Weight Bias in Eating Disorder Treatment: A Paradox

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Abstract

Weight bias runs rampant in our culture and within the healthcare institution. However, weight bias in eating disorder treatment has yet to be thoroughly researched. The purpose of this study is to investigate the presence and effects of weight bias within the treatment of eating disorders. To do this, participants completed an online survey in which they provided both quantitative and qualitative data. Results suggest weight bias does exist in treatment, and shows up in a variety of forms: in food specific comments, the reinforcement of fear, through diagnostic bias, and in examples of medical neglect.

Introduction

The biggest myth about eating disorders is that everyone who has or has had one looks the same: skinny. This couldn't be farther from the truth. Oddly, though, even the professionals involved in care do not recognize that eating disorders come in a variety of sizes.

I entered treatment for a raging eating disorder halfway through my senior year of high school. After years of internalized diet culture and a fierce pressure to sculpt my body into the "right" form, I, along with thousands of others, had spiraled into the depths of body shame. Unable to do one of the few things we are all born knowing how to do – eat – I shuttled myself off to a 24/7 residential care center. When I arrived, a group of ogling women peered out at me from behind doorways, checking out the newcomer as they pretended to need the phone. Women of all sizes were there: skinny women, fat women, and women of all sizes in between. And as I got settled and got to know the other people (we called ourselves clients), it was evident that, despite the different sizes of our bodies, we all shared the same experience of having a pathological disorder of eating, in some way.

Working with us, deciding on our treatment plans, eating meals with us, and running group therapy were medical professionals from a variety of different domains. There were recovery coaches − the staff we spent most of our time with − and therapists, dieticians, doctors, and psychiatrists. The entire place is dedicated to helping those who arrive heal from their struggles with food and body. The staff are typically specially trained and equipped to work with the eating disorder population. Yet they, too,struggle to recognize the diverse bodies that can be afflicted with eating disorders. As someone who has been part of the recovery community for six plus years, I have heard countless whispers and quiet rumblings from eating disorder clients with larger bodies who felt they were not treated the same as thin clients. Because of the importance

of eating disorder care, it's uncomfortable to think that even the most trained professionals could bring weight bias – conscious or unconscious negative beliefs and biases about fat people – to their practice. Nonetheless, on Reddit subs and throughout Instagram and TikTok, there are stories of people receiving inadequate or negligent care because they were not "medically underweight."

It's well established that weight bias exists in healthcare generally. "Overweight" or "obese" people are less likely to seek out medical care and are more likely to have medical problems overlooked by their doctor because of their weight (Hebl & Xu, 2001). But what about weight bias in eating disorder treatment? We know that people seeking help for an eating disorder are highly preoccupied with their weight and potentially hyper-aware of reasons why they aren't "sick enough." Is it possible that weight bias is also present among treatment providers? If so, how is weight bias showing up?

Let's briefly step back and situate weight bias within the larger medical context. Although most people would like to believe that going to the doctor's office or another healthcare setting will guarantee quality care and treatment, abundant research illustrates that many healthcare professionals hold conscious or unconscious weight bias. Weight biases among healthcare professionals prevents doctors from taking fat patients seriously and can even influence the medical recommendations that patients receive (Freeman, 2020; Hebl & Xu, 2001). For example, fat people with pressing problems like cancer often go undiagnosed because doctors assume the problem is their weight rather than a rapidly growing cluster of cancer cells. In other instances, fat people bring up complaints such as back pain or gastrointestinal troubles. Instead of being listened to and treated for that complaint, doctors often blame patients' weight for their health issues and recommend weight loss treatment. Weight bias in healthcare has been

discussed thoroughly. However, weight bias in the actual treatment of eating disorders has yet to be extensively researched.

Goals of Current Study

The presence of weight bias in eating disorder treatment would be particularly harmful. Most people actively struggling with an eating disorder deal with varying levels of intense body image related issues. Weight biased practices in this setting have the potential to affect recovery outcomes, cause psychological and physical harm for fat patients, and perpetuate the fear of gaining weight in all clients. Given the established harm of weight-bias in healthcare and the likelihood that weight biases are present in the treatment of eating disorders, it is imperative to investigate if weight biases show up, how they show up, and what the effects on clients are.

This study aims to examine weight bias in treatment by exploring how client experiences differ depending on size. First, I describe the stigmatized experience of living in a fat body. Then, I briefly cover the field of fat activism which arose to combat weight bias. Next, I go into the medical context to examine weight bias in healthcare. Following this, I discuss the evidence and potential for weight bias in eating disorder treatment. Concluding the literature review, I then describe the study methods. The results, both qualitative and quantitative, follow the methods section. Finally, I propose policy recommendations and future research for the eating disorder field based on the results of this study.

Literature Review

The Everyday Experiences of Fat People

I am interested in the role weight bias plays within eating disorder care. However, to get at this, we first have to step back to see that weight biases in healthcare do not exist within a vacuum. On the contrary, the healthcare system is in constant interaction with a culture saturated

with standards and suggestions about what bodies should look like, how people should eat, and what it means to be healthy. Weight bias is created by and perpetuated by this culture. And, in a feedback loop, weight bias helps produce this culture.

Weight bias is defined as the negative attitudes and beliefs held about fat people. Weight bias is discriminatory and prejudicial; fat people are thought of and treated as worse than thin counterparts. Whether in healthcare, education, the media, or within interpersonal relationships, whether obvious or discrete, intentional or not, weight bias is incredibly damaging (Obesity Action Coalition n.d.). Whether weight bias originates in the healthcare system – held captive by what we are told to be medical truths, such as that the body-mass index (BMI) is a highly significant health metric – or in our social interactions, weight bias is so prevalent that beliefs about good and bad bodies are likely to be encountered in any setting, whether at the doctor's office, while shopping for clothing, buying groceries, or at home.

Here's what we're told: if you are thin, fit, and within a certain BMI, then you are healthy. Underneath this body ideal is the assumption that you can be thin only if you don't eat too many carbohydrates or saturated fats and exercise regularly. On the other hand, if you are fat, then you are unhealthy, and it must be because you are eating poorly and disregarding your health. People who fall into the latter category experience the effects of weight bias daily.

The experience of living in a stigmatized body shows up in a plethora of ways for fat people. For example, fat people may struggle to buy the "in" clothing because there are no available sizes. They may have to worry about whether seating in public spaces will fit their bodies or be comfortable to sit in. They may experience employment discrimination due to their size. They may feel judged for ordering food that thin people would not be judged for ordering or enter gyms or fitness spaces and have the experience of others making assumptions about their

lifestyle. In a study of people who experience stigmatization due to body weight, researcher Andrea Bombak highlighted one interviewee as saying, “like you go to the store and you’re buying stuff and people look, and will make comments, or will say things to their friends, do that behind the hand thing …” (2015, p. 690).

These lived experiences suggest that fat people are constantly being subjected to weight based stigmatization. Even children, picking up on culturally produced ideas from adults, put fat peers last in a lineup of who they like the most, including fat children themselves. This suggests that fat-related prejudice in individuals and the experience of feeling that one’s body or existence is not okay begins as early as childhood (Koroni, 2009). Despite engaging in the same amount of exercise and having similar diets, fat bodies are often considered “unhealthy” compared to thin bodies (Wray & Deery, 2008).

“Fat” Doesn’t Have to be an Insult

A field of activism known as fat activism evolved and continues to evolve to combat weight bias and size discrimination. Many fat activist groups and organizations, such as the National Association to Advance Fat Acceptance (NAAFA) and Fat Underground, work to challenge assumptions around weight (Meleo-Erwin, 2008). The book, *Fat!So?* is an informational guide to living life without apologizing for your weight. It is a manifesto on how to take back one’s fatness and embrace it rather than try to shame it away. The author, Marilyn Wann, argues that being fat is not only not bad, but can on the contrary be empowering. Wann’s manifesto reclaims spaces where fat people have been ostracized, like gyms, and social roles that fat people have been rejected from holding, such as an athlete or someone who is fit (Wann, 1998).

You may have noticed the word “fat” appears in this paper rather than “overweight” or “large-bodied.” While some argue that the word “fat” is stigmatizing, others point out that avoiding it gives it more negative power (Wann, 1998). When we describe someone as thin, we say “thin.” But, when we describe someone as fat we often dance around using “fat.” Proponents of using “fat” as a descriptor argue that words such as “large-bodied” act as euphemisms for a body that shouldn’t be feared. In the medical sphere, terms like “obese” or “overweight” are used in place of “fat.” Using such words to dance around “fat” can actually be pathologizing and stigmatizing (Freeman, 2020). We don’t refer to skinny people as “skinny-boned” or avoid saying the word “thin” (Freeman, 2020; Meleo-Erwin, 2008; Wann, 1998). If fatness isn’t bad, then we shouldn’t avoid the word “fat.”

When Your Doctor Doesn’t Like Your Body

Weight bias is rampant in our culture. And unfortunately, medical establishments are not immune. In *Fat!So?,* Wann writes about her own encounters with the healthcare institution as a fat woman. Wann discusses how, though fat people can have healthy bodies and live a healthy lifestyle, medical professionals continue to see their health through their weight. She writes, “If you’re fat and you decide you do visit the doctor, he or she might decide to treat your weight, rather than your symptoms. You get a diet, rather than a diagnosis. The doctor says all your ills are caused by your fat” (Wann, 1998).

Research supports Wann’s narrative and suggests that weight biases impact the way physicians treat patients. In one study conducted by Rice University and the University of Texas, physicians were given patient charts that were either of someone with “normal” weight or someone classified as “overweight,” and they were asked to recommend medical interventions and offer their attitudes about their patients. Compared to the physicians who received a patient

chart of someone with a "normal" weight, the physicians who received patient charts of an "obese" person were more likely to think meeting with them was a waste of time, that the patient would be lazy and lack self-discipline, and that the patient wouldn't take care of themselves (Hebl & Xu, 2001).

Some argue that healthcare is not just situated in a weight biased culture, but that it *feeds into* it. For example, doctors prescribe weight loss to patients. Furthermore, health information that is latent with weight bias permeates healthcare. Medical terminology such as "obese" and "overweight" create an expectation of pathology.

Despite the common myth, there is little data to back up the assertion that longevity is correlated to BMI. Weight and health are not linked in the way that we are indoctrinated to believe (Bacon, 2010). Wann's lived experiences shed light on this topic. She states about her own health that, "I am five-feet four-inches tall, and I weigh 270 pounds. My blood pressure, cholesterol, and blood sugars - the three best indicators of health - are all normal. I have no history of serious illness" (Wann, 1998). Nonetheless, the health information that circulates on social media, shows up in leaflets at doctor's offices, and is written all over medical self-help sites such as "Healthline" induce fear about health and weight (Wray and Deery, 2008; Plyey & Burfoot, 2021).

Clinical Context: Weight Bias in the Treatment of Eating Disorders

The little research we have on weight bias in the treatment of eating disorders suggests that eating disorder professionals, including doctors, dieticians, and therapists, share the views of their peers. In one survey, clinicians were asked to report their degree of weight bias and that of their colleagues. Results revealed that clinicians reported weight bias in their colleagues and demonstrated weight bias in their own answers as well. Furthermore, "overweight" patients that

the clinicians in this study treated were reported as having worse off treatment outcomes, as compared to thin clients, when their therapist or dietician held weight biased beliefs (Puhl et al, 2014).

Researchers also point out that discrete and unconscious ways professionals approach food and weight, such as how weight is brought up in therapy, potentially perpetuate weight bias in clients (Rothblum & Gartrell, 2019). In other words, even if blatant and purposeful bias in the eating disorder field is only minor, seemingly trivial aspects of treatment, such as what language is used or how topics of food and body are discussed, can have implicit and harmful meanings (Bombak, 2015). While there is existing research on weight bias in the treatment of eating disorders, this study seeks to understand weight bias from a client perspective.

Methods

This study examines the presence and impact of weight bias in the treatment of eating disorders through all levels of care. Initially, the goal was to conduct in-depth interviews with participants. Interviews can provide detail and richness about their experience that a survey would not capture. Particularly with research that aims to study stigmatized niche populations – such as those who suffer from eating disorders – interview methods best articulate the lived experience of the population (Compton, 2018; Weiss, 1995).

However, interviews also have several drawbacks, compared to surveys. Because they take longer to complete than a survey, it can be difficult to obtain enough participants. Furthermore, a sensitive research topic can discourage participants because face-to-face conversation is intimate and vulnerable. The anonymity and convenience of surveys, on the other hand, makes participation easier.

Possibly for these reasons, I struggled to recruit participants for interviews and decided to pivot to survey research instead. However, to allow participants to share their experiences in more than a multiple choice question format, I decided on a survey that includes long response answers, too.

I initially planned to look at weight bias within residential treatment settings. Due to the difficulty in recruiting participants, I opened up participation to all levels of care when I moved to a survey method of data collection. In the survey, participants are asked what levels of care they have received. However, after data collection closed, I realized that I had asked participants to reflect on their experiences in general rather than on their experiences at a specific level of care. As a result, this study reports participants' experiences at multiple levels of care, including outpatient, partial hospitalization (PHP), residential, and inpatient.

Participants

All participants received treatment for an eating disorder, whether outpatient, PHP, residential, and/or inpatient. A total of 231 participants completed the survey. Of those, 72% identified as female, 2% identified as non-binary, 2% identified as male, and 24% did not say. All participants were required to be 18 or older to participate. The majority of participants are within the ages of 18 and 30, with an average age of 26 and the oldest participant at age 57. Most participants reported being White (64%), 23% did not say, and the remaining 13% came from several different racial categories: Asian (3%), Asian and White (2%), Black or African American (1%), Hispanic or Latino (5%), Middle Eastern or North African (1%), and other (1%). Participants were not compensated for their participation.

Materials

Participants found out about this survey study via social media advertisements on Instagram and Facebook. Using a snowball sampling method, participants discovered this study either via the original post or through a re-post. A benefit of this type of sampling is that a greater number of participants can be reached, particularly for a study such as this, that requires a niche experience. This study's survey was published through Qualtrics. Data analysis was conducted with JASP. All data was stored on a password protected computer.

Procedure

This study was approved through the Institutional Review Board (IRB) prior to the beginning of data collection. Before beginning the survey, participants were required to give their informed consent. Participants were then asked if they have received treatment for an eating disorder. Those who selected "no" were brought to the end of the survey. Next, participants were asked to select all types of care they have received: outpatient, PHP, residential, and/or inpatient. Those who received more than outpatient were asked how many times they have received more than outpatient treatment and how many different centers they tried, although this data was not used. Participants were asked to place themselves on a scale of 0-100 in terms of percentage recovered. Participants were then asked how many years they have been either in recovery or recovered, although this data was also excluded because of poor question validity. Next, participants were asked a series of questions about how they felt during treatment in Likert scale form (see Table 1 below). The results of these particular questions will be referred to as the "treatment satisfaction ratings."

Participant responses for the set of treatment satisfaction questions were coded to a number rating and averaged for each person to produce an aggregate rating. The higher the rating, the higher their satisfaction. A few questions were asked inversely. These questions were

reverse-coded. On the basis of these results, each participant was given an aggregate treatment satisfaction rating that was used in data analysis.

Next, participants were asked whether medically recommended weight gain was a part of their recovery process or not. Here, not all participants were shown the same following questions to avoid potentially triggering any participants. For example, when participants were asked whether medically recommended weight gain was a part of their recovery process, possible answer choices were "no," "yes," and "sometimes no, sometimes yes." Those who responded "sometimes no, sometimes yes" were further asked if they felt they had received the same care depending on whether they were "underweight" or not. Those who responded either "no" or "I'm not sure" were prompted to share why in long response form. Participants who did not gain weight as part of their treatment were asked if they felt they had been treated the same as clients who were on "gain" plans.

All participants were then asked whether they ever felt that they were treated differently because of their body shape or size. Whenever possible, participants were asked to elaborate in long response boxes. Before finishing the survey, all participants were briefly told the purpose of the study and were asked whether there was anything else they wanted to share on weight bias in treatment. Upon completion of the study, participants were directed to a resource page and were encouraged to utilize resources if they felt any distress as a result of the study. Because this study included multiple choice questions and long responses, the data analyzed in this study is both quantitative and qualitative.

To what extent do you agree with the following statements. In treatment:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
I felt supported	○	○	○	○	○
I felt taken seriously	○	○	○	○	○
I felt advocated for	○	○	○	○	○
I felt ignored	○	○	○	○	○
I felt neglected	○	○	○	○	○
I felt validated	○	○	○	○	○
I received the same quality of care as others	○	○	○	○	○
I was given the same amount of time as others	○	○	○	○	○
Any medical issues that arose were addressed	○	○	○	○	○
My doctor accepted my body	○	○	○	○	○
My dietician accepted my body	○	○	○	○	○

After data collection closed but before data analysis, participant responses for the set of Likert-style questions pertaining to treatment satisfaction were translated into a number score and averaged for each person. The higher the score, the higher their ratings. Each person then had an aggregate treatment satisfaction score that was used in data analysis. A complete set of the questions asked on the survey can be found in Appendix A.

Results

A one-way ANOVA was conducted to determine if there was a difference in participant treatment satisfaction ratings depending on whether participants were medically recommended to gain weight (Gain group), not recommended to gain weight (No Gain group), or were at times recommended to gain weight and at times not recommended to gain weight (Both group). Results revealed a moderately significant difference among groups $F(2, 200) = 2.61$, $p = .076$, $n^2 = 0.025$, using the aggregate treatment satisfaction rating for each participant.

Specific question-related one-way ANOVA tests were further conducted to see if participant treatment satisfaction ratings differed question to question. Participants were asked the extent to which they agreed or disagreed with the statement, “My dietician accepted my

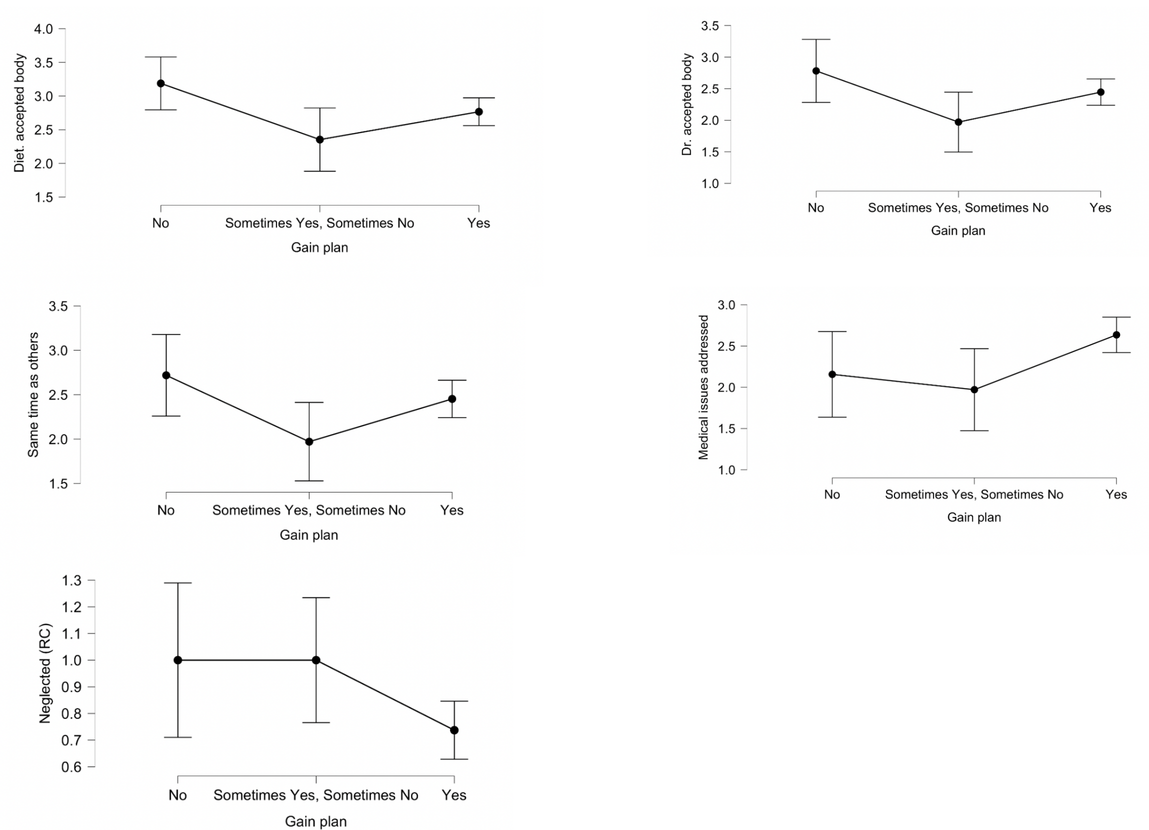
body.” Results revealed that participants in the Both group had significantly lower scores than both the Gain group and the No Gain group $F(2, 200) = 3.84$, $p = .023$, $n^2 = 0.037$. The mean rating for the Both group was the lowest ($M = 2.35$, $SD = 1.35$), the No Gain group had the highest ratings ($M = 3.12$, $SD = 1.09$), and the Gain group had ratings in between ($M = 2.77$, $SD = 1.22$).

Participants were asked the extent to which they agreed or disagreed with the statement “My doctor accepted my body.” Results revealed that participants in the Both group had significantly lower scores than both the Gain and No Gain groups $F(2, 200) = 3.40$, $p = .036$, $n^2 = 0.033$. The mean rating for the Both group was the lowest ($M = 1.97$, $SD = 1.34$), the No Gain group had the highest ratings ($M = 2.78$, $SD = 1.39$), and the Gain group had ratings in between ($M = 2.45$, $SD = 1.24$).

Participants were asked the extent to which they agreed or disagreed with the statement “I received the same amount of time as others.” In a similar pattern, results revealed that participants in the Both group had significantly lower scores than both the Gain and No Gain groups $F(2, 200) = 3.13$, $p = .046$, $n^2 = 0.030$. The mean rating for the Both group was the lowest ($M = 1.97$, $SD = 1.27$), the No Gain group had the highest ratings ($M = 2.72$, $SD = 1.28$), and the Gain group had ratings in between ($M = 2.45$, $SD = 1.25$).

Participants were asked the extent to which they agreed or disagreed with the statement “Any medical issues that arose were addressed.” Results revealed that participants in the Gain group had significantly higher scores ($M = 2.16$, $SD = 1.44$) than both the No Gain group ($M = 2.16$, $SD = 1.44$) and Both group $F(2, 200) = 4.35$, $p = .014$, $n^2 = 0.042$. The mean rating for the Both group was lowest ($M = 1.97$, $SD = 1.43$).

And lastly, participants were asked the extent to which they agreed or disagreed with the statement, “I felt neglected.” Results suggest that participants in the Gain group had significantly lower scores than the No Gain and Both group $F(2, 199) = 3.35$, $p = .037$, $n^2 = 0.033$. The mean score for the Gain group was lowest ($M = 0.74$, $SD = 0.65$) and the Both group ($M = 1.00$, $SD = 0.66$) and No Gain group ($M = 1.00$, $SD = 0.80$) had similar means.



Of the quantitative data, consistent among all significant results, excluding one, is that the Both group reported the lowest ratings. The Both group — people who at times gained weight in treatment and at other times did not — might have reported the lowest ratings on the treatment satisfaction section of questions because this group has the experience of receiving treatment in

both a body that looks stereotypically sick and in a "normal" body. Being able to compare and contrast these experiences potentially makes weight bias more obvious.

The most significant ANOVA analyzes how much participants felt their medical issues were addressed. The Gain group reported substantially higher ratings when it came to their medical issues being addressed. Because bodies that are underweight often are (wrongly) associated with greater sickness, it makes sense why this group received the most attention to medical issues. However, this assumption about weight and sickness is seeped in weight bias.

Qualitative data in the form of long-response answers was also collected. Results produced four key results: responses that highlighted the ways in which clients were allowed access to or were restricted from food depending on their size, responses that demonstrate a reinforcement of the fear of weight gain from treatment providers, responses that focused on poor or inadequate care due to diagnostic biases, and responses that exemplified the medical neglect of clients who presented in fat bodies. These categories are named, respectively, Food Specific, Reinforcement of Fear, Diagnostic Bias, and Medical Neglect. A few of the most representative responses were selected for each key result.

Food Specific:

I had much smaller meal plan amounts and wasn't allowed the same access to snacks as my smaller peers
Because they saw eating disorders as weight disorders, when I reached a certain weight they decreased my meal plan even though I said I wanted to eat more
In treatment, if you were below a certain BMI you were given a higher meal plan, but if you weren't you could opt out of dessert. It was awful, as people who were clearly wanting dessert and extra snacks had to ask while the rest of us ate it in front of them. So triggering
I was sometimes asked by Recovery Coaches if I was "sure" I was still hungry, whereas thin clients were given more food without question

I was put on lower meal plans (way below maintenance) and told I didn't need snacks because I didn't need to gain weight

Reinforcement of Fear:

My doctor comforted me in my fear of weight gain by showing me that I could eat more and still lose weight.
My therapist told me I had the unique privilege of being able to eat whatever I like without having to worry about putting on weight.
Multiple dietitians have promised to "not let me get fat."
I had multiple clinicians tell me that I "wouldn't get fat" if I followed the meal plan in an attempt to reassure me, however this is fatphobic and not always true.
My doctor did not address my fear of weight gain and reassured me in telling me I could still lose a bit of weight while eating.

Diagnostic Bias:

My intake provider told me I would have been recommended to a higher level of care based on my behaviors, but I hadn't lost enough weight yet
One lady told me I didn't have anorexia long enough to get help and it probably wasn't so bad. When they saw me a few weeks later, they treated me completely different because I had lost weight
My first referral to ED services I was only slightly underweight and was completely dismissed…I didn't get accepted for another assessment with them until months later when I was dangerously underweight. I was not taken seriously until I ended up in the hospital.
I believe I was diagnosed incorrectly because of my body size. I did not appear underweight so I didn't fit certain criteria. This meant that my treatment did not address a lot of my issues.
I was told multiple times "you're too heavy to be anorexic" so I was diagnosed with just eating disorder unspecified. This just made me want to starve myself more.

Medical Neglect:

[Those of us at a healthy weight] were seated at the table all the way in the back. Usually a Recovery Coach sits with clients to talk and check in. We got none of that.
It took my Health at Every Size outpatient doctor to call my residential providers and tell them to continue checking my labs, even though they were off to begin with
In one PHP program when I was at a higher weight, I went three weeks without seeing my dietician. When I was at the same program at a lower weight, I saw my dietician twice a week.
I had to advocate for weighing gowns and towels that fit at several different treatment centers, and instead of changing the procedure for everyone, I was singled out as the one who needed the different stuff
Even though my body was failing (low heart rate, osteoporosis, amenorrhea), there were no consequences for ED behavior or weight loss. My team was unsure how to handle overweight patients with a restrictive ED

Discussion

Results demonstrate that weight bias exists and is pervasive in eating disorder treatment at all levels. Turning first to the qualitative data, four key results emerged in the long-response answers: food specific responses, responses that show reinforcement of the fear of weight gain, responses demonstrating diagnostic bias, and responses that point at medical neglect within eating disorder care. The names used throughout the next sections are pseudonyms.

Food Specific

Many participants, when asked to elaborate, explained that they did not get the same food options as thinner clients. This is the first major result: clients of different sizes were treated differently in the specific context of eating and food. Some participants' experiences are blatant, such as being put on what is called a "below maintenance" plan – one that does not have enough calories to maintain body weight. Others described unintentional but still harmful comments. Melissa, a woman in her late-twenties, recounted being asked by a staff member whether she was *sure* she was still hungry while encouraging thin clients around her to eat more instantaneously.

Sandra, a woman in her early forties, reported that those above a certain BMI were allowed to opt out of dessert when she was receiving inpatient treatment. Eating disorders, though, are extremely competitive and validation-seeking. By nature, having to ask to eat dessert would be a challenge in treatment for someone who is seeking validation of their experiences. Thin patients were encouraged to partake in dessert, while fat patients were allowed to eat dessert but not required to practice eating dessert, an important aspect of recovery. Sandra commented that, "It was awful, as people who were clearly wanting dessert…had to ask while the rest of us ate it in front of them. So triggering."

Katherine, a woman of 26 years, wrote that she was put on a meal plan that was well below maintenance, meaning it wasn't enough food to support maintenance of weight as opposed to weight loss. Katherine also wrote that she was told she didn't need snacks because she didn't need to gain weight. Interestingly, it is preached to thin clients that snacks serve the body by feeding it what it needs, keeping metabolism stable throughout the day, and staving off blood sugar crashes. However, fat clients are instructed not to eat snacks, despite having similar eating histories. Restricting food, or not being allowed enough food, is dangerous to physical health. And we know that those receiving eating disorder treatment are more likely to have health issues due to their eating disorder.

Restricting food is also dangerous to the mentality of a person in recovery. For those recovering from an eating disorder, feeling restricted is often detrimental to recovery. For example, feeling that you aren't allowed to eat when hungry reinforces a restrictive mentality. A restrictive mentality can mean you allow yourself all foods, except chips. Or, you believe you shouldn't eat more than X amount of calories, despite being hungry. A restrictive mentality is a schema of thinking in which an individual denies themselves either physical and/or mental

needs. Some with a restrictive mentality don't eat enough food, others might avoid certain foods, and another group might eat only within a specific time-frame. Restrictive thoughts differ from person to person; the common theme is the limitation of food. While eating disorders have physical presentations, they are mental illnesses and matters of mindset. Maintaining a restrictive mentality during recovery actively works against one's recovery. In this sense, because thin clients are sometimes encouraged or even allowed to eat more readily than fat clients, thin clients can be challenged in ways that providers shy away from with fat clients.

Reinforcement of Fear

A second key result is the reinforcement of the fear of weight gain in treatment. Seemingly innocuous language to someone without an eating disorder can be detrimental for those struggling with an eating disorder. Often, in an attempt to encourage their clients to eat more, providers nonetheless insinuate that weight gain is undesirable. Emily, a 31 year old woman, wrote that "multiple dietitians have promised to 'not let me get fat.'" Several other participants also commented on how they were reassured that eating wouldn't make them gain weight. Not only is this not necessarily true – nobody can dictate what will happen to a malnourished body once it starts being nourished again – but it also sends the underlying message that, yes, weight gain is something to be afraid of. This type of biased language explicitly attacks fat bodies or bodies that have gained weight and reinforces a fear of weight gain in clients who might be in the process of gaining weight or about to.

Diagnostic Bias

The third notable result in the qualitative data is the prevalence of diagnostic bias. We know that weight is not an indicator of health nor of how sick someone is. And we know that less than 6% of those who struggle with an eating disorder are underweight (National Association of

Anorexia Nervosa and Associated Disorders), yet many people go untreated because they are at a "healthy weight" or are told they are "overweight."

One participant, a 27 year old woman named Sarah described her experience of diagnostic bias as leading to bad treatment decisions. Sarah wrote, "I believe I was diagnosed incorrectly because of my body size. I did not appear underweight so I didn't fit certain criteria. This meant that my treatment did not address a lot of my issues." Nicole, a 22 year old woman, reported that the first time she tried to get help she was told she didn't have anorexia long enough and it "probably wasn't so bad." When Nicole went back a couple weeks later and had lost weight, she reported being treated completely differently. Yet another woman was denied a higher level of care because she "hadn't lost enough weight yet," despite needing more support based on her eating disorder behaviors.

Despite the fact that people of all sizes, genders, races, and sexual orientations struggle with eating disorders, the stereotype of an emaciated, White, cis young woman with anorexia continues to be the image of what someone with an eating disorder looks like. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is used by professionals to diagnose clients, specifies that, to have anorexia, one must have a significant low body weight. However, 25% to 40% of the patients receiving inpatient care have Atypical Anorexia, or the presence of Anorexia at a normal body weight (Golden and Mehler, 2020). Only 6% of those with anorexia are underweight, yet clients can't be diagnosed with anorexia unless they have a significant low body weight. This discrepancy leads to many with anorexia going undiagnosed and undertreated.

The categorization of eating disorders based on weight has psychological effects as well. More specifically, eating disorders are incredibly competitive illnesses, despite the irony of what the competition is: physical and mental decline. Cara, a young woman in her early twenties

highlighted the potential harms of diagnostic bias in her response. She reported being told multiple times that she was "too heavy" to be anorexic so was diagnosed with Other Specified Feeding or Eating Disorder (OSFED). Cara wrote, "this just made me want to starve myself more." Whether produced externally, internally, or both externally and internally, diagnostic bias causes psychological harm.

Medical Neglect

The fourth major result gathered from the qualitative data is the presence of medical neglect of fat clients in eating disorder treatment. When thin patients are seen as more dire, clients at higher weights get the backseat, literally: one woman commented that patients at a healthy weight were seated at a table in the back. From there, they didn't get the same level of support from Recovery Coaches. Another woman, Miranda, went three weeks without seeing her dietician when she was at a higher weight. Miranda notes, though, that when she was at the same program at a lower weight, she saw her dietician twice a week. Consistent appointments with medical providers is an essential part of eating disorder recovery. The discrepancy between how often this participant saw their dietician when they were at a lower weight versus a higher weight raises a red flag. Even though eating disorder sufferers of all sizes are at the same medical risks, a thin body was given more time and attention than a fat body.

Samantha, a woman in her mid thirties, reported that "my team was unsure how to handle overweight patients with a restrictive eating disorder." Samantha further elaborated that, even though her body was failing (she had a low heart rate, osteoporosis, and amenorrhea), there weren't consequences for eating disorder behavior or weight loss. In other words, serious medical issues caused from malnourishment went untreated, *and* weight loss went unchallenged. Although many people gain and lose weight naturally from lifestyle changes, weight loss is not

recommended for those recovering from an eating disorder. Moreover, a thin client who lost weight during treatment would most likely be required to up their meal plan and/or reduce exercise.

The responses shared here are only a few of dozens and dozens. Many participants who received treatment multiple times shared in their responses how their care differed depending on their weight. This pattern stands and is even more apparent in our quantitative data.

An Analysis of the "Both" Group

Before collecting data, I hypothesized that the most dissatisfied group would be those who were never required to gain weight because they would have experienced the most weight bias. Interestingly, however, the group with the lowest scores on the set of treatment satisfaction questions was the group that at times were required to gain weight and at other times were not required to gain weight. A possible explanation for why this group (the Both group) reported the lowest ratings is that they have the lived experience of receiving treatment in a body that is stereotypically considered "sick" and another experience of receiving treatment in a body that does not appear stereotypically "sick" yet is often considered problematic. Perhaps being able to compare these experiences and the quality of care they received at different times gives more insight into the weight bias present in treatment. Participants corroborate this possibility in long response answers below.

Mellissa, 28; Female

"I started my treatment/recovery journey…in an underweight body. My clinicians were more attentive to my physical health needs when I was gaining weight and while I was still in a relatively thin body compared to when I moved into a larger body. It's ironic,

*because the times I was most physically compromised were actually when I was ‘ob*se’ (due to restrictive eating disorder behaviors)”*

Ryan, 24; Non-binary

“I have been hospitalized for complications of my eating disorder five times at varying weights, I received far better care underweight than at a normal weight”

An Analysis of the “Gain” Group

Of note is also that, in general, participants who were medically required to gain weight reported lower ratings than those who were not required to gain weight. While I hypothesized, and the qualitative results appear to confirm, that weight bias does exist and negatively affects clients who don’t present as thin, underweight clients didn’t rate their treatment experiences as highly as did clients who might be subjected to weight bias. How do we make sense of this seemingly incongruous result?

It is possible this discrepancy is due to poor validity such as how this study’s survey questions were worded or perceived. Is it also possible that those who are medically required to gain weight do not face weight bias but experience what feels like unfair treatment from being underweight. For example, Meg, a 23 year old woman, noted in a long response that “no matter how much better I began to feel, my dietician, therapist, and psychiatrist told me I still looked too skinny and ignored [the] beginning of positive thoughts.” In this sense, Meg reported feeling like her progress was invalidated because her team continued to focus on her weight and not her mental state. Interestingly, this experience is similar to those who experience weight bias in

treatment, in that, in both cases, weight is central to care. In both cases, clients report negative feelings about their treatment team focusing on their weight.

Limitations and Advantages

This study comes with several significant limitations. First, data collection relied on snowball sampling through social media. This means that those who found out about the study did so via social media friends or re-posts. While snowball sampling granted access into different groups of the online recovery community, this type of sampling is not representative.

Second, people with eating disorders are hyper aware of reasons why they might not be "sick enough." For those in the initial stages of recovery, it can be hard to differentiate between legitimate reasons treatment isn't up to par versus thoughts that are part of the eating disorder. For example, someone's eating disorder might say something (as it were) like, "you aren't thin enough to have an eating disorder," or, "you don't deserve treatment at this weight." Are eating disorder thoughts affecting the extent to which clients felt their body wasn't accepted by their dietician or doctor, for example? Is it possible that clients project their own anxieties about their body onto their provider? Absolutely, it is possible; this warrants further consideration in future studies.

Third, as noted earlier, the question formatting in the survey didn't allow a fine-grained analysis of participants' experiences at different levels of care, from outpatient through inpatient. This means that, for people who reported receiving outpatient, partial hospitalization, and residential, it is not possible to determine whether their comments pertain to all their experiences or just to one. Therefore, level of care was not a factor in this study. Future studies should focus on specific levels of care to see if weight bias differs throughout levels of care.

Fourth, the format type for certain survey questions also meant that no further analysis could be done on the Both group. This is relevant because the Both group has multiple experiences: being underweight in treatment and not being underweight in treatment. Unfortunately, it is not possible to ascertain which treatment occasion pertains to their long response answers. Further research should examine the Both group more thoroughly. What can people who have experienced care in different body sizes and shapes tell us about treatment?

Additionally, this study is largely white. Because white people have historically been and continue to be a privileged group, white people tend to have greater financial resources to pay for treatment or have insurance that will cover the expenses. Stereotypes about who struggles with an eating disorder — a white, cis, thin woman — also act as a barrier to treatment for those who don't fit this mold. The lack of diversity in this study, therefore, represents the lack of diversity in eating disorder treatment. This is a limitation of this study, but also of eating disorder treatment itself. A close friend of mine who received treatment as a person of color has spoken with me about the lack of representation in treatment, reporting feeling isolated and like the other women couldn't understand her lived experiences. This fear, along with harmful stereotypes that suggest white girls struggle with eating disorders more, make treatment a white space. Studies such as this are inherently racialized because treatment is racialized. This is important to keep in mind for future research and as the eating disorder field works to improve its care.

On the other hand, this study also comes with notable advantages. As a researcher, I come to the table bringing my own insider-knowledge on weight bias in treatment. Throughout the years that I have been tied to the eating disorder community, I have had countless conversations with people I went to treatment with. Friends have shared horrific accounts of neglect, invalidation, and blatant discrimination. I have witnessed weight bias with my own eyes

when I received treatment in a residential setting. I have read hundreds of social media posts of people in recovery recounting their experiences with weight biased care. This is not a subject I come to lightly. On the contrary, weight bias in treatment is an issue I am thoroughly invested in *because* I know how harmful its effects can be.

A second advantage to this study is that it utilizes a mixed methods approach. Although it was not my original plan to include both qualitative and quantitative data, doing so allows me to dissect weight bias on multiple levels. Not only does this study use statistical tests to analyze the effects of weight bias, but participants also share personal anecdotes that paint a more vivid picture. This triangulated approach increases the validity of my results and reduces the bias that can come with a narrower view of a topic.

Policy Recommendation and Conclusion

The results from this study suggest that weight bias does, in fact, exist. Participants reported weight bias in the form of food-specific comments – such as being told to eat less after gaining weight – feeling their fear of weight gain was affirmed, diagnostic bias, and medical neglect. While the qualitative data suggests those who present in a fat body felt they had the poorest care, the quantitative data suggests that those in the Both group had the lowest treatment ratings.

Eating disorder treatment is complicated. Regardless of body size, most people who get treatment don't feel they are sick enough. Studies such as this one that research weight bias in eating disorder care need to address the possibility that results are affected not by facts, but by psychological schemas that reinforce to a sufferer that they aren't "sick enough." However, there is a thin line between considering the factors that might be affecting participants' responses, such

as believing they aren't sick enough or having extreme body dysmorphia, and invalidation of lived experiences.

So what do we do? We know that eating disorders have the highest risk of death among mental illnesses (Johns Hopkins All Children's Hospital) and need to be treated. And, mounting evidence offers the possibility that, even though we need professionals and programs to treat eating disorders, having them does not guarantee unbiased and equal care for all.

To combat weight bias, eating disorder professionals, including therapists, dietitians, medical doctors, psychiatrists, and client support staff such as Recovery Coaches, need more thorough training. More specifically, from the results produced in this study, eating disorder professionals need education prior to working with clients. Health At Every Size (Bacon, 2010) principles like weight inclusivity and the acknowledgment of our own biases are among the recommended topics to include in training. Only when practitioners come to the table having learned how to administer weight-inclusive and unbiased treatment will there be a reduction in weight bias. This means professionals themselves need to look at their own weight bias and fat-phobia. They need to ask questions such as, "how does my definition of health and what I think and feel about weight impact the kind of care I give?" "How does my own fear of gaining weight play into the treatment I recommend?"

Moreover, eating disorders are weight-obsessed. Treatment attempts to direct one's attention away from weight and toward more meaningful parts of life. And while some programs and approaches are more successful than others, all approaches have room to improve. Eating disorder treatment should work to provide more weight neutral care. More specifically, weight neutral care should use, as infrequently as possible, weight plans that implicitly categorize eating disorders based on weight. Additionally, as soon as a client has established hunger and fullness

cues, meal plans should be increasingly replaced with intuitive eating. This puts trust in the client and their body rather than in a food plan that is not very different, in its rigidity and structure, from a diet regimen.

Some will respond that, because eating disorders are so deadly, the physical aspects of recovery like weight and food intake *need* to be closely monitored. True. And, as soon as is medically possible, the focus should shift toward addressing the psychological aspects of an eating disorder and establishing a sense of trust between a client and their own body rather than trust in a meal plan.

The issue of weight bias in treatment is by no means inapplicable for men. Yet, the prevalence of women with eating disorders is greater than men, with women comprising about 75% of those struggling with an eating disorder (Mond et al., 2014). It seems to me that because women are more likely to receive treatment *and* are subject to particularly strict body standards, weight bias in treatment is more relevant for women. However, future research should examine the effect of weight bias in the context of gender to look into this assertion.

As we continue to learn more about weight bias in treatment, we will have to consider the new factors that will undoubtedly arise. For example, a new drug called Ozempic — a drug designed to treat Type 2 Diabetes — has increasingly been the center of conversation when it comes to new fatphobic trends. This drug can cause dramatic weight loss when abused. Celebrities have begun to speak, albeit only a few, about using Ozempic for weight loss. How will new drugs like this one affect body standards, and thus have downstream consequences on the prevalence of eating disorders? Is skinny coming “back in” after a period of pop culture embracing “thiccness,” which although a more representative body standard, is still a harmful mold. The eating disorder field should now, but will increasingly have to monitor what messages

around bodies arise, such as what an ideal body is and how to “achieve” it. These types of weight biased, social factors inevitably affect the risk of developing an eating disorder and attaining full recovery. It is my guess that unless significant changes take place in our culture around bodies and weight, body dissatisfaction, eating disorders, and weight bias will only increase.

This study sought to examine the presence and effects of weight bias in eating disorder treatment. Despite the rising prevalence of eating disorders, this issue has remained largely unstudied. My research questions were, more specifically: does weight bias show up in the treatment of eating disorders, a setting in which it might be particularly harmful? How does weight bias show up? And with this data, what can we do to improve how we treat eating disorders going forward? This study suggests that there are improvements to be made. Even in treatment for eating disorders, weight bias has real and tangible harmful effects.

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Appendix A

Survey Questions

1. Have you received treatment for an eating disorder? (Yes/No)
2. What types of care have you received? Select all that apply:
   a. Outpatient
   b. Partial hospitalization
   c. Residential
   d. Inpatient
3. How many times have you received more than outpatient care?
4. How many different programs have you tried?
5. Do you currently see eating disorder professional(s)? Select all that apply:
   a. Therapist
   b. Physician/doctor
   c. Dietician
   d. Other
6. On a scale of 0-100% recovered, where do you place yourself?
7. Approximately how many years have you been in recovery?
8. To what extent do you agree with the following statements? (5 point Likert scale)

   In treatment:

   a. I felt supported
   b. I felt taken seriously
   c. I felt advocated for
   d. I felt ignored

e. I felt neglected
f. I felt validated
g. I received the same quality of care as others
h. I received the same time as others
i. Any medical issues that arose were addressed
j. My doctor accepted my body
k. My dietician accepted my body

9. Was medically recommended weight gain a part of your process?
    a. No
    b. Yes
    c. Sometimes yes, sometimes no
10. Do you feel you received the same quality of care depending on whether you were "underweight" or not?
    a. If not, or you are unsure, please elaborate. Share as much as you can.
11. Did you feel like you were treated the same as those on gain plans?
    a. If not, or you are unsure, please elaborate. Share as much as you can.
12. In your treatment experience, did you ever feel like you were treated differently because of your body shape or size?
    a. If so, why? In what ways?
13. The purpose of this study is to learn about experiences of weight bias in treatment. Is there anything else you would like to share on this topic?
14. What is your age? Use the slider below.
15. What is your gender identity?

a. Woman

b. Man

c. Non-binary

d. Prefer not to say

16. What is your race/ethnicity? Select all that apply

a. Asian

b. Black or African American

c. Hispanic or Latino

d. Middle Eastern or North African

e. Native Pacific Islander

f. White

g. Other ________