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Words with weight: The construction of obesity in eating disorders research

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Abstract

In current public health discourse, obesity is conceptualized as a disease epidemic, with treatment being weight loss. The pursuit of weight loss as a treatment for the "disease" of obesity is in direct contradiction to the history of research in eating disorders, which has demonstrated the risks for the development of eating disorders. In this study, we critically examined the eating disorder literature to explore this contradiction. We analyzed 30 of the top-cited articles in the eating disorder literature between 1994 and 2011, asking: how is the concept of obesity examined in eating disorder research? We identified tensions related to body mass index and the perceived associated risks of lower or higher body mass index, assumptions of the "causes" of fatness (i.e. overeating and inactivity), and the anti-diet voice challenging the prescription of dieting for those in fat bodies. In our analysis, we highlight the problematics of, for instance, prescribing a body mass index range of 20–24 in eating disorder recovery, how many studies in eating disorders do not problematize the presumption that a higher body mass index is necessarily associated with ill health, and a lack of cultural sensitivity and acknowledgment of intersectional spaces of belonging. We discuss these themes in the context of biomedical discourses of obesity contributing to the cultural thin ideal. We argue that biomedical discourses on obesity contribute to the thin ideal nuanced against discourses of healthism that permeate our society. Rather than an ideal of emaciation,

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it is an ideal of a healthy, productive person, often constructed as morally superior. The moral panic around obesity is evident throughout the eating disorder literature, which is a concern given that we would hope that the aim of eating disorder treatment would be to promote wellness for all—not only those who are thin.

Keywords
discourse and conversation analysis, gender and health, mental health

Introduction

A preoccupation with assessing and regulating body size has been observable in public health discourse since 1994, when major health authorities such as the Centers for Disease Control and Prevention and the World Health Organization (WHO) began classifying "obesity" (based on Body Mass Index (BMI)) as a disease (Oliver, 2006). A vast body of literature states the harms associated with adiposity deemed "excessive," saying that those who fit into the BMI categories of overweight and obese are at risk for metabolic syndrome, type 2 diabetes, hypertension, cancers, and other diseases (Kopelman, 2000). Here, the prevalence of obesity is often termed "epidemic," with intervention presented as a pressing need to ensure population health (e.g. Caballero, 2007); obesity is herein presented as a "worldwide phenomenon" (Popkin and Doak, 1998). In these accounts, obesity is generally described as being borne of the confluence of fast food, automobile reliance, technology, and other aspects of White, Western culture that have infused our world (Nestle and Jacobson, 2000).

A parallel body of literature, including meta-analyses, systematic reviews, empirical studies, and theoretical analyses, has emerged to challenge assertions about obesity that tether people's moral character and fitness or health to their body size. Alternative perspectives on body size and health risks suggest that we need to critically evaluate the obesity literature, by arguing that the risks, or at least the causes, of obesity have been exaggerated. Within these alternative perspectives, some have referred to an "obesity paradox," (Lavie and Loberg, 2015) wherein the mortality rate may actually be lower among those in the overweight BMI category compared to those in the normal weight BMI category (Flegal et al., 2005), as evidence that the purported risks of obesity need to be critically evaluated. One approach for moving beyond a focus on weight as exemplifying ill health and taking a more holistic stance on wellness is Health at Every Size® (HAES). Those following HAES principles advocate for adopting healthful behaviors (not dietary restraint) to improve health, regardless of whether weight changes. HAES advocates take an alternate perspective on weight, eating, exercise, and health, emphasizing body size diversity, the ineffectiveness of dieting, the benefits of engaging in non-restrictive and intuitive eating, and how health is shaped by physical, social, and psychological interactions (Bacon, 2010).

Assertions about the ability to untether weight and health are often met with skepticism or outright hostility (e.g. De Gonzalez et al., 2010), demonstrating the tenacity of arguments for the described harms associated with larger body sizes. Furthermore, there is significant evidence for the ill effects not of fatness itself, but of the stigma that is

associated with larger body sizes (Puhl and Suh, 2015). People in larger bodies are routinely faced with systemic discrimination, including harassment by friends, family, and strangers (Ernsberger, 2009; Kirkland, 2008; Puhl and Heuer, 2009); denial of services (Jeffrey and Kitto, 2006; Merril and Grassley, 2008); and more. They are less likely to present to their doctors when they have health concerns and may be less likely to engage in physical activity for fear of being shamed (Rice, 2007). These stigmas are exacerbated when people face multiple axes of marginalization; size intersects with race, class, gender, sexual orientation, ability, and more to create conditions of significant social and health strain (Association for Size Diversity and Health [ASDAH], 2016). Stigma can lead to the opposite effects intended (i.e. shame may result in weight gain, rather than weight loss)(Puhl & Suh, 2015). However, arguing that weight stigma leads to weight gain can be experienced as de-humanizing, as it reinforces the idea that weight prejudice in itself is not problematic, suggesting instead that the problem is that people are not becoming thinner. The problem with stigma is not that it does not induce weight loss, but that it impacts people's mental and physical health in negative ways.

Anti-obesity discourse and marginalization

It is impossible to explore constructions of obesity in the absence of a consideration of other markers of bodily difference that themselves intersect with body size to inform people's responses to bodies. "Anti-obesity" discourses tend to call out those who are marginalized along other lines to an even greater extent, including women (Hartley, 2001; Rice, 2007), racialized and indigenous people (Campos et al., 2004; Fee, 2006; Herndon, 2001; Poudrier, 2007), working class/poor people (Ernsberger, 2009; McPhail et al., 2011), and rural people (McPhail et al., 2013). Messages about the kinds of bodies we must have in order to be healthy, happy, and productive circulate everywhere from doctors' offices to gyms to schools (Rail, 2012; Rich, 2011). There is an expectation that by following the strictures issued by those endorsing an anti-obesity perspective, we will all be able to achieve a certain body size, defined within very strict parameters. We might begin to question whether this is actually the case or whether it is even desirable: fat activists and scholars and practitioners working from a critical perspective have long argued that body size diversity is desirable; they advance a view that all bodies—including fat ones—are desirable and beautiful, healthy, and vital (Wann, 1998). HAES advocates argue that the body does and how it feels, rather than what it looks like or any external gauge of health based on size (Burgard, 2009).

Public health scholars have recently turned to investigating whether obesity prevention and eating disorder prevention might be brought together to effectively and efficiently target a wider range of bodily distress (e.g. Sánchez-Carracedo et al., 2013; Stice et al., 2013; Wilksch and Wade, 2013). They argue that prevention efforts might target dieting, body dissatisfaction, media consumption, depressive symptoms, perfectionism, short sleep duration, social problems, and emotion regulation issues to assist people in developing healthier relationships with bodies and food, regardless of manifestation of symptomatology (e.g. Haines et al., 2006, 2007). In short, these approaches suggest that both obesity and eating disorders stem from bodily discontent that might be prevented. However, some critique these approaches, suggesting that eating disorders and obesity

prevention are fundamentally incommensurable because obesity is a socially inscribed category for a body size, whereas eating disorders can occur at any size; hence, the argument that obesity prevention and eating disorders prevention might be combined problematically equates a body size (obesity) to a (pathologized) style of eating (eating disorders; O'Reilly and Sixsmith, 2012; Wann, 2009).

Weight stigma within the eating disorder field

Weight stigma also circulates within eating disorder prevention, treatment, and research spaces. One might expect that those involved in promoting eating disorder prevention, treatment and activism would be open to different modes of embodiment and challenge body norms. Unfortunately, those involved in helping others develop compassionate and accepting relationships with their bodies are no more immune to the powerful social dicta around which bodies fit than are people in general (Yager and O'Dea, 2005, 2008). People with eating disorders, who have a predisposition for developing them or who are in recovery from them are often told in subtle or overt ways that they can recover—but only if their bodies end up looking a particular way. These messages collude with other stereotypes about who might develop an eating disorder and thus who is able to recover (LaMarre and Rice, 2015). Despite strides to identify how anyone can suffer from an eating disorder, regardless of race, class, socioeconomic status, gender, sexuality, ability, body size, and more, the pervasive stereotype of the young, White, emaciated woman with an eating disorder persists and informs public and medical opinions about who is likely to suffer from distress around food, weight, and shape (Becker et al., 2010; Gordon et al., 2002). If someone in a larger body, someone of a lower socioeconomic status, or someone from a minoritized background (or someone who crosses multiply marginalized locations) presents with distress, the assumption may be that this person struggles with overeating; eating disorders in people in fat bodies are commonly missed or misdiagnosed (LaMarre et al., 2017; Lebow et al., 2015). "Obesity" and restrictive eating disorders are often binarized, making it seem as though there is a direct correlation between body size and behaviors around food (e.g. Grabe et al., 2008) in a way that undermines the complexity of the relationship between behaviors around good, body size, and distress, (Allison and Stunkard, 2005).

The term "eating disorder" bears its own unpacking. In general, diagnostic labels are used to delineate what "counts" as an eating disorder (i.e. the clinical labels of anorexia nervosa, bulimia nervosa, binge eating disorder, and otherwise specified feeding and eating disorders—American Psychiatric Association [APA], 2013). However, these labels and their associated diagnostic criteria do not necessarily capture the wide spectrum of behaviors around food, weight, and shape that may be distress-inducing for those experiencing them. To us, the distress sufferers' experience is the salient determining factor for eating disorders. In the articles examined in this article, however, eating disorders were primarily defined as clinical entities characterized by meeting certain diagnostic criteria. A thorough exploration of the purpose, utility, accuracy, and so on of diagnostic labels is beyond the scope of this article. What we do wish to problematize, however, is the binarization of anorexia and obesity that was common in the discourse around eating disorders

in the articles examined in this review. Exploring this binarization is key to an analysis of the construction of obesity in eating disorders literature, reflecting how obesity is positioned in relation to eating disorders in the eating disorders literature, our primary aim.

The amount of distress that we have (or do not have) around food, weight, and shape is not apparent in outward appearance. Assumptions about who has or does not have an eating disorder can lead to significant delays in seeking and obtaining needed support (Becker, et al., 2010; Katzman and Lee, 1997; Lebow et al., 2015; Striegel-Moore et al., 2000). Given that early intervention has been shown to be a promising practice in treating eating disorders (Treasure et al., 2011), these barriers take on added significance. That serious restrictive eating disorders can occur at any weight is a fact seldom acknowledged in the literature, with a few notable exceptions (e.g. Lebow et al., 2015).

There is a mismatch between that which is proposed as health strategy for those with restrictive eating disorders and those medicalized as "obese." That which is diagnosed as an eating disorder in a thin person being prescribed as health behavior for those in larger bodies, as Deb Burgard has so often highlighted in public fora to call out the problematics around how we treat various bodies in our society (Burgard, 2016, personal communication). This leads to a paradox with respect to body surveillance and management in recovery: recovery might be configured as "counter cultural" when we take into account how normative prescriptions for weight loss are in society writ large (LaMarre and Rice, 2015). Though this tension floats tacitly around the edges of the eating disorder literature, to our knowledge, this is the first review to systematically unpack conflicting discourses about how bodies should be managed as they manifest in the eating disorder research literature. In this article, we explore this contradiction, asking the following research questions: How is the concept of obesity (or obesity as a disease) taken up in eating disorder research? How is 'obesity' discussed and understood from an eating disorder research perspective?

Method

This study comprised a literature search and thematic analysis of a set of research articles. While thematic analyses of research articles is not a common approach to research, we found this approach to be a productive way of exploring how power circulates within research itself, in line with a feminist research praxis (e.g. Ackerly and True, 2010). The first author (S.G.) searched PsycINFO using the key terms: obesity, obese, overweight, BMI, fat, eating disorders, anorexia, bulimia, body image, body dissatisfaction, diet*, fear of fat, drive for thinness, and weight loss. The search was restricted to peer-reviewed journal articles published after 1994 in English, a cut-off year chosen as it can be seen as the beginning of the obesity as a disease epidemic discourse in medical and public domains. From 1993 to 1995, we saw the first use of the phrase "obesity epidemic," the International Obesity Task Force was established, and the WHO published its report suggesting the worldwide adoption of BMI categories to define obesity (Paradis et al., 2013). Over 3000 articles were identified and then sorted by citation record and area of research (obesity or eating disorders). We retained articles that represented empirical research. Articles primarily situated in the eating disorders field were retained, to address the research questions, which specifically aim to explore how obesity is constructed in eating

Table 1. Articles retained for analysis.

Article	Journal	No. cited
Polivy and Herman (2002)	*Annual Review of Psychology*	312
Stice et al. (2002)	*Health Psychology*	230
Paxton et al. (1999)	*Journal of Abnormal Psychology*	229
Stice and Shaw (2002)	*Journal of Psychosomatic Research*	225
Stice and Bearman (2001)	*Developmental Psychology*	210
Grabe et al. (2008)	*Psychological Bulletin*	158
Akan and Grilo (1995)	*International Journal of Eating Disorders*	156
Tiggemann and Pickering (1996)	*International Journal of Eating Disorders*	150
Cattarin and Thompson (2007)	*Eating Disorders: The Journal of Treatment & Prevention*	132
Presnell et al. (2004)	*International Journal of Eating Disorders*	128
Johnson and Wardle (2005)	*Journal of Abnormal Psychology*	125
Mann et al. (2007)	*American Psychologist*	124
Stice et al. (2000)	*International Journal of Eating Disorders*	119
Jones et al. (2004)	*Journal of Adolescent Research*	113
Foster et al. (1997)	*Journal of Consulting and Clinical Psychology*	108
McCabe and Ricciardelli (2001)	*Adolescence*	106
Stice et al. (2006)	*Journal of Consulting and Clinical Psychology*	104
De Zwaan et al. (1994)	*International Journal of Eating Disorders*	94
Schwartz and Brownell (2004)	*Body Image*	87
Schur et al. (2000)	*International Journal of Eating Disorders*	87
French et al. (1997)	*International Journal of Eating Disorders*	84
Furnham and Baguma (1994)	*International Journal of Eating Disorders*	81
Presnell and Stice (2003)	*Journal of Abnormal Psychology*	80
Durkin and Paxton (2002)	*Journal of Psychosomatic Research*	80
Smolak et al. (1998)	*Journal of Psychosomatic Research*	80
Stice et al. (1998)	*Psychology of Addictive Behaviors*	79
Rosen et al. (1995)	*Behavior Therapy*	76
Wilfley et al. (1996)	*International Journal of Eating Disorders*	76
Morgan et al. (2002)	*International Journal of Eating Disorders*	76
Smith et al. (1999)	*International Journal of Eating Disorders*	74

disorder research. The top 30 most-cited articles were retained for analysis, chosen because they have arguably had significant influence on the discipline or represent some of the most dominant perspectives of the discipline. Understanding research as itself tied up in the discourses and power dynamics that shape our worlds more broadly, the discourse in these articles holds power to shape the discipline/area of research into which they speak. Table 1 shows article authors, journal name, and number of times cited.

Following article selection, authors performed a thematic analysis on the data (Braun and Clarke, 2006). Researchers explored the data for mentions of BMI, obesity, diet, and other constructions related to body size. Each of these was then explored in situ in order to unearth the broader context in which the theme occurred. To analyze the data using

thematic analysis, we noted not only how many articles mentioned each of the identified themes, but also how these themes operated in context and in relation to one another. We took an iterative approach to article analysis, reading and analyzing articles twice each to explore how BMI, obesity, diet, and the pursuit of thinness and body dissatisfaction were constructed. This information was placed into an Excel table. We considered contextual factors, including a focus on ideas of risk, and how these ideas of risk intersected with ideas of gender, ethnicity, class, and other marginalized identities. These contextual factors help to get to the heart of the overall construction of obesity within the eating disorders literature.

Notably, thematic analysis requires more than counting codes and deciding upon which themes have the most salience based on these counts (Braun and Clarke, 2006); it is theoretically-driven and acknowledges that all data analyses are influenced by researcher perspectives and subjectivities. That is, we explored how we related to our "data" as graduate students in bodies that have been labeled or understood as alternately eating disordered, "normal," or fat at various points in time. Beyond identifying which themes *existed* in the articles, we also sought to better understand which discourses they were reinforcing. We used a critical feminist lens, attending to how ideas about who might be seen as "at risk" for developing eating disorder and/or obesity collude with other manifestations of social marginalization, for instance, gender, ethnicity, class, and ability. Thematic analysis is no more "neutral" than any other approach to analysis; what we have located in the data as themes are necessarily tied to what we attended to, theoretically—that is, how power and gender operate within the articles and the field in general. While we present theme counts below, it is important to acknowledge that the salience of themes relies not only on their prevalence in the data set but also on their power as social discourses with implications for whose bodies are seen as morally superior (or inferior), privileged, or marginalized.

Results and discussion

Overall, eating disorder articles constructed obesity as a problem to be solved. Articles did not take up the contradiction between the promotion of eating disorder prevention and/or recovery and the promotion of weight loss for health. Instead, the assumption that there is a normative BMI that is objectively healthier for all pervaded the selected articles. The perceived health risks of obesity were constructed as outweighing the risks of eating pathology. This reinforces a dichotomy between thin and fat bodies where body size is described as controllable and as inextricably tethered to health. Here, we will discuss each of the identified themes in more detail and provide quotes illustrating each thematic construction. In Table 2, we present themes with prevalence across the 30 articles (main themes bolded and italicized, with subthemes italicized).

BMI and risk

Of the 30 articles, 28 referred to the idea that BMI is somehow tied to risk, whether for eating disorders or for other health concerns. In many of these articles, BMI was described as a reliable and valid measure. Often, discussions of BMI and risk were tied to broader

Table 2. Theme counts across article set.

Theme	Number of articles
BMI and risk	*28*
BMI and risk factors for eating disorders	21
Obesity as health risk/disease	16
Valid/reliable BMI	8
Assumptions about fatness	*17*
Fat stereotypes	14
Binge eating	5
Influences on body size	*11*
Body image and obesity	7
Culture and obesity	5
Alternative discourses/anti-diet voice	*9*

BMI: body mass index.

anti-obesity discourses; obesity was discursively positioned as a health concern of major public health significance. Though eating disorders were framed as being a serious health concern, eating disorders were discursively tied to thin bodies and binarized with other problematized (and deemed riskier) bodies—those exceeding a BMI of 24.

BMI and risk factors for eating disorders. BMI was explicitly positioned as tied to eating disorder risk in these articles. Authors described how body dissatisfaction, weight concern, weight-related teasing, perceived pressure to be thin, history of dieting or weight loss attempts increase with BMI (Johnson and Wardle, 2005; Presnell and Stice, 2003; Stice and Shaw, 2002). As these are risk factors for eating pathology, it would follow that the risk for developing eating disorders increases with weight. However, only 2 of the 21 articles exploring BMI and risk factors explicitly noted that children in larger bodies might be at increased risk for developing eating disorders due to the cultural impact of weight stigma. Instead, larger bodies themselves were positioned as implicated in an increased prevalence of eating disorders. One study mentioned how anti-obesity efforts may place children at increased risk for developing eating disorders; however, the article did not problematize such efforts among adult populations (Schur et al., 2000; Smolak et al., 1998). Another level of risk was laid over this discussion of BMI and risk for disordered eating: namely, that binge eating increases the risk for obesity. That binge eating would lead to larger body sizes was herein positioned as a compelling reason for intervention. Stice et al. (2002) use the energy-balance theory of body mass to articulate this risk:

> Because the importance of understanding the risk factors for binge eating is predicated on the evidence that binge eating predicts obesity (Stice et al., 1999), we first attempted to replicate this finding. As expected, the relation between binge eating and risk of obesity onset replicated in this sample, providing increased confidence in the reliability of this effect. Theoretically, episodes of uncontrollable overeating produce a positive energy balance that eventually leads to obesity. (p. 135)

Obesity as health risk/disease. Concordant with dominant discourses that position obesity as a health risk, many of the selected articles described obesity as a disease or significant health risk. Sixteen articles made unproblematized reference to "obesity" or "obese people" and/or discussed the "obesity epidemic." For instance, the first sentence of Wadden et al.'s (2004) article about dieting and eating disorder risk tells us that "America is experiencing an epidemic of obesity" (p. 560). Other articles advise us that "adolescent obesity is associated with serious health problems" (Stice et al., 2002: 131), "levels of obesity are increasing throughout the world" (Mann et al., 2007: 220), and "obesity is a significant health problem among Black women of all socioeconomic strata" (Wilfley et al., 1996: 377); notably, this risk is often mentioned *before* eating disorder risk. We might consider how this finding presupposes that eating disorder recovery entails regaining only enough weight to position oneself within the "normal" BMI range so as to not become a "health risk" or "diseased." Likewise, positing that obesity is a health risk or disease in an eating disorder article discursively positions those with eating disorders as not already fat. An alternative approach would be to see BMI as something other than just a categorizing variable. For instance, we might consider how BMI ranges, which sort participants into underweight/normal weight/overweight/obese, might be seen as related to larger societal understandings of what it means to be living in a larger body (i.e. that occupying a larger body is inherently negative and needs to be controlled or managed).

Valid/reliable BMI. BMI was endorsed as an efficient marker of health status in eight of the studies. While BMI was not necessarily the only measure used to assess health status, these studies positioned BMI as an objective measure of an individual's eating disorder status (or lack thereof) or the use of BMI was not questioned. When rationale for using the BMI was presented, it was generally related to prior research use of the BMI: for example, "prior research has documented that the BMI is a reliable and valid measure of adiposity" (Presnell and Stice, 2003: 167). BMI is often used as a proxy measure for remission or recovery, as well as a marker of risk for eating disorders or predictor of eating disorder treatment outcome. Many articles explicitly mentioned that recovery could be considered to have occurred if BMI is *between* 19 and 24. In the eight articles that endorsed the validity and reliability of BMI as measure, there was no discussion about how BMI was developed as a population health tool, rather than as an indicator of individual fitness. While we noted this explicit endorsement of BMI as valid and reliable health marker in only eight of the studies, combined with the other themes that arose in the articles, this endorsement gestures toward a conceptualization of body size as significant to eating disorders or the lack thereof.

Assumptions about fatness

Assumptions about what it means to be a fat person were present in the eating disorder research articles in this study. Fatness was positioned as something that is controllable, a construction underscored by a weight-based paradigm: health is discursively associated with smaller bodies, whereas larger bodies are seen as unhealthy, problematic, and/or lazy. The articles also binarized and binge/purge type eating disorders and obesity;

furthermore, a larger body size was associated with loss of control overeating or binge eating disorder. The 17 articles containing assumptions about fatness did not unpack the assumed relationship between energy consumption and expenditure and body size.

Fat stereotypes. In 14 articles, authors employed stereotypical constructions of fatness. For instance, fatness was linked to sedentary lifestyles and overeating, implying that weight is necessarily controllable and tied to health behaviors. This discourse is tied to a weight-based paradigm of health that has been described as being problematic for eating disorders (O'Reilly and Sixsmith, 2012). Often, this was done with reference to the need to "balance" concerns about the increasing prevalence of bulimia nervosa and anorexia nervosa against concerns about the "obesity epidemic." For instance, Grabe et al. (2008) write,

> Concerns about eating disorders—specifically, anorexia and bulimia—must be balanced against concerns about the epidemic of obesity in the American population, including the population of American women. Obesity, of course, carries its own set of health risks as well. (p. 471)

This positions restrictive (and binge/purge) type eating disorders as lying on the opposite end of a continuum with overeating. Overeating is positioned as necessarily yielding corpulence and restriction as yielding thinness. These assumptions pervaded research methodologies and results; for instance, one study hypothesized that increased TV viewing would be associated with increased BMI, but this did not bear out in analysis (Tiggeman and Pickering, 1996). Perhaps most prevalent was the assumption that obesity is necessarily the result of "obesogenic environments" that lead to poor diet and exercise (Johnson and Wardle, 2005). In the absence of accessible options for changing these environments, some studies concluded that "until environmental changes can be implemented that might halt the growth of obesity, there will be little option but for individual efforts to resist the lure of the 21st century food supply" (Johnson and Wardle, 2005: 124). Articles described a pursuit of a "healthy ideal" as preferable to the pursuit of a thin ideal (Stice et al., 2006), but left largely unexamined the potential for iatrogenic effects of a focus on dietary quality and exercise (Pinhas et al., 2013). The primary fat stereotype that emerged was, thus, that our environments are "obesogenic," and individuals must develop resiliency to the sway of such environments by pursuing a "healthy ideal" through individual health behaviors. Tacitly, those in large bodies are assumed to not be engaging in health behaviors—elsewise, the environment might be termed "ill-health promoting" rather than "obesogenic."

Binge eating. There is a trend in eating disorder literature of associating binge eating disorder with larger body sizes. The approaches described in the five articles that addressed this topic may promote contradictory messages about body management. The focus in such messaging tends to be to encourage adolescents in particular to achieve "healthy weights" as a strategy of insulation against appearance ideals (Stice et al., 2002, 2006). This perspective implies that individuals are responsible for changing themselves to fit the "healthy ideal" in order to reduce the distance between actual and ideal body size (Stice et al., 2006), rather than encouraging a societal acceptance of a broader array

of body shapes and sizes. Obesity and binge eating were themselves often discursively equated—for instance, articles might begin with a note about the frequency of binge eating in those categorized as overweight. Sentences like "binge eating is a frequent behaviour in overweight adults" (Morgan et al., 2002: 431), commonly foregrounded articles on the topic of binge eating. Some studies only recruited participants with larger body sizes, without assessing for binge eating prior to the study (Morgan et al., 2002). Studies adopting a focus on binge eating often cited only research with short-term follow-up that reinforced their claims that, for instance, low calorie diets result in decreased binge eating (Presnell and Stice, 2003).

Influences on body size

Studies did not, in general, situate participants' experiences in their embodied, lived realities as people with diverse and intersecting social locations. Some did explore aspects of social location; for instance, accounts of body image and culture in relation to body size. However, they stopped short of exploring how multiple marginalizations might contribute to ill health, focusing instead on how socioeconomic status, minority ethnic belonging, and more might act as either risk or protective factors for eating disorders and "obesity."

Body image and obesity. Studies described the relationship between body image and body size in conflicting ways. Some authors highlighted how weight loss is not an effective treatment for negative body image, citing studies that demonstrate that the body image of those who have lost weight remains less positive than that of always-thin folks (Schwartz and Brownell, 2004). However, the framing of the "appropriateness" of negative body image among those in larger bodies (e.g. Smith et al., 1999) warrants further exploration. Several studies referenced how those in larger bodies were expected to feel worse about their bodies (Smith et al., 1999; Stice et al., 2006), and this was not ascribed to the cultural impacts of weight stigma wherein those in larger bodies are repeatedly told that their bodies are unacceptable. Instead, a posited solution to this "accurate cognitive appraisal" was to help those in larger bodies lose a moderate amount of weight in order to more closely approximate the same cultural ideals these articles generally described as unhealthy. There was a subtle endorsement of the "positive" role of negative body image; this was positioned as a future area of research, such that "modifications of body image concerns (may) foster appropriate weight loss behaviours among individuals has not been investigated" (Smith et al., 1999,: 80). The assumption here is that "healthy weight management" that would reduce body dissatisfaction by way of reductions in obesity—despite a lack of evidence to support this correlation.

Culture and obesity. Several of the articles contained reductionist speculations about the associations between race/ethnicity and socioeconomic status and weight. For instance, one article posited that there is a "greater acceptance of higher body weight […] and higher levels of body satisfaction at heavier weights" amongst black women suggesting that this body acceptance may be contributing to a purported epidemic of obesity (Smith et al., 1999: 72). As Wilfley et al. (1996) state,

> Overweight is associated with body dissatisfaction for both black and white women, but black women had lower body dissatisfaction at each level of overweight. So Black women may live in an environment permissive of overweight which may have negative indications for weight control. (p. 386)

Other articles suggested that women of all ethnicities experienced similar levels of body dissatisfaction regardless of measurable body size. While articles noted that cultural body size preferences need to be taken into account in designing eating disorder and obesity programming, the predominant discourse around the meaning of fatness retained a Western orientation: that fatness is a social problem that needs to be managed by individual strategies (e.g. "healthy eating" and exercise, which were seldom unpacked in terms of their cultural meanings or varied definitions). Explorations of ethnic differences do not appear to have been undertaken in the name of better understanding the lived experiences of multiply marginalized people, which might yield insight into how better to support these individuals or provide more culturally competent eating disorder treatment. As Furnham and Baguma (1994) write, "to many Western eyes it appears self-evident from all the media information that obesity is not only considered ugly but is also unhealthy" (p. 88). Rather than describing culture without such a focus as more in tune with the differences between health and size, authors reference the "dangers" associated with "inappropriate" body satisfaction (Smith et al., 1999).

Alternative discourses/anti-diet voice

Many of the articles presented the obesity epidemic as fact and advanced the assumption that restrictive and binge-purge eating disorders are the purview of those in normative and/or thin bodies. However, some articles (9) presented the pursuit of weight loss as ineffectual and as something that causes further health problems both physical and mental. Two articles reported the risk of anti-obesity measures leading to eating disorders later in life for children exposed to them. These articles acknowledged how reducing fat prejudice in society—rather than encouraging fat people to lose weight in order to fit more closely with societal norms—might reduce the incidence of eating disorders. Schur et al. (2000) note the dangers of a cultural preoccupation with dieting: "it is also clear from talking with children that they are immersed in a culture where messages about dieting are prevalent and that they soak up the information that is so widespread in their environment" (p. 80). However, most of the nine articles that did make mention of the ineffectual and risky pursuit of weight loss still mentioned the health risks of obesity or the "obesity epidemic." That some of these nine articles contained messages about both the failure of diets and the dangers of "obesity" illustrates a key point about health (and other) discourses – competing and conflicting discursive frames often coexist or live in tension (Foucault, 1979). When these competing discourses appear within the same article, there was no acknowledgment of the contradiction. Presenting evidence that the pursuit of weight loss/dieting is ineffectual and a potential health risk does not dismantle dominant anti-obesity discourse, but draws into question the most effective way to combat this "problem" or "epidemic." Without a critical examination of these competing discourses, anti-diet messages can still be lost within the larger anti-obesity discourse.

Conclusion

The articles reviewed predominantly presented obesity as a significant health risk—often a health risk against which there was a need to "balance" concerns about rising rates of eating disorders. These articles subtly dichotomized eating disorders and obesity such that those with restrictive eating disorders or binge-purge-type eating disorders were assumed to be normatively sized or thin, and those in larger bodies were presumed to engage in overeating or binge eating, if they experienced eating disorders at all. Body dissatisfaction was formulated as normative among those in larger bodies and pathological in thin people. While many articles noted the negative health effects of body dissatisfaction, several suggested that the way to reduce body size dissatisfaction was for those in larger bodies to lose weight—presumably to more closely approximate normative bodies. Alongside the construction of larger bodies as problematic, weight was largely configured as controllable, despite a simultaneous acknowledgment, in some of the articles, that dieting does not lead to better health. It is worth noting that concerns about the "obesity epidemic" often featured at the beginning of articles, discursively framing the remainder of the content in a way that orients the reader toward the described significance of this public health construction.

Articles did not, in general, implicate social location and spaces of marginalization and privilege as having bearing on people's lived experiences of eating disorders and "obesity." When social location was present in the articles, it was generally configured as a variable impacting body size, health, and eating disorder status. This is not surprising, as in general, psychology is concerned with grouping people into categories and exploring experiences in a comparative approach, for instance, understanding the rate of certain behaviors (like restrictive eating) among White people and people of color. This is not necessarily concerning in and of itself; what is worth noting, however, is how spaces of social belonging were described in reductionist ways in these accounts. For instance, Black women were portrayed as more satisfied with their bodies while these bodies were simultaneously configured as risky bodies. In other words, Black women were seen as being more inclined toward loving their bodies, but these bodies were framed as problematic—thus, body love was seen not as positive, but as supporting ill health and thus in need of fixing. Exploring how bodies have historically been surveilled and disciplined—and how those in certain social locations, such as race and class, have faced more surveillance and discipline than bodies deemed normative—we might question this approach. People from marginalized locations may experience distress in their bodies due to the significant impacts of racialization and other oppressions. Thus, we might consider that it is perhaps not their belonging to a certain group that in and of itself provokes feelings of satisfaction or distress within their bodies, but the way that the social group is treated in society.

Most markedly, these articles speak to a major concern around how larger bodies are constructed in research discourse around eating disorders. Noted risk factors for eating disorders—including body dissatisfaction, internalization of the thin ideal, and dieting attempts—seem only to apply to those who occupy normative bodies in this literature. Those who are living in larger bodies are *expected*, according to the articles, to dislike their bodies: some articles even encouraged them to engage in dieting practices deemed

"healthy weight loss strategies." Given this, we might ask, why is an eating disorder in a thin person now a health behavior in a fat person?

Our analysis is not without limitations. Though we selected articles on the basis of their citation counts, which will hopefully ensure that these articles are at least fairly influential in the field, it is possible that we missed other key articles that contest the framings we present here. Importantly, however, this illustrates the nature of discourse itself—as ever-changing, dynamic, and always in tension (Foucault, 1979). The date range of the articles is also fairly wide, which may be seen as either a limitation or a strength. That little has changed between 1994 and present day does reveal something about the power and tenacity of these discourses. While the selection may have neglected more radical or critical framings of the issue, we also see this as a possible strength, as the lack of citation of these alternative approaches reveals their lesser impact on the field as a whole—something we would wish to challenge. Another limitation is that although we counted mentions of the various themes we illustrated, the extent to which the article focused on each of these themes was not equivalent: for instance, an entire article might focus on culture and obesity, and another might mention it in a single paragraph. Nonetheless, our analysis captures a selection of the eating disorders literature and offers at least a preliminary look at how it frames obesity.

Based on the way that obesity is constructed in these articles, we suggest that biomedical discourses on obesity *contribute to* the thin ideal; but, this thin ideal is nuanced against discourses of healthism that permeate our society. Rather than an ideal of emaciation, it is an ideal of a healthy, productive person, often constructed as morally superior. The moral panic around obesity has led to a broad societal construction of obesity as lying at the root of all ills. That this framing exists within the eating disorders literature encourages us to think critically about how to encourage body acceptance and eating disorder recovery among diverse people. To ensure that clinical and research practice meets the needs of diversely embodied clients, we suggest that eating disorder researchers and clinicians consider how they are using language to describe bodies. We would also encourage the uptake of more HAES-friendly practice that focuses less on the attainment of body norms and more on the promotion of quality of life and wellbeing for people in all kinds of bodies. Becoming more attuned to people's distress, regardless of body size, might help with the recognition and earlier treatment of eating disorders among, particularly, those who occupy multiple marginalized spaces of belonging. Identifying possibly oppressive body standards within the eating disorders field is a key move toward making space for diverse bodies in eating disorder prevention, treatment, and recovery.

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