understanding of and treatment of eating disorders also needs to shift dramatically to include working with these societal and relational messages and reality.

Eating disorder treatment from a feminist and social justice lens is inextricably linked to body liberation. The goal of treatment must be this. As Sonya Renee Taylor, author of The Body Is Not An Apology (2018) writes, "Our society requires a drastic political, economic, and social reformation in the ways in which we deal with bodies and body difference.” This includes
looking at these larger systems and the way they impact organizations, families, and individuals.

Body liberation goes beyond focusing on intrapsychic elements of eating disorders and makes explicit the connections between body image/eating disorders, trying to control and change our bodies, and other body-based oppressions such as race, gender, and class. Body liberation aims to free all bodies from all types of oppression. While the goal is societal and systemic change, this is a big undertaking that cannot be done in any of our lifetimes. However, we can address the relationships in a person’s life and explore the ways in which they are perpetuating harm or aiding in liberation.

**Implications**

There are several research and societal implications that can be drawn from this study.

While somewhat obvious, one implication is that weight stigma is clearly a major issue and has detrimental and sometimes irreparable effects on individuals and families. This implies a need to take these issues seriously and focus attention and resources on reducing this stigma at all levels – individual, relational, societal, and systemic. There is harm being done, and it is the responsibility of researcher and clinicians to try to stop it, especially as marriage and family therapists whose core values are social justice oriented.

In addition, this study shows the importance of formal treatment for eating-related distress. This research makes a case for the fact that people who have gone to some form of treatment, and specifically treatment that is fat positive and Health At Every Size aligned, do better in recovery than those who do not. The implications that follow are increasing treatment accessibility for everyone, especially those from marginalized groups, and ensuring that all eating disorder treatment is fat positive and safe place for those even on the highest end of the weight spectrum which currently is not the case.
There are also a variety of clinical implications and ways this study can inform clinical work. One thing that became apparent in participants’ stories is that while it is clear that weight stigma harmed the individuals and their relationships, the people (often caregivers) who perpetrated the weight stigma were often unaware of the harm they were causing. It is my belief that most parents are doing their best and do not intentionally harm their children. Weight stigma is a challenging issue because it is widely accepted and reinforced by society, and often by medical providers. Parents need education and support to understand that their actions around food/body may be harmful and need opportunities to learn to talk about food and bodies with children differently. This also includes providing parents with the knowledge and tools to intervene and protect children from weight stigma when it occurs from others. Many people perpetrate weight stigma because they struggle with these issues themselves. Multiple participants shared that as adults they were able to understand that many of the messages that came from their families occurred because the parent themselves struggled with food/body-related distress; in other words, these issues are intergenerational. Providing intervention to caregivers to recover themselves and work through their own fatphobia could have a major impact on protecting future generations. Similarly, prevention interventions that target parental weight stigma are likely more impactful than body image groups at schools, given that the results of this study (and other research) support the notion that family messages are more influential than messages from others for young children. These are important prevention interventions that are currently absent. All of these suggestions are consistent with feminist principles which aim to not only understand and explain social phenomena, but also offer opportunities to create meaningful change and integrate individual, interpersonal, and societal and systemic change.
Lastly, involving families and partners in eating disorder treatment is an important implication of this study. While many eating disorder treatment centers do this in some ways, it is my opinion informed by this study that not enough is being done to include family and partners in treatment in ways that specifically address and combat weight stigma. Feminist theory and RCT asserts that humans develop through and within relationships, and therefore we must incorporate a relational understanding of recovery (Piran, 2010). There is an opportunity for treatment providers to incorporate the results from theme four, which shed light onto what about supportive relationships is helpful in recovery, and to specifically include interventions that target weight stigma within the family.

Limitations

There are inherent limitations to the study. First, people with diverse experiences around recovery or people who have not had access to any type of formal eating disorder treatment may have been left out of or were less represented in this study. Through the analysis, I found that people who had had access to some kind of formal eating disorder treatment were better able to recognize and articulate their experiences and were less emotionally charged likely as a result of already having processed these experiences. As such, potential participants who have not had treatment may have not participated in the study due to lack of awareness or understanding of their struggles, or difficulty talking about it. Similarly, while everyone in the study was plus sized (2x or larger), there was some diversity in terms of body size spectrum, but it is possible that people at the highest end of the weight spectrum were not included for the same reasons mentioned above. This is significant because the amount of oppression usually increases the higher up on the spectrum someone lies.
Lack of diversity is also a limitation in the study. While the there was sufficient diversity in various demographic areas, the majority of the participants were still white cisgender women which is consistent with much of the existing research on eating disorders. This lack of diversity limits the results and ability to infer how people with different identities may experience weight stigma from family. In particular, there was the least diversity around age. All participants were between the ages of 21-39, and therefore there is no information in this study about how people of different ages may experience this issue. Specifically, eating disorder recovery is known to be a very long process, and hearing from people at different points in recovery would be beneficial.

Additionally, all interviews were conducted virtually over Zoom. While this is a positive for the study in many ways such as increasing accessibility and increasing access to different regions of the United States, it also limits the study in other ways. There may be people who do not have access to internet or do not feel as comfortable conducting an interview virtually who were therefore left out of the study. Lastly, every participant was given an opportunity to review their transcript and make changes in a process of member checking, however only 4 out of 12 participants responded. Therefore, the analysis is my best attempt at staying with the intended meaning of participants but there may be times where my interpretation deviated from the participants’ intention.

**Recommendations for Future Research**

First, it would be beneficial for similar studies such as this one to be conducted with increased diversity or different demographics such as race, age, and gender. Similarly, it would be useful for future research to explore the same general topic of weight stigma, eating disorders, and relationships, but looking specifically at the intersection with other marginalized identities
such as gender expansive identities, older adults, and people of color, all of which are not typically represented in eating disorders research.

Another suggestion for future research directly related to the results of this study is to explore and understand how eating disorders and weight stigma harm family relationships. Much research has been done to understand how weight stigma and eating disorders harm individuals, but research exploring how weight stigma harms relationships is severely lacking. This research is important to understand the complexity and multi-faceted harms of weight stigma, and it would also be in line with systemic and social justice approaches to eating disorders that advocate for expanding the current model of research and treatment of eating disorders from an individualistic perspective to a more systemic one that acknowledges and incorporates the importance of relationships and larger systems.

Similarly, this study implied that there is a potential link between the ability to set boundaries and differentiate from family and improved eating disorder recovery, and that when people are more stuck or enmeshed in harmful relationships, this hinders eating disorder recovery. This is also consistent with anecdotal clinical evidence; however, there has been little formal research done to understand this connection. Future research should explore this link on a larger scale which would add to our understanding of the interplay between relationships and eating disorder recovery, and potentially lead to crucial relational interventions in the treatment of eating disorders.

Lastly, I recommend that future research explore the potential that parental support and protection from weight stigma could be a protective factor. Theme 1, Subtheme 5: Family Relationships as a Vector for Fatphobia, highlights how families reinforce fatphobia and miss an opportunity to protect against it. Existing research shows that the level of internalized weight
stigma often mediates the relationship between experienced weight stigma and eating pathology (Hayward et al., 2018). Most research focuses on individualistic ways to cope with external stigma so that it does not become internalized. However, this misses a key opportunity for reducing internalization of stigma. What if parents could be the buffer for children in larger bodies, and could teach fat children that nothing is wrong with their body? Children would still experience weight stigma from other places, but they may learn to cope and not internalize it, and therefore mitigate the negative consequences of experiencing weight stigma like eating pathology and low self-esteem. This is a crucial area of intervention that currently has been overlooked. This discussion is also timely because of the recent guidelines put out by the American Academy of Pediatrics for the “guidelines for evaluation and treatment of children and adolescents with obesity” (Hampl et al., 2023). These guidelines are ill-informed and incredibly harmful, and the harm is highlighted in the results of this study. If followed, these guidelines would perpetuate and replicate the harm that the participants described. There have been many wonderful eating disorder informed and Health At Every Size aligned responses to these guidelines and urging of medical providers and parents to push back against them. Journalist Virginia Sole-Smith articulates the issue perfectly in her NYT article (2023). She says, “We cannot solve anti-fat bias by making fat kids thin. Our current approach only teaches them that trusted adults believe the bullies are right – that a fat body is just a problem to solve.” We need trusted adults in children’s lives to intervene and teach them the opposite – that their bodies are acceptable, worthy, lovable, and do not need to be changed – or we will be continuing this harmful cycle for generations to come.
Conclusion

This study explored the experiences of people in larger bodies in recovery from eating-related distress with weight stigma within close relationships. The study sought to answer the questions: What are the emotional, relational, and psychological impacts for people in larger bodies who experience weight stigma from family and/or intimate partners while trying to recovery from eating-related distress? And how do these impacts affect the course of recovery from eating-related distress? The study utilized a phenomenological reflexive thematic analysis design and consisted of 12 semi-structured interviews with diverse participants. The results consisted of four themes and 16 subthemes. The four primary themes are: It Matters That It Comes From Family, It’s Different When You’re Fat, Weight Stigma Harms Relationships, and Relationships Heal. The results highlight the importance of understanding the pervasive and lasting impact that family relationships have on people, and the specific experiences of people in larger bodies. Similarly, the results clearly show the importance of relationships in recovery as well. The results and subsequent discussion shed light on the importance of working directly with and combatting weight stigma at the family system and societal level in order to create more significant and meaningful change for people struggling with eating-related distress, and particularly people in larger bodies. This begins to fill a gap in the literature about working with weight stigma in families, and the bidirectional effect that weight stigma has on relationships and family systems. It is my hope that fellow researchers, mental health professionals, and families of anyone who has struggled with eating-related distress realize the importance of these issues and find ways to incorporate the combatting of weight stigma in all areas such as research, clinical treatment, eating disorder prevention, and society as a whole in order to better treat and
prevent eating disorders for generations to come and to protect those who are most affected and marginalized by society.
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Appendices

A. Recruitment Letter
B. Demographics Questionnaire, Survey, and Informed Consent Form
C. Recruitment Poster
D. Modified Verbatim Conventions
E. Screening Call EDA-5/Acute Risk Assessment
F. Codebook
Appendix A: Recruitment Letter
Dear CONTACT PERSON,

I am sending a request for your assistance with a potentially important qualitative study conducted at Antioch University New England by me as part of my dissertation requirement of my doctoral degree in Couple and Family Therapy. I will be focusing on the experiences of people of all genders in larger bodies in recovery from an eating disorder who have experienced weight stigma from family and/or partners. I am particularly interested in hearing from people who hold one or more marginalized identities who are not typically represented in eating disorder research.

You can help me by forwarding the attached flyer (and this letter if you choose) to any people in larger bodies in recovery from an eating disorder who may be interested in being part of this study. The study will consist of a one-hour interview with me and will receive a $25 amazon gift card for participating. This study is voluntary, and the participants may choose to withdraw at any time. The identities of the participants will be kept confidential and will not be identifiable in any publications or presentations resulting from this research.

No study is completely risk free. However, I do not anticipate that the participants will be harmed or distressed during this study. However, it is possible that there may be minimal risk. Distressing emotions may arise during the program or in the interview process. If this happens, I am an experienced therapist and am trained to know when to proceed or move out of the researcher role and provide referrals to therapy, if needed.

There are potential benefits to participating in the study. First, discussing experiences can be inherently therapeutic. Second, volunteering to support research and improvement of eating disorder treatment can be altruistic and create positive feelings for the participant. The participants will be given a voice in this important discussion on weight stigma and eating disorders. The study could potentially benefit research and clinical work in this area. All information gathered by me will be confidential and kept locked.

I hope that you will invite people in larger bodies in recovery you know to participate in this study by forwarding this flyer to them or giving them my contact information. Participants who are interested in participating in this study should contact me at xxxxxxxx or x xxxxxxx by phone or text. Or they can visit this survey to provide their contact information: https://www.surveymonkey.com/r/EDresearch1

This study has been approved by the Antioch University New England Institutional Review Board. If you have any questions about this study, please feel free to contact me. You may also contact my dissertation chair Dr. Kristi Harrison at xxxxxxxx.

Gratefully,

Becky Belinsky, MA, LMFT

Couple and Family Therapy Doctoral Program Antioch University New England
Appendix B: Demographics Questionnaire, Survey, and Informed Consent Form
Thank you for participating in our survey. Your feedback is important.

Informed Consent Form

Title of Study
Family Impact of Weight Stigma on Higher Weight Folks with Eating Disorders

Investigator(s)
Becky Belinsky, PhD Candidate - Primary Investigator
Dr. Kristi Harrison - Dissertation Chair Advisor

Purpose
The purpose of this pilot study is to explore the experience of people in larger bodies who are in recovery from an eating disorder (or disordered eating) and have experienced weight stigma from family and close partners. The results will be used to inform prevention and treatment of eating disorders in people in larger bodies.

Procedures
Participants will complete an online screening form via SurveyMonkey, and this information will be automatically sent to the researcher. If participants meet all study criteria, they will receive a call or email from the researcher to schedule a time for an interview. The central part of the study is an hour-long audio recorded interview in which the participant will share about their experiences. Following the interview, participants will have an opportunity to review the transcript from their interview and make any changes to the transcript they feel are necessary. If you have questions about the research prior to consenting, you may contact me. Eligible participants will also have the opportunity to ask the researcher questions prior to participating in the study interview.

Risks/Discomforts
The risk for those participating in this study is minimal. This study is designed to minimize potential risk to participants. It is not our intention to elicit distressful responses; however, self-reflection regarding some of the topics about relationships and eating disorders. If, at any time, participants have any concerns, questions, or upsets, the researcher will be available to discuss them with you. Should participants need further assistance, the researcher will provide you with a list of resources and therapists for extra support. Participation is entirely voluntary. Participants have the right to refuse to answer any questions or to discontinue their involvement in this study at any time, for any or no reason, without being subjected to any judgment on the part of the investigator.

Benefits
For Participants:
  - Share your experiences in a safe and supportive space
  - Contribute to knowledge about the experience of weight stigma in recovery for people in larger bodies and this knowledge could improve the prevention and treatment of eating disorders specifically for the marginalized group of people in larger bodies as well as the larger eating disorder community as a whole

For Others:
  - Assist treatment providers in improving eating disorder treatment for people in larger bodies
  - Provide research toward understanding of the impact of weight stigma on eating disorder recovery
  - Various community and public health benefits of improving eating disorder treatment and reducing weight stigma

Indirect benefits may include informing clinical practice that will improve treatment outcomes for people in larger bodies with eating disorders.
Confidentiality

The following procedures will be followed in an effort to keep participants personal information confidential. All transcripts will be coded with false names for all the participants. The only people who will be able to identify you are the research investigators. False names will be used in all publications and/or presentations. All transcripts will be secured in a private location and will be password protected.

Questions or Problems

For further information about the study contact primary researcher: Becky Belinsky, PhD (c) at bbelinsky@antioch.edu or (424) 231-5677. You may also contact Dr. Kristi Harrison at kharrison1@antioch.edu.

If you have any questions about the rights of research subjects or research-related injury, please contact Dr. Kevin Lyness, PhD, Institutional Review Board Chair at Antioch University New England at (603) 283-2149 or Dr. Shawn Fitzgerald, Provost at Antioch University New England at 603-283-2150.

By providing my name and contact phone number, I am consenting to participate in this research. I understand that I may stop participating at any time.

* 1. Signature (type your name):

* 2. Date:

Date / Time

Date

MM/DD/YYYY
The purpose of this study is to explore the experience of people in larger bodies who are in recovery from an eating disorder (or disordered eating) and have experienced weight stigma from family and close partners. The results will be used to inform prevention and treatment of eating disorders in people in larger bodies.

If you choose to participate, the study will consist of a one hour video interview, and you will receive a $25 amazon gift card.

Please fill out the information below. If you qualify for the study, I will contact you to schedule an interview.

3. Address

Name

Email Address

Phone Number

4. What is your gender?

○ Female

○ Male

○ Transgender

○ Non-binary

○ Other (specify)

5. Which category below includes your age?

○ 17 or younger

○ 18-20

○ 21-29

○ 30-39

○ 40-49

○ 50-59

○ 60 or older

6. What is the highest level of school you have completed or the highest degree you have received?

○ Less than high school degree

○ High school degree or equivalent (e.g., GED)

○ Some college but no degree

○ Associate degree

○ Bachelor degree

○ Graduate degree

7. Which of the following categories best describes your employment status?

○ Employed, working 40 or more hours per week

○ Employed, working 1-39 hours per week

○ Not employed, looking for work

○ Not employed, NOT looking for work

○ Retired

○ Disabled, not able to work
8. How much total combined money did all members of your HOUSEHOLD earn last year?

- $0 to $9,999
- $10,000 to $24,999
- $25,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $124,999
- $125,000 to $149,999
- $150,000 to $174,999
- $175,000 to $199,999
- $200,000 and up
- Prefer not to answer

9. What is your race or ethnicity?

- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African
- Multiracial or Multiethnic
- Native American or Alaska Native
- Native Hawaiian or other Pacific Islander
- White
- Another race or ethnicity, please describe below

Self-describe below:

10. Are you of Spanish, Hispanic, or Latino origin?

- I am not Spanish, Hispanic, or Latino
- Cuban
- Cuban-American
- Mexican
- Mexican-American
- Some other Spanish, Hispanic, or Latino group
- Chicoano
- From multiple Spanish, Hispanic, or Latino groups
- Puerto Rican

11. Are you in a larger body? (Wear plus size/big and tall/2X or larger size clothing?)

- Yes
- No

12. Are you attempting to recover from diet culture/disordered eating/eating disorder?

- Yes
- No
Appendix C: Recruitment Poster
Eating Disorder Research Participants Needed

Are you in a larger body?*

Have you experienced harmful comments from family or close loved ones about your body?

If you are a larger bodied individual who is in the process of recovering from diet culture or an eating disorder, please consider participating in my research exploring the experience of receiving weight stigma from family, partners, and close loved ones. I am particularly interested hearing from all genders and people with one or more marginalized identities.

More information:
https://www.surveymonkey.com/r/EDresearch1

Contact me:
Becky Belinsky
e: xxxxxx
c: xxxxxxx

Participation involves:
- A one hour video interview
- A $25 Amazon giftcard

*Wears plus size/big&tall/2X or larger clothing

Chair: Dr. Kristi Harrison
e: xxxxxxxxxxxxx
Appendix D: Modified Verbatim Conventions
Conventions for Transcription and Transcript Validation

1. Listen to the audio file with the transcript document open. Follow along in the transcript to ensure audio matches up with written transcript.

2. We are using a modified verbatim format, meaning that filler words (e.g. like, um, uhs) and false starts (I I I went to the doctor → I went to the doctor) are often omitted. Please feel free to add in any filler words or false starts as you are able to in the verification process, but try not to let this get in the way of your flow. The ultimate goal is to have a transcript that captures the participant’s voice, and meaning, not necessarily all of the verbal idiosyncrasies. Similarly, filler words such as “like” and “um” are usually omitted and that’s okay.

3. If there are filler words or false starts that you think are particularly important, feel free to add them in.

4. Also, if you happen to notice important emotional information (someone is crying, laughing, sighing, being sarcastic, joking, tearful, etc) please feel free to add that in in square brackets as this will add to the richness of the transcript and could be meaningful. Add in any “feeling words” or descriptive words for what is going on and UNSAID in the transcript in square brackets. Examples [both laugh], [participant laughs], [researcher says sarcastically], [tearful], [both tearful], [gesture], “that was great” [said sarcastically].

5. When listening, check for the accuracy or words said.

6. De-identify as you come across identifying names such as names of people, locations, treatment centers. As you replace put the new names in [square brackets].

7. Highlight anything you can’t hear or think maybe wrong in yellow, e.g [inaudible 01:34:12] or “and then I went to this other place where I met a donkey”. If possible put a timestamp next to it. The transcriber may have already done this. If you are able to discern what was missing or inaudible in a previously highlighted section, great! If there are still places that are unclear, please highlight in yellow so that Erin can go back through the transcript to try to decipher these areas.

8. Upload your finished, validated and de-identified document to the first line “Upload qual interview here with your initials at the end “_WJ”.”

TIP: **In general, anything not actually spoken by the participant should be in [square brackets], and any transcription that you are not certain of should be highlighted.

**List of Words and Abbreviations Commonly Messed Up by Transcriber:**
Here are some common abbreviations or odd/unusual words you might run into in the transcript, so I hope this list will help you as you hear the weird words:

- "HAES" (pronounced "hays"): Health At Every Size
- ED (sometimes pronounced E-D, and other times pronounced like the name, "Ed"): Eating Disorder (e.g. my ED mind, my ED, ED says x, y, z)
- IOP: Intensive Outpatient
- PHP: Partial Hospitalization Program
- IP: Inpatient
- Res (pronounced "Rez"): Residential treatment
• **Opal**: Opal Food and Body Wisdom, an eating disorder treatment center
• **PCP**: Primary care physician
• **purge**: self-induced vomiting
• **Refeeding**: process of refeeding after a period of starvation
• **Pro-ana or Pro-mia**: usually referring to websites that promote anorexia or bulimia as a positive lifestyle choice
• **Step-down**: process of reducing level of care
• **Boost, Ensure, etc**: refeeding products
• **Tube/tubed, e.g. getting tubed**: having a feeding tube
• **BED**: binge eating disorder
• **Ana or Mia**: anorexia or Bulimia
• **AAN**: Atypical Anorexia
• **OSFED** (pronounced "Oss-Fed"): Other specified feeding and eating disorder
• **EDNOS** (pronounced "Ed-Noss" or E-D-N-O-S): Eating disorder not otherwise specified
• **LOC**—higher or lower level of care

**Transcriber conventions for Modified Verbatim:**

Modified verbatim consists of omitting “um,” “uh,” and unnecessary filler words. It also involves spelling out words like “gonna,” “wanna,” “gotta” and “kinda.” Also, “sorta,” but NOT “lotta.” NOTHING is typed verbatim, including “’cause” and “’em.”

The following guidelines are followed:

a. gonna - (always typed when dictated)
b. wanna – (always typed when dictated)
c. etc. – (always typed when dictated)
d. Uh huh (meaning “yes”) – (always typed when dictated)
e. Nuh, uh (meaning “no”) – (always typed when dictated)
f. ‘em (meaning “them”) – (NEVER typed unless instructed to do so)
g. ‘cause (meaning “because”) – (NEVER typed unless instructed to do so)
h. i.e. (meaning “for example”) – (always typed when dictated)
i. “um” (a “stumble” word) – (NEVER typed unless instructed to do so)
j. “uh” (a “stumble” word) – (NEVER typed unless instructed to do so)
k. Um hm (an agreement) – (always typed when dictated)
Appendix E: Screening Call EDA-5/Acute Risk Assessment
Screening Call

1. Modified EDA-5 Assessment
   1. Are you having any problems with your eating? For example, is it hard for you to maintain your weight or alter your diet? (e.g., eat certain types of food, eat at particular times of day)? Do other people feel you have a problem in these areas?
   2. Is the problem with your eating getting in the way of your day-to-day functioning? For example, at work, at school, or in your relationships? Is the problem interfering with your health? Is it distressing or upsetting to you?
   3. Are you afraid of gaining weight Or are you worried that if you start to gain weight, you will continue to gain weight and become fat?
   4. What behaviors/actions do you take to try to lose weight or prevent yourself from gaining weight? (Restriction, exercise, purging)
   5. Does your body shape or weight impact how you feel about yourself? For example, if you were to have a day when you did not like the number on the scale, or the way your clothes fit, or how your body shape felt in general, how much would this impact you? Would it make you feel very badly about yourself? Please tell me a little about this.
   6. In the past 3 months, were there times when you felt a sense of loss of control while eating? Or times you felt you could not stop eating? Or could not control what or how much you were eating? Have there been times when you felt you could not prevent yourself from eating?

2. Acute psychosis/Suicide assessment:
   1. Suicide assessment: Are you currently having thoughts about killing yourself? If so, do you have a plan of how you would do this? If so, do you intend to act on this?
   2. “Do you ever hear things that other people cannot hear, such as noises, or the voices of other people whispering or talking?”
   3. “Do you ever have visions or see things that other people cannot see?”
   4. “Do you ever feel that people are bothering you or trying to harm you?”

3. Do you have any questions about the study?
4. What is your availability for scheduling an interview?
5. What is your preferred way to be reached? Phone, email, text?
Appendix F: Codebook
<table>
<thead>
<tr>
<th>Code Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting Body</td>
<td>Participant describes being able to feel or working towards acceptance of body</td>
</tr>
<tr>
<td>Appearance/Beauty (Messages)</td>
<td>The experience of receiving messages about appearance/beauty and how this relates to weight/shape</td>
</tr>
<tr>
<td>Attempt to explain to family</td>
<td>Attempting to explain to family participant's experience or the harms done by diet culture, or attempting to share HAES/IE with family</td>
</tr>
<tr>
<td>Centrality of food/focus on food (Message &amp; Impact)</td>
<td>The experience of focus on food being a central and constant theme/value in participant's life/family</td>
</tr>
<tr>
<td>Centrality of Weight/Body Size (Message &amp; Impact)</td>
<td>The experience of focus on weight and body size being a central and constant theme/value in participant’s life/family</td>
</tr>
<tr>
<td>Dating/Sexuality</td>
<td>The importance and impact of dating and sexual experiences on relationship with food and body, both positive and negative</td>
</tr>
<tr>
<td>Direct Message</td>
<td>Family member gives direct message about participant’s body/directly to participant (i.e., &quot;You need to lose weight,&quot; or &quot;You shouldn't be eating that much&quot;)</td>
</tr>
<tr>
<td>Disability</td>
<td>The theme of disability and how this has been part of participant's experience in general and specifically with food/body</td>
</tr>
<tr>
<td>Excerpt</td>
<td>Excerpt I want to use</td>
</tr>
<tr>
<td>Exercise (Message &amp; Impact)</td>
<td>The experience of exercise being part of the messaging around food/body</td>
</tr>
<tr>
<td></td>
<td>The participant's experience of weight stigma impacting their relationship with exercise</td>
</tr>
<tr>
<td>Family's Own Struggle with Food/Body</td>
<td>Family member's issues and how it impacted participant’s relationship with food and body</td>
</tr>
<tr>
<td></td>
<td>Understanding that family member struggled in their own relationship with food/body</td>
</tr>
<tr>
<td>Fat as Child</td>
<td>Being in a larger body/fat as a child was hard and was part of the reason these messages were so prevalent/were so ingrained</td>
</tr>
<tr>
<td>Focus Away from Weight/Body/Appearance</td>
<td>An experience that shifted the focus away from weight/body/appearance, usually towards internal experience or body neutrality</td>
</tr>
<tr>
<td>Gender</td>
<td>Participant mentions gender as a significant factor in their relationship with food/body</td>
</tr>
<tr>
<td>Harming Family Relationships/Separation/Isolation (Impact)</td>
<td>The experience of weight stigma harming family relationships and often resulting in separation and isolation</td>
</tr>
<tr>
<td>Health</td>
<td>Diet and weight loss being connected to health, the importance of health</td>
</tr>
<tr>
<td>Concept</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indirect Message</td>
<td>Family member gives indirect message about participant's body or food. (i.e., &quot;I'm so fat, I need to lose weight&quot; referring to self, or &quot;I really shouldn't have that cake, I need to reset.&quot;)</td>
</tr>
<tr>
<td>It's Different When You're Fat</td>
<td>The experience and impact is different being a fat person. People don't believe you, etc.</td>
</tr>
<tr>
<td>Lack of Support</td>
<td>Experiencing a lack of supportive people/resources</td>
</tr>
<tr>
<td>Lasting Impact</td>
<td>Participant explains the lasting impact these experiences have had, even years later.</td>
</tr>
<tr>
<td>Making Sense</td>
<td>Trying to make sense of body size/messages/focus on body size</td>
</tr>
<tr>
<td>Medical/Professional Weight Stigma</td>
<td>Experiencing weight stigma from medical or treatment professionals</td>
</tr>
</tbody>
</table>
| Messages About Weight (Messages & Impact) | Messages participant received about weight  
Impact of family member's issues influencing core beliefs/messages about weight                                                                                     |
| Negative Messages from Media    | The experience of and impact of negative messages about food/body from media                                                                                                                                  |
| Neutral Messages                | Neutral messages/relationship about/with food/body                                                                                                                                                           |
| Other Family Dynamics           | Other family dynamics (like enmeshment, respect of elders) that reinforce the issue                                                                                                                        |
| Other Identities & Intersectionality | Mention of other identities and how these intersect with body size or the struggle with food/body                                                                                                        |
| Other Impacts                   | Other things that impact relationship with food/body (such as ADHD, trauma, depression, etc.)                                                                                                                |
| Positive Focus on Self Expression | Positive Focus on Self Expression such as through clothing                                                                                                                                                |
| Positive Interaction with Medical Provider | Positive Interaction with Medical Provider and impact of this                                                                                                                                           |
| Race/Culture & Food             | Intersection of Race/Culture & Food                                                                                                                                                                         |
| Reinforcing Disordered Behavior (Action & Impact) | The experience of family members reinforcing disordered behavior in participant                                                                                                                        |
| Relationship/Messages about Food (Messages & Impact) | Messages participant received about food  
How these messages impacted participant's relationship with food                                                                                                                                         |
| Role Model                      | Being a role model for others/awareness of impact on others  
Usually used in context of things that have been helpful/shifting relationship with food/body                                                                                                      |
| Self'-Worth/Self'-Esteem/Self'-Concept/Values (Messages and Impact) | Messages correlated self'-esteem and self'-worth with weight/shape/size  
The impact this has on participant's self'-worth and self'-esteem                                                                                                                                       |
| Shame about Body and/or Food (Messages & Impact) | Shaming language or messages about food and/or body from family  
Results in feelings of shame/beliefs about food and/or body                                                                                                                                         |
<table>
<thead>
<tr>
<th>Support: Body Positive Media/Intuitive Eating</th>
<th>Experience of finding body positive media and resources supportive in healing relationship with food/body</th>
</tr>
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<tbody>
<tr>
<td>Support: Boundaries/Separation from Family</td>
<td>Experiences of setting boundaries/differentiation/separation from family as an important part of healing</td>
</tr>
<tr>
<td>Support: Challenging Fatphobia/Diet Culture</td>
<td>Experience of challenging fatphobia/diet culture alone or with others and how this is supportive in healing relationship with food/body</td>
</tr>
<tr>
<td>Support: Community</td>
<td>The experience of general community or fat positive community and how this has been supportive of healing relationship with food/body</td>
</tr>
<tr>
<td>Support: External Acceptance of Body</td>
<td>The experience of finding external and explicitly acceptance of participant's body, i.e., experiencing partners who say and show that they love and are attracted to participant's body Different from general supportive relationships which are about how the participant's body is not that important</td>
</tr>
<tr>
<td>Support: Relationships Supportive</td>
<td>The experience of having positive and how this has been supportive of healing relationship with food/body. Often support is directly connected to food/body experiences.</td>
</tr>
<tr>
<td>Support: Systemic Issues/Social Justice</td>
<td>The experience of finding it helpful to understand and address systemic social justice issues related to recovery such as fatphobia, racism, sexism, capitalism, etc.</td>
</tr>
<tr>
<td>Support: Treatment</td>
<td>Formal mental health/ED specific treatment and finding it helpful to healing</td>
</tr>
<tr>
<td>Value System Messaging</td>
<td>Family teaching a value system</td>
</tr>
<tr>
<td>Young and Vulnerable</td>
<td>Being young was a significant part of this experience because children are vulnerable emotionally and practically</td>
</tr>
</tbody>
</table>