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## Typical-Atypical Interactions: One Patient's Experience of Weight Bias in an Inpatient Eating Disorder Treatment Setting

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### Abstract

This article examines one patient's experiences with weight bias in an inpatient eating disorder treatment setting with a focus on interactions between the patient and her primary therapist. These therapeutic interactions had multiple unintended consequences, including bolstering feelings of denial, modeling of disordered behaviors, and disrupting the therapeutic alliance. Additional instances of weight bias with other treatment professionals, including an inpatient nutritionist and psychiatrist, are briefly discussed. The article ends with several brief recommendations for how clinicians can more skillfully approach issues of weight and size in the therapeutic alliance in order to resist size-related oppressions rather than reinforce them.

### Keywords

Weight bias; therapists' weight bias; atypical anorexia; higher-weight restrictive eating disorders; refeeding; inpatient eating disorder treatment

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Eating disorders have the highest mortality rates of any psychiatric illness (Beumont & Touyz, 2003; Harris & Barraclough, 1998). These deaths are attributable both to the physical consequences of self-starvation (Fairburn & Harrison, 2003) and purging behaviors (Brown & Mehler, 2013) and to suicidality, as one in five patients with anorexia nervosa dies by suicide (Arcelus, Mitchell, Wales, & Nielsen, 2011). Atypical eating disorders do not meet the diagnostic criteria for full syndrome disorders, yet present with virtually identical sequelae of symptoms, psychiatric comorbidities, courses of treatment, severity, and levels of impairment (Fairweather-Schmidt & Wade, 2014; Sawyer, Whitelaw, Le Grange, Yeo, & Hughes, 2016; Thomas, Vartanian, & Brownell, 2009; Wade & O'shea, 2015). For example, according to *DSM-5* criteria, patients who have all of the symptoms of anorexia nervosa, but fail to meet the diagnostic threshold of a body mass index (BMI) less than 18.5, are diagnosed with atypical anorexia nervosa. Patients with atypical anorexia whose bodies are not only "not thin enough," but also "fat," face, in essence, two major hurdles: (a) challenges related to the eating disorder itself (anorexia nervosa), and (b) issues related to encountering and coping with weight-stigma as a result of their body size.

Compared to patients with typical anorexia, patients with atypical anorexia present with distinct clinical challenges, including delay of diagnosis, longer duration of symptoms,

greater levels of weight loss, and increased distress related to eating and body image (Sawyer et al., 2016). By definition, these patients are also more likely than patients with typical anorexia to present with higher BMIs and bodies pathologized by the medical community due to their size; some individuals with atypical anorexia also have a diagnosis of “obesity,” despite their engagement in severe caloric restriction (Sawyer et al., 2016). Research suggests that these individuals may also experience greater delays in care than patients with anorexia who are considered underweight due to avoidance of healthcare (Drury, Aramburu, & Louis, 2002), providers’ lack of knowledge about assessment of typical eating disorders (Hudson et al., 2013), providers’ weight bias (Lebow, Sim, & Kransdorf, 2015), misdiagnosis (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001), and structural barriers due to stigma (Cachelin et al., 2001).

### **On Positionality: Embodying “Patient” and “Clinician”**

I write this article to reflect on my experiences as a larger-bodied, atypical anorexia patient at an inpatient eating disorder treatment setting. Having embodied a thinner body previously, and having “qualified” for a “typical” anorexia nervosa diagnosis in years past, I am able to compare my experiences with inpatient treatment providers based on my different bodily presentations. Though I presented with the same behavioral, emotional, and cognitive symptoms of severe anorexia during two separate inpatient hospitalizations, I experienced radically different treatment from providers when I presented as an emaciated, typical anorexia patient and when I presented as a starving, fat-identified, atypical anorexia patient years later. Here I focus on my interactions with my primary therapist during an inpatient hospitalization and briefly address similar experiences of weight bias with my inpatient nutritionist, physician, and psychiatrist.

Following this last inpatient hospitalization, I went on to earn a master’s degree in clinical social work and to begin work toward a Ph.D. in social welfare. In my academic life, I study the intersection of weight stigma and eating disorders. Thus, I write from the positionality of a patient, clinician, fat advocate, and academic. I also write from a positionality of White privilege and class privilege. I mention these identities because they have facilitated my access to many opportunities (e.g., education, employment, social connections), including my access to eating disorder treatment. Thus, the difficulties I have experienced in obtaining quality care for my eating disorder would be compounded for those with more marginalized identities.

I end this paper with a brief discussion of the missed opportunities within the therapeutic interactions with my therapist, from a clinician’s perspective. In addition to causing harm through denial and body-shaming, my therapist missed a critical therapeutic opportunity to impart a much-needed critical perspective about the overvaluation of weight in our culture. As opposed to discussing how to cope with (or actively resist) experiences of weight stigma, she became an instrument in the system of weight oppression. Much of my healing from my eating disorder has occurred through the bravery of later therapists who were willing (however imperfectly) to discuss frankly issues related to weight, fatness, and weight-based discrimination. I end with some brief recommendations for how clinicians can more

skillfully approach issues of weight and size in the therapeutic alliance, in order to resist size-related oppressions rather than to reinforce them.

## Setting the Scene: Re-Admission to Inpatient Treatment

Prior to my admission to inpatient treatment care, I had a 20-year-history with anorexia nervosa. Onset of the disorder had occurred in early childhood, and I had been in and out of hospitals, outpatient treatment, and inpatient treatment centers since my diagnosis. My disorder was characterized as “severe,” “chronic,” “recurrent,” and “enduring,” and it had multiple impacts on my life and functioning. I had “given up” on therapists and had experienced therapists “giving up” on me. I had survived kidney and heart failure, muscle atrophy, tachycardia, bradycardia, orthostatic hypotension, and amenorrhea; been forced to leave school three separate times; lost my housing once; and incurred hundreds of thousands of dollars in medical bills. I had spent much of my life with no health insurance, as I was at my sickest when there was no mental health parity, and my anorexia was considered a “preexisting condition,” which disqualified me from health coverage. As a result, the care for my eating disorder was exorbitantly expensive yet also low quality; multiple providers who had had no formal training in eating disorders attempted to treat me. For some providers, I was the first anorexic patient they had diagnosed or treated. I attribute much of the longevity and severity of my eating disorder to delays in care (there was a 10-year gap between symptom emergence and diagnosis) and a lack of quality care. While treatment centers and providers profited from high treatment costs, I became sicker, and my sense of hopelessness grew.

However, despite these difficulties, I finally obtained excellent care in my early 20s at an inpatient treatment center, due to the benevolence of a family friend, several family members, and my church. Following this treatment, I experienced a period of recovery I had not imagined possible. Though I still struggled significantly with body image, I was able to eat normally and maintain my body’s recovery weight for several years.

Having experienced this period of “successful recovery,” asking for help when I relapsed in my late 20s was difficult. I felt ashamed, as if I had failed my recovery and the treatment providers who had done so much to help me. However, I knew that recovery was possible for me because I had experienced it before. Though my eating disorder symptoms were once again severe, I wanted help. I desperately wanted to stop the disordered behaviors, heal my body, and resume my life, but I could not do it on my own. So, when my treatment team said, in no uncertain terms, that I required inpatient treatment again, I was willing to go.

In order to enter inpatient treatment, I had to satisfy my insurance deductibles and maximum yearly expenditures. This cost my family thousands of dollars—all of our savings, and we again had to ask for assistance from extended family and from our church. Despite these hardships, I was happy to go, as I knew this level of care was necessary and my best shot at remission. Having been to a different inpatient center four years prior, I knew a bit about what to expect. However, I was completely unprepared for the weight bias that I would encounter as a woman in a larger body in an inpatient setting. As I was presenting with the same *symptoms* and (in my mind) *same disorder* as at my previous admission, I had

expected a similar treatment experience. However, I soon realized that my experience was very different—and much of the difference was due to my body size.

## Meet “Cindy,” the Therapist

I met my primary therapist, “Cindy,” in my first few days at the center. During our initial meeting, I remember her asking me, “Why are you here?” I briefly explained that my outpatient treatment team had told me that I needed inpatient care again. She pressed again, “But why are you here?” I wondered then if this was a rhetorical question or a therapeutic device to try to tap into my motivation for treatment. I explained that my eating disorder was out of control, I wanted help, and I couldn’t seem to eat enough on my own. Then she asked, again, “But what do you need treatment for? Drug addiction?” I was confused and exasperated. She had access to my intake paperwork; I had completed a 2-hour phone assessment, and my doctor had faxed my lab results, an EKG, and all of my other health history information. This was an inpatient eating disorder facility—not a drug rehab center or a general psych ward. I clearly needed inpatient care for an eating disorder. I had a diagnosis of anorexia nervosa, a 20-year history with the disorder, and symptoms severe enough to land me in an inpatient hospital. I had been unable to feed myself for months prior to admission, purged multiple times a day, and had lost a significant amount of weight. I was orthostatic. I fainted if I stood up too fast. I was there because I had anorexia; outpatient care was not a sufficient level of care given my symptoms, and I needed help.

Cindy then proceeded to tell me that she thought my primary problem was not actually an eating disorder, but substance abuse. I explained to her that I did have a history of substance abuse; however, I had gotten clean during my last inpatient eating disorder treatment admission, had finished a 2-year addiction treatment program, and still regularly attended Narcotics Anonymous meetings. I told her that I had been clean for four years, had had no relapses, and was relatively happy with my recovery. I explained that my primary problem was the eating disorder because I had, for all practical purposes, recovered from my substance abuse.

Cindy maintained her belief that my primary problem was substance abuse throughout the duration of my stay at the inpatient eating disorder treatment center. Despite my having been admitted for treatment of starvation, purging behaviors, and over-exercise, she insisted that my primary problem was not the eating disorder, but substance abuse. At the time, I was confused; I could not understand why she viewed my history of addiction as more important than my current eating disorder. Today, I understand this experience through a lens of weight bias; she was not able to see past my body size to the psychological and behavioral issues at hand. To her, I did not *look* anorexic, and so I couldn’t possibly *be* anorexic. She had also shared with me that she had a personal history with substance abuse and recovery; perhaps she was simply unable to see my symptoms clearly because her own life experiences had colored her perspective.

In a similar fashion, at a later appointment, Cindy told me that she believed that I had “sexual anorexia” and suggested that I was scared of sex and felt asexual. At the time, I shrugged it off; I had a healthy sex life and did not feel the need to justify my sexuality to a

therapist who did not accept my diagnosis. However, in retrospect, I now wonder how much her assumptions about my body size impacted her belief that I was asexual. Larger women are often either desexualized or hypersexualized (usually humorously) in media and society. Perhaps she ascribed problems with “sexual anorexia” to me because she could not conceive of a larger woman having a healthy sex life. Cindy’s inability to pay attention to my presenting, and clinically relevant, symptoms (i.e., the eating disorder) significantly impacted my quality of care. I spent countless hours on therapy homework assignments recounting my addiction history at the expense of addressing the more pressing concerns of self-starvation, compulsive exercise, and purging, which had landed me in the hospital in the first place.

## A Moment of Crisis and Therapeutic Intervention

Two and a half weeks after I entered inpatient treatment, Cindy met with me to inform me that I had lost my insurance authorization and would have to leave the hospital after the weekend. I was shocked, confused, and devastated. The last time I had been an inpatient, I had stayed in treatment for three months. How could I be discharged after less than three weeks? I began crying uncontrollably. I felt hopeless. Cindy looked startled and said something like, “Why are you upset? You’re going to be okay.”

In a jumble of emotion and despair, I explained to her how desperate I was for treatment. I described how severe my eating disorder symptoms had become and how the only way I had been able to stop starving, exercising, and purging was by coming to this inpatient center. I explained how I had tried to stop these behaviors on my own, to no avail. I felt powerless in the face of my eating disorder. I had struggled with it for 20 years; perhaps I would die with it. I think part of me thought that, if I could make her understand how much I needed treatment, perhaps it would change the insurance company’s mind. Perhaps she could advocate for me for more days. I explained that we had spent all of our family’s savings to meet the deductible to get into the center in the first place, and now I was being told to leave so soon. I had barely begun to get actual treatment. In that moment, I wished that I had never been admitted to the inpatient center at all. I would rather have saved the money than been given false hope and so little treatment.

After my outburst, Cindy took me into the main group room, where my peers were hanging out during some free time. She pointed to my peers and asked me, “When you look at them, what do you notice?” I struggled to understand her point, and asked her what she meant. She went on to say, “Look at them, and compare them to yourself. What do you notice?” I was dumbfounded. It seemed as if she was instructing me to compare my body to the bodies of my peers. I was obviously larger than most of them; I compared my body to my peers’ bodies all the time. In fact, body comparison is a main feature of my disorder.

Cindy went on to explain. She pointed to some of the emaciated women sitting on a couch. “Do you see them? Do you see how thin they are? They *need* this treatment. They *need* to be here. Look at yourself. You’re going to be fine.” I was dumbfounded. In one small, seemingly insignificant interaction, my therapist had invalidated my emotions, denied my illness, and shamed my body.

This “therapeutic” interaction had multiple unintended consequences. First, it bolstered my feelings of denial, rather than confronting them. One of the most challenging aspects of eating disorder treatment is helping patients to recognize that they have a problem and to accept the reality of their disorder. In this brief interaction, my therapist denied my illness and need for treatment, instead of fostering motivation for behavior change. Second, my therapist modeled disordered behaviors, rather than problematizing them. Some hallmark symptoms of eating disorders include body checking, body comparisons, and overvaluation of thinness, all of which were modeled by my therapist in this interaction. Instead of problematizing these behaviors and beliefs, she reified them and instructed me to participate in them with her. Finally, this interaction disrupted the therapeutic alliance by body-shaming me, instead of embodying empathy for me. In her attempt to reassure me, my therapist argued that my body was less deserving of care and treatment because it was larger than my peers’ bodies. I already carried immense shame about my body size, both because of sociocultural pressures to be thin and the internalized oppression of the eating disorder. This interaction deepened my sense of shame and lack of self-worth.

### Reflections on other Treatment Experiences of Weight Bias

During my inpatient treatment for atypical anorexia, I experienced weight bias from multiple providers, in addition to my primary therapist—including nutritionists, a medical doctor, and a psychiatrist. Prior to admission, I had lost 20–25% of my body weight through food restriction, over-exercising, and frequent purging behaviors. When I entered inpatient treatment, instead of being put on a weight-restoration or weight-stabilization meal plan, I was put on a restricted caloric meal plan that mimicked my disorder. I vividly remember eating a dinner of two chicken nuggets, half a corn muffin, and half a plate of steamed vegetables, while my thinner peers were expected to eat plates heaped high with calorie-dense foods. Being given such drastically different meals from my peers caused multiple harms: (a) it affirmed my disordered beliefs that my body was somehow “different” or “broken,” incapable of “handling”—or needing—food, (b) it affirmed my peers’ disordered beliefs that larger or fatter bodies should be starved or restricted, (c) it visibly separated me from my peers with similar diagnoses and behaviors, solely based on my physical appearance, and (d) my body continued in a state of caloric deprivation for two additional months during the inpatient process, which necessitated refeeding on an outpatient basis. No matter how much clinicians may say that “eating disorders aren’t about the food or weight,” if patients are treated differentially based on weight, harm occurs.

I was bullied for my weight by my eating-disordered peers multiple times; several of these interactions took place in front of staff at meal times. Staff did not intervene; I was told to “deal with it” and feel pity for my “sicker” (i.e., thinner) peers. Sometimes, the bullying resulted in my refusal to eat. When I refused to eat my minimally sufficient meals, I was not offered any supplement or meal replacement, which is standard procedure in inpatient settings. When I requested supplement instead of the meal, I was not permitted to have any; instead, I was told that it was fine if I didn’t eat the meal because I “didn’t need it.” When my home nutritionist contacted my inpatient treatment team and attempted to advocate for more appropriate meals for my “refeeding” process, she was met with resistance from the



staff. I was discharged with a meal plan that left my body severely deprived, and I required months of continued refeeding post-discharge on an outpatient basis once I returned home.

While an inpatient, I repeatedly attempted to advocate for my recovery needs (e.g., meal supplement, less-disordered meals, less prescribed exercise), but was unsuccessful. It was very challenging for me as an *anorexic* patient to *actively advocate for* options such as meal supplementation. However, having experienced recovery in the past, I knew that refeeding was a necessary part of my recovery process and that without nutritional stabilization, my recovery would be haphazard at best. The low-calorie diet that I was prescribed (and mandated!) created disordered eating behaviors that mimicked anorexic eating more than recovery. For example, I was limited to three teaspoons of fat per day (e.g., three teaspoons of salad dressing or butter or mayonnaise) and not permitted “normal” use of fat. My fats were meticulously measured with teaspoons; my protein portions were measured with a scale. I was offered “diet substitutes” for normal foods for which I was considered “too fat.” For instance, I was required to make my grilled cheese sandwiches with a low calorie non-stick cooking spray instead of, like my peers, butter spread with a knife. I was offered a mini, bite-size bagel for breakfast instead of the normal, adult-sized bagels my peers ate. I was permitted a teaspoon of avocado *or* a teaspoon of mayonnaise on a sandwich, compared to the slices of avocado and “normal mayonnaise spreading habits” encouraged for my peers. The degree to which my food demarked me as “different” and “problematic” was obvious, dehumanizing, and confusing in a milieu espousing to destigmatize food and fat. I vividly remember comparing my quarter of a slice of a sandwich (they cut it length-wise to look like a stick) to the two whole sandwiches my friend was required to eat and thinking, “Wow, I’m glad I don’t have to eat two whole sandwiches—but what is wrong with this picture?” It did not seem fair to either one of us. His mountain of sandwich seemed completely insurmountable to both of us anorexic folks, and my sliver of sandwich seemed to be just the slightest nod to the concept that “food is medicine.”

On one occasion, I vividly remember advocating with my nutritionist for the “right” to eat cheese on a hamburger. She asserted that a cheeseburger did not fit my meal plan; it was too much fat because of the slice of cheese. I asserted that (a) cheeseburgers are a fear-food that needed to be addressed, (b) cheeseburgers are a normal part of the modern human experience, (c) intuitively, cheeseburgers are tastier than hamburgers, and (d) that no slice of cheese on one cheeseburger is powerful enough to cause irreparable bodily harm. Ironically, in this interaction, my nutritionist came to embody the voice and fears of my eating disorder, as she argued that food (i.e., the cheese slice) was harmful for my body and that my body would not be able to handle it. By arguing with her for the right to a slice of cheddar cheese, I was, in essence, starting to find my wise voice, honor my intuitive eater, and fight for my recovery. However, I would not consider this a therapeutic intervention or even an effective one; my recovery voice was so effectively shut down by the eating disorder professional that this was the last time I ever spoke up in disagreement with my meal plan.

Ultimately, my nutritionist won this argument; I was not permitted to have cheese on my burger, and I left her office crying in shame for deigning to ask for *more* food. I didn’t argue with her because I actually felt passionately about having cheese on my burger (my eating disorder was thrilled to have an easier meal); I argued with her because I did not want to be

treated differently from my peers. Every meal was a visible, obvious reminder that my body was too fat and unacceptable—even to professionals trained in eating disorder treatment, body image, and “intuitive eating.” This reinforced for me the faulty, disordered belief that my body could not “handle” normal foods such as grilled cheese sandwiches or French toast, and it harmed the therapeutic milieu in that it reinforced for my thinner peers that, if their bodies ever gained weight or (God forbid!) looked like mine, then they would not be able to handle foods such as a piece of cheese or slice of avocado, either. Ironically, as a result of the low-calorie diet I experienced as an inpatient, my cravings for dietary fats increased significantly, and my metabolism did not show signs of recovery until I was discharged and began refeeding with my outpatient nutritionist. I bring up these experiences to highlight the stark contrast between my experiences as a larger patient and the standard treatment for anorexic patients in thinner bodies. During previous inpatient hospitalizations as a thinner patient, supplementation for refused meals (or parts of meals) was standard protocol. If I was “caught” engaging in non-prescribed exercise, I had to drink extra supplement. Though treatment “rules” such as these caused me frustration and anxiety at the time, they helped to heal my body and mind by decreasing my engagement in disordered eating practices and sending a clear, consistent message that my body needed, and was worthy of, food. However, during inpatient care in a larger body, these important recovery messages were blurred, inconsistent, and at times blatantly negated.

Regarding medical care, one situation stands out as particularly illustrative of the more paternalistic model of care I received as a higher weight patient. Upon admission, I was immediately placed on a blood-pressure medication, which is also used to treat opiate withdrawal, though I had no history of elevated blood pressure or opiate addiction. I was prescribed this medication because my blood pressure at admission to the inpatient center, which had been taken immediately following a strip search and weighing, had been elevated. I asked to be taken off this medication because I had no history of elevated blood pressure and had been prescribed the medication based on one measurement, rather than a series of elevated blood pressure readings. However, the doctor dismissed my concerns, told me that the medication was also used to treat opiate addiction, and recommended that I speak with the psychiatrist. When I asked the psychiatrist why I was on the medication when I did not have a history of opiate addiction and had not used any mind-altering substances—including alcohol—for the past four years, he insisted that I stay on the medication because he believed it was “necessary.”

Looking back on this experience, I believe that, had I had a thin body, my experience would have been radically different. I suspect that my doctors would have reassured me that my slightly elevated blood pressure at admission to an inpatient treatment setting might have been due to increased stress levels (e.g., due to the admission, to the strip search, to having been weighed immediately prior), and they may have re-checked my blood pressure later in the appointment to see if it was still elevated after some time had passed. Or, perhaps they would have waited for me to have several elevated blood pressure readings before beginning medication. These are the types of experiences I had had as a thin person when I had anomalous blood pressure readings. However, my doctors instead assumed that my larger body had caused certain symptoms, and I was placed on an unnecessary medication for months.



After discharge, my primary care physician at home was surprised to find that I had been prescribed a blood pressure medication. I shared that I was worried about having been put on an unnecessary medication. She brought up several additional concerns with the specific medication, including that it was used more commonly to treat opiate withdrawal and that going off of the medication often caused spikes in blood pressure. We both agreed it would be best for me to be off the medication if possible. She took me off of it and monitored me closely, and my blood pressure returned to normal without need of medication. It is unfortunate that my inpatient medical providers did not model this type of collaboration. As clinicians, when we are quick to medicate and slow to collaborate, we miss the chance to empower our patients by helping them to participate more meaningfully in their care and to adopt changes that can be sustained after discharge. I recognize that patient-clinician relationships in inpatient settings are often complicated by the symptoms of eating disorders, such as denial and “fighting” the treatment team, yet it is unfortunate when valuable opportunities for collaboration are missed. As a result, clinical care and patient outcomes suffer.

### Looking Forward: Recommendations for Mental Health Professionals

Having reflected on my experiences of weight bias in an inpatient eating disorder treatment center, there are three points I would like to highlight, which are salient for mental health clinicians. First, it appears that, for many clinicians, body size is linked (however unconsciously) to our understanding of body dysphoria. When a very thin woman asserts that she is “fat” and that this “fatness” makes her unattractive, undesirable, and unworthy, clinicians view this self-appraisal as problematic and often as the result of a mental disorder such as anorexia nervosa or body dysmorphic disorder. However, when a fat woman views herself as unattractive, undesirable, and unworthy due to her fatness, her self-appraisal may go unquestioned, or potentially even justified, thus affirming a culturally-based internalized fatphobia. Although her mental health may be questioned in regard to her presumed unhealthy eating habits (e.g., bingeing), her body dysphoria may not be questioned and may be left untreated. Body shame is viewed as problematic in thin persons, but it is assumed that fat persons do (and *should*) feel this way. In sum, body size—not clinical impairment—determines, to some extent, what is considered pathological behavior and disordered experience.

Second, weight bias may be unconsciously interfering with the assessment practices clinicians use when diagnosing eating disorders. As opposed to using a universal, consistent screening process for those with body image and eating concerns, a patient’s body size may dictate the screening tool or assessment the clinician conducts. For example, if a patient is fat, clinicians may choose to investigate bingeing behaviors, which also commonly co-occur in patients with anorexia (Eli, 2015), rather than questioning whether the patient engages in caloric restriction or compulsive exercise. Thus, we run the risk of overvaluing body size in our diagnostic processes for eating disorders, at the cost of ignoring other potentially more salient diagnostic criteria. Ironically, in this instance, clinicians may mirror the pathological “overvaluation of weight” reflected in their own patients with eating disorders.

Third, and perhaps most important, when eating disorders are viewed as “spectrum disorders” that range from anorexia nervosa to “obesity” or binge eating disorder (Baskaran et al., 2016), from extreme emaciation to “glorified obesity,” from starvation to over-indulgence, an unintended consequence may be that eating disorder treatments are also viewed as existing along a similar spectrum. For example, the treatment for anorexia (the thin, starvation end of the spectrum) becomes “food is medicine,” whereas the treatment for binge eating disorder (the fat, overeating end of the spectrum) becomes “food is restricted and controlled.” Essentially, the disordered behavior of one disorder (food restriction, or food compulsion, respectively) becomes the “solution” for the other disorder. As clinicians, we should be wary of prescribing any behaviors for fat patients that are considered pathological for thin patients—regardless of their eating disorder diagnosis. I argue this both from an ethical standpoint of providing humane care by not prescribing clinically impairing, emotionally distressing, or disordered behaviors, and from a research-based standpoint, in that eating disorder symptoms commonly co-occur, and individuals often transition from one eating disorder diagnostic presentation to another, which makes prescription of disordered eating especially risky (Eddy et al., 2010). In sum, the “spectrum” model ignores the reality that body size is not unequivocally linked to behavior, physical health (Tomiyama, Hunger, Nguyen-Cuu, & Wells, 2016), or mental health and that there are fat persons who struggle primarily with anorexic symptoms, just as there are thin persons who struggle primarily with bingeing behaviors.

Finally, as I reflect on my experiences of weight stigma at an eating disorder inpatient facility, I am struck not only by the harm caused by these incidents of weight bias, but by the missed opportunities for positive therapeutic interactions. I know many therapists who shy away from conversations about body size, fatness, and body image with their clients due to their own concerns with weight bias and internalized oppression. We can start by not fearing issues related to fatness, weight, and body. Although silence may be preferable to imparting harmful messages, we miss great opportunities for healing if we stay silent. Conversations about weight and body image—however imperfect—are valuable therapeutic opportunities to explore and resist weight-based oppressions. First, to engage more knowledgeably in such conversations, it is important to become educated about weight-based oppressions, how they function in society, and how they intersect with other forms of oppression (e.g., gender, race, class, ability status). Second, as clinicians we can develop our own critical perspective about the overvaluation of weight in our culture and engage clients in discussion about this. Third, we can point out instances of weight discrimination to increase clients’ awareness, and we can discuss how to cope with or resist size bias. Finally, we can become more knowledgeable about fat activism and body positivity movements in order to connect our clients to the communities who are actively engaged in this important work. Dismantling oppression does not occur in isolation; finding community is key to building solidarity and finding a voice. By wrestling with our own internalized oppressions and seeking to empower our clients to resist systems of weight-bias, we can partner with our clients to dismantle systems of oppression, and we can stop participating in them.

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