Article

health:

Health
2017, Vol. 21(1) 21–37

DOI: 10.1177/1363459316674788
journals.sagepub.com/home/hea
SAGE

Treating the binge or the (fat) body? Representations of fatness in a gold standard psychological treatment manual for binge eating disorder

Amy Brown-Bowers, Ashley Ward and Nicole Cormier
Ryerson University, Canada

Abstract
This article reports the results of a Foucauldian-informed discourse analysis exploring representations of fatness embedded within an empirically based psychological treatment manual for binge eating disorder, a condition characterized by overvaluation of weight and shape. Analyses indicate that the manual prioritizes weight loss with relatively less emphasis placed on treating the diagnostic symptoms and underlying mechanisms of binge eating disorder. We raise critical concerns about these observations and link our findings to mainstream psychology's adoption of the medical framing of fatness as obesity within the "gold standard" approach to intervention. We recommend that psychology as a discipline abandons the weight loss imperative associated with binge eating disorder and fat bodies. We recommend that practitioners locate the problem of fat shame in society as opposed to the individual person's body and provide individuals with tools to identify and resist fat stigma and oppression, rather than provide them with tools to reshape their bodies.

Keywords
binge eating disorder, fat studies, obesity, treatment

Corresponding author:
Amy Brown-Bowers, Department of Psychology, Ryerson University, 350 Victoria Street, Toronto, ON M5B 2K3, Canada.
Email: abrownbowers@psych.ryerson.ca

Introduction

Western discourses of anti-fat

Anti-fat discourses are entrenched within Western industrialized cultures, where fatness exists as a medicalized condition termed "obesity" vis-à-vis an alarmist "obesity epidemic" rhetoric. Defined by the World Health Organization (WHO, 2014) as "an escalating global epidemic of overweight and obesity—globesity—[that] is taking over many parts of the world" (para 1), the "obesity epidemic" positions high amounts of body fat as a grave medical risk. While medicine has previously harnessed fatness as a means to assess one's overall health status, the emergence of objective measures such as the body mass index (BMI) led to the discursive production of fatness as a medical condition in and of itself (e.g. Jutel, 2006, 2009).

Medical literature has a long-standing and powerful "repository of truth" on body weight (Jutel, 2009: 67), positioning fatness as increasing risk for several health conditions affecting morbidity and mortality (e.g. National Heart, Lung, and Blood Institute, 1998; WHO, 2000). Discourses of overweight and obesity are constituted via taken-for-granted "health truths," such as being fat[1] is a disease; being fat equates to poor health, while thinness represents optimal health; fat results from a mismatch between caloric intake and physical energy expenditure; and that responsible citizens must maintain a healthy, slim body (Saguy and Riley, 2005; Tischner, 2013). However, contemporary medical theories frame obesity as a multidimensional disease incorporating biochemical processes such as energy regulation, nutrition choices, metabolism and endocrinology, environmental conditions, and genetics. These theories are in partial conflict with the causal presumption contained in the term *obesity*, whose Latin root "*obesus*" translates as "having eaten until fat," as fat is recognized to be more than a consequence of a person's caloric intake. However, the majority of medical theories and practitioners nonetheless position volitional food intake as a primary culprit and weight loss dieting as the front-line remedy.

In addition to its designation as a medical condition, fatness has become a signifier of psychopathology. Obesity, positioned as an addiction within psychiatry (Parr and Rasmussen, 2012; Ziauddeen et al., 2012), was considered for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association (APA), 2013) by the Eating Disorders Work Group; however, this proposal was rejected due to the "complex and incompletely understood etiology" of obesity (Marcus and Wildes, 2012: 434). Binge eating disorder (BED), however, was added to DSM-5 (APA, 2013). DMS-5 diagnostic criteria for BED include the following: (1) Recurrent episodes of binge eating characterized by (a) eating within a 2-hour window an amount of food that is larger than what most people would eat in a similar period of time under similar circumstances and (b) having a sense of lack of control over eating during the episode, and (2) binges are associated with three of the following: eating much more rapidly than normal, eating until uncomfortable full, eating large amounts of food when not physically hungry, eating alone because of feeling embarrassed by how much one is eating, and/or feeling disgusted with oneself, depressed, or very guilty afterward (APA, 2013). In addition, binges must occur at least once a week for 3 months, there must not be associated inappropriate compensatory behavior, and there must be marked distress associated with binge eating (APA, 2013). Research has correlated this diagnosis with fatness

(e.g. Grucza et al., 2007), and the treatment manual analyzed herein reports that the likelihood of BED increases as fatness increases (Agras and Apple, 2007).

Critical fat scholarship

Approaching fatness as an embodied, social phenomenon (e.g. Cooper, 2010; Rice, 2007, 2009, 2015; Rothblum and Solovay, 2009), critical weight studies or fat studies connect the fatness-as-obesity discourse to current practices in medicine and public health, as well to ideological shifts beginning in the 20th century emphasizing individualism, neoliberalism, and "the increasing commodification of health and health care and the 'risk society'" (Hansen and Easthope, 2007: 12). Fat scholars acknowledge that the construct of obesity has been legitimated by medicine, epidemiology research, popular media, and other discursive practices related to health and beauty, which have succeeded in eclipsing the sociocultural and economic contexts of weight (Rothblum and Solovay, 2009). Fat scholarship finds that contemporary approaches to obesity treatment are seriously flawed (Campos, 2004, 2011; Campos et al., 2006; Gard and Wright, 2005; Gibbs, 2005). For example, it has been demonstrated that there are greater health costs and harms associated with being underweight compared to overweight and to some classes of obesity, as well as health benefits to being overweight relative to normal or underweight (Campos et al., 2006). Contrary to the premise that weight loss interventions will improve health via decreased body mass, research has shown significant and long-term weight loss is virtually impossible for the majority of individuals and does not improve morbidity and mortality (Bacon and Aphramor, 2011). Weight loss can produce harmful consequences such as preoccupation with food and body, cycling of weight loss and gain, distraction from efforts to improve wider health determinants, lower self-esteem, eating disorders (EDs), and weight discrimination (Bacon and Aphramor, 2011; Olson et al., 2000; Patton et al., 1999).

Socioculturally, lifestyle rituals regarding weight, health, and the body are influenced by neoliberal depoliticization of health as an individual rather than collective or state responsibility. As Rich et al. (2011) describe, "this approach … reflects a rationalist view of the body where it is assumed 'enterprising' individuals (see Petersen and Lupton, 1996) can achieve control if they make the 'right choices' and modify their bodies and health accordingly" (p. 12). While citizens are ostensibly free to make choices to construct their own life, they nonetheless must enact the *right* choices that reflect accountability and that satisfy their civic obligation to be their best possible self: a thin and fit self. Similarly, discourses of healthism relate to a White, middle-class set of practices (e.g. regular exercise, practice of a particular dietary profile, and keeping an eye on one's weight/figure) believed to prevent obesity and associated illnesses. Healthiest discourses dictate that with strict, regimented adherence to these activities, one can achieve and maintain a properly regulated body and shape.

Anti-fat bias and discrimination

Consequential to their bodies falling outside of a legitimated norm, large individuals face hate, discrimination, and oppression in multiple spheres of life. Anti-fat biases

saturate the health and helping professions (e.g. medicine, psychiatry, psychology, and counseling) and have been identified among mental health professionals (e.g. Agell and Rothblum, 1991; Davis-Coelho et al., 2000; Schwartz et al., 2003; Teachman and Brownell, 2001; Teachman et al., 2003), as well as those working in psychiatry (Brotman et al., 2012; Parr and Rasmussen, 2012), medicine (Pulh and Heuer, 2010), and nursing (Brown, 2006). Specifically within psychology, Rothblum (1999) asserted that "psychologists have a major role in perpetuating errors and inconsistencies related to body weight" (p. 355). This has been clearly demonstrated by psychologists' stigmatizing biases and attitudes toward fat clients. For instance, Agell and Rothblum (1991) solicited the responses of members of the American Psychological Association's Psychotherapy Division on case vignettes with variability in gender and weight. Psychologists endorsed cases of "heavier" people as more physically unattractive, more embarrassed, softer, and kinder. Another study found that members of the American Psychological Association were more likely to diagnose clients labeled obese with an ED and to list the treatment goals of "improve body image" and "increase sexual satisfaction" (even when these issues were not raised by clients themselves) compared to clients with an average body type (Davis-Coelho et al., 2000). Furthermore, obese clients were determined by mental health professionals to have greater psychopathology (see also Young and Powell, 1985), more self-consciousness, less physical attractiveness, and poorer prognoses. Presently, the American Psychological Association (Bennett Johnson, 2012) and The British Psychological Society (2011) have organized obesity working groups targeting multiple aspects of intervention in day-to-day citizen life. Additional evidence of anti-fat biases within psychology can be found in introductory psychology textbooks (e.g. Touster, 2000), and analyses of psychological literature found that content privileged a medical framing of fat, presented fat as a problem to be treated, and failed to recognize oppression experienced by fat people (McHugh and Kasardo, 2012).

Our study

We add to the growing discussion of critical weight scholarship critiquing fat as obesity by examining anti-fat messages embedded within a gold standard psychological treatment manual for BED (Agras and Apple, 2007), a psychological disorder for which overvaluation of weight and shape is a key characteristic (Grilo et al., 2008, 2010, 2012). Our analyses are guided by the following two central research questions: What messages about fat bodies are embedded within and communicated throughout this manual? And, in what ways are psychologists instructed to treat fatness? Our analyses are inspired by our experiences as fat activists and as graduate students in two mainstream psychology programs where fat bodies are primarily visible through the lenses of psychopathology and behavioral medicine. Analysis revealed a dominant discourse (i.e. a *weight loss imperative*) that was buttressed by four discursive themes: (1) BED is positioned as a disorder of (over)weight, (2) as a psychiatric problem of poor self-management, (3) as a medical emergency, and (4) treatment is framed as a fat intervention requiring patient self-control.

Method

Theoretical lens and analytic approach

This work falls within the umbrella of social constructionism (Burr, 2003). A critical stance is adopted toward knowledge and toward the position that facts (i.e. fat is always unhealthy, fat is a medical condition) are based on objective, unbiased observation of the world. Rather than a singular monolithic knowledge surrounding any given topic, there always exists a multitude of knowledges, interpretations, and constructed meanings jockeying for position as the dominant knowledge. Language is viewed as actively constituting meaning and experience as opposed to neutrally and transparently conveying meanings and experiences that exist prior to being put into words (Willig, 2001). Thus, our perspective places emphasis on discourse and the discursive construction of objects of analysis.

Foucauldian discourse analysis

Our work was informed by the principles of Foucauldian discourse analysis (FDA; Parker, 2002). We adopted the meaning of discourse articulated by Foucault; that is, discourses are "practices that systematically form the objects of which they speak" (Foucault, 1972: 49). Discourses are frames of reference through which we come to understand and make sense of things in the world, offering a conceptual backdrop against which we can derive meaning and organize our experiences (Burr, 2003). There are always multiple discourses converging upon any given thing, which are all vying for dominance. Discourses closely aligned with institutions (e.g. medicine, government, and science) tend to be offered privileged status, while other discourses are positioned as peripheral, less valid, or abject (Burr, 2003: 76). FDA asks what kinds of subjects or possibilities for self-identity are produced through discourses and how this occurs (Arribas-Ayllon and Walkerdine, 2008). These *subject positions* are shaped by the discourses available to people at any given point in time. Subject positions shape how a person comes to experience and make sense of themselves, others, and the world and are associated with actions, determining what is possible for a person to do or not do (e.g. Davies and Harré, 1990). For example, the subject position of the obese patient is associated with prescriptions to diet, regulate food intake and exercise levels, intensified medical scrutiny and observation, and fat shaming.

Finally, central to FDA is the analysis of power and the relationship between knowledge and power (Arribas-Ayllon and Walkerdine, 2008; Willig, 2001). This involves identifying and exploring mechanisms of power that operate within and through discourses and examines the ways in which power moves, is accessed, and is made available or not available to people through the various subject positions that people adopt in relation to discourses. Discourses more closely aligned with science, medicine, and empiricism tend to be afforded greater truth status and consequently greater power. Discourses are thus linked to power, knowledge, and material practices in day-to-day life (Foucault, 1977). The subject positions of obese patient versus fat person are associated with different possibilities of existence, self-identity, knowledge, and power. The obese

patient necessitates expert surveillance to decode and treat her necessarily problematic body, whereas a fat person does not necessarily require medical/expert help, and she is the expert on her own body's needs and well-being.

Selecting our material for analysis

We selected our material by asking the following questions: What published treatment manuals for BED exist, and which are positioned as evidence based within the discipline of psychology in North America? Which manuals do the Canadian and American Psychological Associations endorse, and which are considered the "gold standard" treatment for BED? Our search yielded a small group of published treatment manuals. We selected *Overcoming Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder Therapist Guide* (Agras and Apple, 2007) because it is part of the TreatmentsThatWork™ series, which is touted as a cutting-edge best-practice resource. The American Psychological Association recognizes the series through their partnership with PsychoEducational Resources, Inc., which provides psychologists with Continuing Education (CE) credits. Thus, this manual has strong institutional endorsement and is positioned as the gold standard within psychology. Furthermore, the manual outlines a cognitive-behavioral treatment (CBT) protocol, one of only two psychotherapeutic modalities considered to be *empirically supported* treatments for BED by the American Psychological Association. The American Psychological Association's Division 12 website (www.div12.org, 2016) indicates that CBT for BED has *strong* research support with regard to clinical efficacy and effectiveness. As such, CBT for BED is imbued with an authoritative stance within medical and psychological discourse. The manual contains 16 chapters and 144 pages and offers step-by-step instructions on patient assessment and treatment. The treatment section is divided into three units: behavior change, identifying binge triggers, and maintaining change.

Analyses

A weight loss imperative

BED: a disorder of (over)weight. BED is framed as a disorder of weight, and the manual introduces weight as a central preoccupation and core feature of BED early on: "The average reported age for the onset of binge eating in both bulimia nervosa and binge-eating disorder is 19 years, usually followed a few months later by purging in bulimia nervosa, and by gradual weight gain in binge-eating disorder" (Agras and Apple, 2007: 5–6). The feature distinguishing BED from Bulimia is thus framed as fatness, and weight gain is presented as an indicator of psychopathology. Further in, the manual explicitly establishes weight as the core "problem" in BED: "Binge-eating disorder presents a problem for treatment because of the accompanying overweight or obesity in most cases" (Agras and Apple, 2007: 16).

The manual constructs "most" patients with BED as overweight or obese: "Binge-eating patients generally range from overweight to seriously obese" (p. 56). The use of the term "overweight" conveys that there is a "correct" weight for patients with BED, a target

that "most" of them fail to achieve or maintain. The framing of BED as a disorder of weight continues in a section that reviews evidence for various treatments: "There is, at present, some controversy about whether weight loss therapy alone may be as effective as CBT in treating binge-eating disorder" (Agras and Apple, 2007: 12). And further in,

> More recently, there has been considerable interest in the use of anti-epileptic drugs, which appear to lead to decrements in both binge eating and weight … Given the effects on weight, these medications may eventually find a significant place in the treatment of binge-eating disorder. (Agras and Apple, 2007: 16)

Here, treatment efficacy is equated with weight loss. Treatments are considered potentially efficacious for BED if they result in weight reduction, and this is considered a stand-alone marker of treatment success. In a comparison of different treatments for BED (e.g. therapist-assisted treatment vs guided self-help based on CBT combined with weight loss treatment), the manual states, "… unfortunately, weight loss was minimal and identical across treatments; therefore, it is possible that the specific effect of weight-loss treatment was absent in this study" (p. 12). The use of the term "unfortunately" frames BED as a disorder of weight and identifies fatness as a central target for treatment. In their review of treatments, the authors presumably hoped to isolate and identify the specific treatment component that would target weight in patients with BED. The data, "unfortunately," did not provide a clear solution for the "problem" of weight in these patients. Interestingly, there is no mention of how either approach would address the cognitive and behavioral diagnostic symptoms of BED. It is instead assumed that fat *is* the disorder, and shedding it is the solution.

BED: a psychiatric problem of poor self-management. BED is framed as a psychiatric problem characterized by lack of (self) control and the patient's corresponding failure to achieve emotional and physical (i.e. weight) stability:

> Binge eating … is characterized by a sense of loss of control over eating. This sense of losing control and being unable to stop eating may be associated with changes in mood and conflicting thoughts about food. Negative transient moods of anxiety, anger, or depression that trigger a binge often result from unsatisfactory interpersonal interactions. There may be an overwhelming urge to eat, accompanied by positive feelings sometimes described as a thrill or as excitement, or negative feelings such as anxiety, anger, guilt, depression, or boredom. (Agras and Apple, 2007: 4–5)

BED is linked with emotional instability leading to poor impulse control (e.g. binge eating). Similarly, a fat body is associated with out-of-control eating and emotional instability. The patient with BED is placed upon an inevitable trajectory of "gradual weight gain" (p. 6) because of her failed self-discipline with respect to food and exercise: "… patients who do not abstain from binging will continue to gain weight" (Agras and Apple, 2007: 31). Also,

> Unlike the patient with bulimia nervosa, most patients with binge-eating disorder do not exercise regularly, if at all … the most promising and least costly exercise program is brisk

> walking for at least 30 minutes a day no fewer than 4 days a week. For the patient who has never exercised, develop a graduated schedule. For example, 10 minutes of moderate-paced walking four times a week, or 30 minutes of moderate-paced walking one or two times a week. (Agras and Apple, 2007: 66)

The patient is presented as rarely or never exercising, her body passive, inert. Here, her fatness is a result of poor life habits, specifically failure to engage in sufficient exercise. The patient is positioned as lazy, an irresponsible steward of her physical/psychological health, and in need of an expert "push" to produce momentum. The manual offers solutions for this pathological lack of self-control through "sensible" administration of self-surveillance and self-management protocols: "It is clear that stopping binge eating and implementing a sensible weight-control program allows these patients to lose a little weight, but, more importantly, it permits them to stabilize their weight" (Agras and Apple, 2007: 56). Absent from the manual are non-pathologizing representations of fatness (e.g. fat as acceptable, normal, healthy, stable, or consistent with self-control and self-care). There are many missed opportunities where the therapist might have been encouraged to challenge and correct dominant (and often factually incorrect) anti-fat assumptions, anti-fat beliefs, and negative constructions of fat individuals. The following excerpt demonstrates once such missed opportunity:

> The patient may raise concerns at this point about potential weight gains using the prescribed regimen. Explain that the studies published to date show that, on average, patients gain at most a few pounds when they begin to regularize their eating patterns. This weight is usually due to the patient's overcoming dehydration (that is it is "water weight"). (Agras and Apple, 2007: 41)

Here, the manual encourages the therapist to reinforce the patient's belief that fat is bad and weight gain is negative by reassuring her either that weight gain is unlikely and minimal, and may be reversible (if patients are strictly adherent), or that any weight gain is innocuous and temporary (i.e. mostly water weight). The manual might have encouraged exploration of *why* the patient is worried about weight gain and facilitated fruitful identification and exploration of the stigma, discrimination, and oppression faced by fat people. Rather than acknowledging and targeting fat oppression and fat stigma, or exploring the question of why it might be so terrifying to be fat in today's sociocultural context, the manual encourages the therapist to collude with the patient in framing fat as problematic.

The treatment proffers the hope of body weight stabilization or reduction via "a sensible weight-control program." A stable or shrinking body mass is equated with reinstatement of wellness. Weight takes on central importance in recovery—it is both a means to and evidence of wellness. Notably, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR) diagnostic criteria for BED, which are included in the manual as a guide for assessment and treatment planning (Agras and Apple, 2007), do not include weight or BMI. Rather, core symptoms include binging, feelings of dyscontrol, embarrassment, disgust, depression, and guilt. In addition, the manual contains an illustrated model of factors thought to maintain both binging and purging, including negative feelings, low self-esteem, and weight and shape concerns (Agras and Apple, 2007: 19). Thus, cognitive factors are presented as core components of BED psychopathology and important targets of treatment (e.g. p. 19), and

the model does not include weight as an etiological or maintaining factor in BED. The medical crisis attributed to fatness provides this justification for the sharp emphasis on weight loss.

BED: a medical emergency. BED patients are designated as "obese" (or approaching "obesity") and in urgent need of intervention to address their pathologically fat bodies. They are constructed as at risk for myriad conditions because of their weight, which they must lose in order to restore good health. The fat body is framed as the core danger of BED:

> Patients with binge-eating disorder tend to steadily gain weight, and many will become obese. It has been shown that as adiposity increases, the percentage of patients diagnosed with binge-eating disorder will increase. In most clinical samples, one quarter to one third of overweight individuals will meet criteria for binge-eating disorder. Hence, the medical complications associated with this disorder are those associated with overweight and obesity. It is now thought that binge-eating disorder and obesity are separate but overlapping disorders … (Agras and Apple, 2007: 28–29)

Yoking BED and obesity together frames BED as a medical crisis. Medical discourses of obesity and risk are incited to highlight the urgency of addressing the client's fat body, and the numerous conditions inscribed upon it:

> Some of the medical problems associated with overweight and obesity are listed here, and many individuals with binge-eating disorder and over-weight or obesity have more than one of these conditions … Medical risks include:
>
> -High cholesterol levels (or high levels of triglycerides)
>
> -High blood pressure
>
> -Type 2 diabetes
>
> -Heart disease (coronary artery disease)
>
> -Stroke
>
> -Gallbladder disease
>
> -Sleep apnea
>
> -Some cancers (endometrial, breast, and colon). (Agras and Apple, 2007: 29)

The fat body is thus constituted as a medical emergency. The patient with BED is saddled with both excess weight and heightened risk of numerous diseases. Her weight weighs heavily upon the medical community, who must care for her and manage her health problems.

Fat intervention: exercising self-control. Further underscoring the weight loss imperative discourse, weight loss strategies such as food restriction are frequently recommended in the treatment: "Begin also to point out items on the patient's completed Daily Food Records, indicating fatty foods that might be reduced. These changes should be introduced gradually" (Agras and Apple, 2007: 74). Also, "In addition to maintaining a regular pattern of

meals and snacks, such patients should also be …, eating more appropriate foods at each meal (no leftover cake or desserts for breakfast), and participating in a regular exercise program" (Agras and Apple, 2007: 81–82).

These excerpts position the BED as a disorder of weight. Patients are framed as problematically fat, overconsuming, and in need of expert advice on how to restrict and control consumption of dangerous foods. Recovery targets the patient's fat body as the core site for change. An infantilizing subject position is evident here. The patient is depicted as lacking awareness about "appropriate" eating and exercise. She makes key errors in self-management such as ingesting the wrong foods (e.g. cake) at the wrong time (e.g. breakfast). The clinician's job is to point out the patient's eating errors so that she can begin to lose weight/recover from her fatness:

> [Homework for session 4]: Instruct the patient to continue self-monitoring using the Daily Food Record. Instruct the patient to continue to weigh herself weekly and to record her weight on the Daily Food Record. Direct the binge-eating patient to continue with the agreed-upon exercise routine. (Agras and Apple, 2007: 75)
>
> **
>
> For patients who want to lose weight and who present with desire to lose weight, clinical experience suggests that such patients will tend to gain weight during cognitive-behavioral treatment. To prevent this, it is suggested that some elements of a weight control program be added to the first phase of CBT. These should include weekly weighing … to track any weight gains; introduced by a mild exercise program and adhering to that program; and gradually reducing fat in the diet. These elements appear to stop substantial weight gain during the course of CBT. (Agras and Apple, 2007: 31)

The salient treatment goal is to address to the patient's weight (as opposed to her body shame, for example); weight is the most heavily emphasized outcome variable and the ultimate marker of treatment success. The importance of weekly weighing, daily tracking of exercise, a prescribed exercise regimen, restriction of high-calorie and high-fat foods, and restricted portions are all repeatedly stressed to the clinician. The patient is recruited into a practice of self-monitoring and self-scrutiny to identity her lapses in judgment and self-control. It is presumed that a lack of awareness about her weight and eating habits is part of the patient's problem:

> For patients with binge-eating disorder (but not those with bulimia nervosa), it is suggested that they plot their weight each week on the Weight Chart on page 55. This will provide the longer-term feedback that will help them control their weight. This chart is not included in the patient workbook because the patient with bulimia nervosa should not plot her weight: the objective for bulimics is to lessen their concern about weight. (Agras and Apple, 2007: 56)

The subtext here is that the patient with BED should be *increasing* her concern about her weight—and this is achieved through the use of a weight monitoring practice considered dangerous for non-fat ED clients. In the pecking order of problems, the patient's fat body ranks higher than her body shame. Yet the emphasized weight-control strategies (e.g. food restriction, increased weight monitoring) are contraindicated for the treatment

of core symptoms of BED. The manual clearly states that dietary restriction is a key mechanism driving BED pathology, and in particular that restriction increases the likelihood of individual binge eating episodes and perpetuates the psychopathology as a whole: "… a vicious cycle leads from dietary restriction to binge eating (and purging) and back to dietary restriction. Negative affect predisposes one to binge eating, particularly in the presence of dietary restriction" (Agras and Apple, 2007: 19; see also p. 91).

The therapist is instructed to explain that the more the patient fears and avoids certain foods, the more likely she is to binge on those foods and that the best way to reduce the compulsion to binge on a particular food is to eat it more frequently so that the food loses its feared/bad/special status. However, the manual also contains many instances where restriction is promoted as a core treatment strategy for the patient with BED: "Begin also to point out items on the patient's completed Daily Food Records, indicating fatty foods that might be reduced. These changes should be introduced gradually" (Agras and Apple, 2007: 74); "… such patients should also be cutting down slowly on high-calorie foods" (Agras and Apple, 2007: 81–82); and "Patients with binge-eating disorder tend to put on weight during cognitive-behavioral therapy; hence, it is important to combine some of the element of a weight-control program with cognitive-behavioral therapy" (Agras and Apple, 2007: 66).

Even though the advice presented in these excerpts contradicts the explanatory model for BED (i.e. restriction as a key mechanism fueling BED), restriction and heightened emphasis on weight are advised here in service of weight loss. Cutting down on "high-calorie foods" is offered as a therapeutic target. This is an example of weight loss being prioritized over treatment goals that are relevant to BED pathology (i.e. binge eating episodes, guilt, and preoccupation with weight and shape) and, indeed, prioritized in ways that directly impede these latter treatment goals.

The manual states that "… distorted thinking about food intake, weight, and shape … may be maintaining the disorder" (Agras and Apple, 2007: 44) and that treatment must target these cognitive factors. Yet the manual also reinforces and promotes these concerns in myriad ways. Body shame is a less important treatment target for the BED patient than body makeover (in the form of weight loss). It is unclear how increased restriction and self-surveillance are relevant to recovery from BED or how they will facilitate reductions in binge eating, shame, and preoccupation with body and weight. The manual endorses the very same practices—food restriction and positioning certain foods and eating practices as "bad"—that it emphatically problematizes elsewhere. Strategies that promote weight loss are privileged over strategies that target the DSM diagnostic symptoms of the disorder or its proposed causal and maintenance mechanisms. This troubling observation speaks to how powerful the medicalized and weight loss imperative discourses are—both this study's authors and a body of scholarship acknowledge the failure of this approach, yet it cannot be helped—fat bodies must be brought back into control.

Discussion

This study analyzed a therapist manual for a gold standard psychological treatment for BED (Agras and Apple, 2007) for representations of and messages about fatness. We employed a Foucauldian discourse analytic framework (Foucault, 1972, 1977; Potter, 2003). The overarching discourse identified was *a weight loss imperative.* This dominant

discourse was supported by four discursive themes: (1) BED is positioned as a disorder of (over)weight, (2) as a psychiatric problem of poor self-management, (3) as a medical emergency, and (4) treatment is framed as a fat intervention requiring patient self-control. The central discourse was also reinforced through patient subject positions (e.g. the BED patient as obese, lazy, out of control, and uninformed) and through reproduction of anti-fat stances (e.g. fat is pathological, the fat person is in need of urgent weight-control intervention). We see links between the way in which fat is framed in the treatment manual and the way it is framed more broadly. Fatness, referred to primarily as obesity within medicine, is positioned as a pathological epidemic that is rapidly spreading around the world (e.g. WHO, 2014). Fat represents a state of ill health; thus, thin becomes a proxy for good health. Losing weight is consequently understood as the means to good health and recovery from pathology.

This promise of physical transformation via self-management practices can be linked to neoliberalism. The neoliberal framing of fat contends that fat is a product of individual failure in self-managing caloric intake and exercise, that fat people are simultaneously ill and responsible for their illness, and that fat people can become thin/healthy through appropriate techniques and efforts (e.g. Saguy and Riley, 2005; Tischner, 2013). Thus, being fat is both a symptom of failed self-regulation and a cause of myriad preventable maladies. Our findings are notably similar to those of other researchers applying a critical lens to weight-centric interventions (e.g. Lupton, 2014).

The manual is positioned as a solution to the fat patient's dangerous weight problem and offers restoration of mental and physical health. Psychological intervention is positioned as a responsible and necessary remedy to the medical risks facing the fat patient. This is representative of a broader movement within psychology to *take on* obesity (e.g. Bennett Johnson, 2012; The British Psychological Society, 2011). Specifically, we see psychology adopting the medical frame for obesity and advocating for individualized behavioral change as a solution. Framing fat as a diseased state curable through individual behavioral intervention legitimizes a treatment, such as Agras and Apple's (2007), emphasizing weight loss strategies such as food restriction, weekly weight monitoring, and prescribed exercise. The transformation from a fat body to a thin body is positioned as within the realm of possibility for each individual via self-management practices. Given the large and increasing body of evidence problematizing the central claims underpinning the war on obesity, it is concerning that the manual reproduces such claims without either substantiating them with empirical evidence or addressing empirical literature that disputes these claims. This raises ethical concerns about an ED treatment manual that emphasizes weight loss strategies and outcomes.

Other researchers have noted a similar lack of critical review of evidence underpinning many weight-based claims, as well as an overreliance on often-repeated truisms about weight without corresponding evidence in analyses of obesity interventions (Lupton, 2014; O'Reilly and Sixsmith, 2012; Tischner, 2013). For example, O'Reilly and Sixsmith (2012) noted that the sources of weight-related public policy claims were most often experts or studies containing significant methodological flaws, "rather than drawing validity from research regarded by mainstream academia as evidence-based" (p. 101). Likewise, Lupton (2014) noted the lack of critical review of evidence underpinning two anti-obesity campaigns. Tischner (2013) has noted that claims about weight and fat in academic and lay contexts are taken at face value and seem to be exempt from the burden

of scientific proof. She writes, "'Facts' about fat seem to enjoy immunity from scrutiny" (Tischner, 2013: 13). We see this "immunity" and "lack of scrutiny" in the treatment manual. We hypothesize that this serves as a veil concealing unquestioned anti-fat beliefs, biases, and long-perpetuated myths about weight that have been adopted and are endorsed by mainstream psychology. We see this as evidence of just how enthusiastically and uncritically psychology has taken up the rhetoric of the war on obesity and how uncontested the belief remains in mainstream psychology that fat is pathological.

The manual is silent about the fat stigma, fat oppression, or fat shaming that many fat individuals experience in multiple spheres (e.g. Agell and Rothblum, 1991; Davis-Coelho et al., 2000; Schwartz, et al., 2003; Teachman and Brownell, 2001; Teachman et al., 2003). In addition, the manual fails to acknowledge the physical and psychological harms of experiencing stigma as an alternative explanation for the harms purportedly caused by fat (Friedman et al., 2005; O'Reilly, 2011). Nowhere is there an acknowledgement or exploration of the larger sociocultural context of being fat and the aversive social conditions bearing upon the fat patient with BED. While fear of fat seems to underlie many EDs, it follows that targeting anti-fat discourse ought to be included in ED treatments. However, the manual reinforces an anti-fat stance by conveying a weight loss imperative and by privileging weight loss as a marker of recovery.

Overall, the manual frames fatness as both psychopathology and disease. Fat is circularly positioned as a disease that contributes to psychopathology (e.g. the patient has poor body image or low self-esteem because they are obese) and as psychopathology that contributes to disease. Weight loss is framed as the means to recovery, and efforts and activities to achieve weight reduction are privileged throughout the manual. To answer our central research question, we conclude that the manual places greater emphasis on treating and targeting the *fat body* and far less emphasis on treating *BED*. The profound embeddedness of anti-fat discourses in the manual suggests that there are serious logical blind spots in the empirically based approach to conceptualizing and treating BED, disrupting the claims of this "gold standard" intervention as the safe, effective, and credible solution. Although it is said that food restriction is causal for the emergence and maintenance of BED, the manual itself employs food restriction as a prime intervention mechanism. Fat shaming and stigma are simultaneously ignored and reproduced by this approach. We see this as an ethical concern that ought to be addressed by the discipline of psychology.

Recommendations

We suggest that psychology as a discipline abandon the weight loss imperative associated with BED and fat bodies, and forego behavioral weight loss treatments that target the client's body size as a marker of outcome. We recommend that practitioners critically address myths about fat by drawing from fat studies and critical weight studies scholarship (e.g. Bacon and Aphramor, 2011; Campos, 2004, 2011; Rothblum and Solovay, 2009). We further recommend a shift in emphasis in psychotherapies for clients presenting with weight-related distress (BED diagnoses or otherwise) to targeting myths about weight. We would like to see prioritization of content on anti-fat bias; experiences of fat shaming, stigma, and oppression experienced by fat people in our current sociocultural climate; and for therapists to address the ways in which our society's continual barrage of negative messaging is detrimental to the psychological and physical well-being of fat people. Thus,

we would like psychology to locate the problem of fat shame in society, as opposed to the individual person's body (and/or mind). Stemming from this, we would like practitioners to provide individuals with tools to identify, understand, and resist shame, stigma, and oppression, rather than provide them with tools to reshape their bodies.

To move beyond the weight loss imperative in therapy (LaMarre and Rice, 2015), and in broader culture (2015), it is important to open up possibilities for the different ways in which fatness may be accepted and explored (Rice, 2015). One example of resistance to the importance of body size is *Health at Every Size* (Bacon, 2010), a public health initiative that emphasizes nutrition, enjoyment of food, and pleasure in movement, while disabusing the erroneous assumption that one can accurately gauge a person's health on the basis of her or his weight. Rice (2015) suggests an ethical approach to body pedagogy, incorporating feminist poststructuralist principles and moving beyond binary good/bad norms of healthy/unhealthy bodies and toward creative ways of exploring physicality and difference in body. Disability arts have been an exciting outlet to explore representations of fatness, qualifying its fluidity, vitality, lushness, and buoyancy. Some argue for a feminist aesthetic, characterized by inclusive ideas of beauty and sensory pleasure (e.g. Frueh, 2001) to explore different dimensions of aesthetic such as temporal beauty or beauty as an experience of aliveness rather than an aspiration.

We suggest that manuals written for practitioners working with BED and other clients with eating and weight-related concerns include content for therapists on the importance of identifying and exploring their own anti-fat biases. We posit that it is impossible to not absorb anti-fat biases in the current sociocultural milieu, and we believe there is an ethical imperative for treatment providers to evaluate, explore, and identify their own attitudes about fatness given the powerful negative effects of fat shaming and the both subtle and overt ways in which anti-fat attitudes can seep into treatment. Finally, we recommend enriching psychology's understanding of fat oppression and anti-fat stigma by spearheading interdisciplinary research initiatives incorporating contributions from sociology, critical disability studies, fat studies, feminist/women's studies, and social work. It is crucial to legitimate the subjectivities and embodied experiences of fat-identified participants, and particularly fat women, as valid sources of knowledge informing the theory and practice of psychology. In doing so, we will be better able to respect and facilitate the unique and diverse needs, barriers, strengths, and goals of fat people as they access and interact with the medical and mental health systems.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Note

1. Terms such as "fat" and "fatness," are descriptors of physical diversity. Re-claiming the term "fat" resists the medicalizing and stigmatizing effects of "obese" and "obesity," whose Latin root term "obesus" translates into a causal proclamation: "having eaten until fat."

References

Agell G and Rothblum ED (1991) Effects of clients' obesity and gender on the therapy judgments of psychologists. *Professional Psychology: Research and Practice* 22: 223–229.

Agras WS and Apple RF (2007) *Overcoming Eating Disorders: A Cognitive-Behavior Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder (Therapist Guide)*. 2nd ed. New York: Oxford University Press.

American Psychiatric Association (APA) (2013) *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: APA.

Arribas-Ayllon M and Walkerdine V (2008) Foucauldian discourse analysis. In: Willig C and Stainton-Rogers W (eds) *The SAGE Handbook of Qualitative Research in Psychology*. Thousand Oaks, CA: SAGE, pp. 91–108.

Bacon L (2010) *Health at Every Size: The Surprising Truth About Your Weight*. 2nd ed. Dallas, TX: BenBella Books.

Bacon L and Aphramor L (2011) Weight regulation: A review of the evidence for a paradigm shift. *Nutrition Journal* 10(9): 1–13.

Bennett Johnson S (2012) Addressing the obesity epidemic: Why should psychologists care? *Monitor on Psychology* 43(4): 5.

Brotman AW, Stern TA and Herzog DB (2012) Emotional reactions of house officers to patients with anorexia nervosa, diabetes, and obesity. *International Journal of Eating Disorders* 3: 71–77.

Brown I (2006) Nurses' attitudes towards adult patients who are obese: Literature review. *Journal of Advanced Nursing* 53(2): 221–232.

Burr V (2003) *An Introduction to Social Constructionism*. 2nd ed. London: Routledge.

Campos P (2004) *The Obesity Myth: Why America's Obsession with Weight is Hazardous to Your Health*. New York: Gotham Books.

Campos P (2011) Does fat kill? A critique of the epidemiological evidence. In: Rich E, Monaghan L and Aphramor L (eds) *Debating Obesity: Critical Perspectives*. New York: Palgrave Macmillan, pp. 36–59.

Campos P, Saguy A, Ernsberger P, et al. (2006) The epidemiology of overweight and obesity: Public health crisis or moral panic? *International Journal of Epidemiology* 35(1): 55–60.

Cooper C (2010) Fat studies: Mapping the field. *Sociology Compass* 4(12): 1020–1034.

Davies B and Harré R (1990) Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour* 20(1): 43–63.

Davis-Coelho K, Waltz J and Davis-Coelho B (2000) Awareness and prevention of bias against fat clients in psychotherapy. *Professional Psychology: Research and Practice* 31(6): 682–684.

Foucault M (1972) *The Archaeology of Knowledge*. New York: Harper & Row.

Foucault M (1977) *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.

Friedman KE, Reichmann SK, Costanzo PR, et al. (2005) Weight stigmatization and ideological beliefs: Relation to psychological functioning in obese adults. *Obesity Research* 12: 907–916.

Frueh J (2001) *Monster/Beauty: Building the Body of Love*. Berkeley, CA: University of California Press.

Gard M and Wright J (2005) *The Obesity Epidemic: Science, Morality and Ideology*. New York: Routledge.

Gibbs WW (2005) Obesity: An overblown epidemic? *Scientific American* 292: 70–77.

Grilo CM, Hrabosky JL, White MA, et al. (2008) Overvaluation of shape and weight in binge eating disorder and overweight controls: Refinement of a diagnostic construct. *Journal of Abnormal Psychology* 117(2): 414–419.

Grilo CM, Masheb RM and White MA (2010) Significance of overvaluation of shape/weight in binge-eating disorder: Comparative study with overweight and bulimia nervosa. *Obesity* 18(3): 488–504.

Grilo CM, White MA and Masheb RM (2012) Significance of overvaluation of shape and weight in an ethnically diverse sample of obese patients with binge-eating disorder in primary care settings. *Behaviour Research and Therapy* 50(5): 298–303.

Grucza RA, Przybeck TR and Cloninger CR (2007) Prevalence and correlates of binge eating disorder in a community sample. *Comprehensive Psychiatry* 48(2): 124–131.

Hansen EC and Easthope G (2007) *Lifestyle in Medicine*. London: Routledge.

Jutel A (2006) The emergence of overweight as a disease entity: Measuring up normality. *Social Science & Medicine* 63(9): 2268–2276.

Jutel A (2009) Doctor's orders: Diagnosis, medical authority and the exploitation of the fat body. In: Wright J and Harwood V (eds) *Biopolitics and the "Obesity Epidemic": Governing Bodies*. New York: Routledge, pp. 60–77.

LaMarre A and Rice C (2015) Normal eating is counter-cultural: Embodied experiences of eating disorder recovery. *Journal of Community & Applied Social Psychology* 26: 136–149.

Lupton D (2014) "How do you measure up?" Assumptions about "obesity" and health-related behaviors and beliefs in two Australian "obesity" prevention campaigns. *Fat Studies: An Interdisciplinary Journal of Body Weight and Society* 3(1): 32–44.

McHugh MC and Kasardo AE (2012) Anti-fat prejudice: The role of psychology in explication, education and eradication. *Sex Roles* 66(9–10): 617–627.

Marcus MD and Wildes JE (2012) Obesity in DSM-5. *Psychiatric Annals* 42(11): 431–435.

National Heart, Lung, and Blood Institute (1998) *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*. Bethesda, MD: National Institutes of Health.

Olson MB, Kelsey SF, Bittner V, et al. (2000) Weight cycling and high-density lipoprotein cholesterol in women: Evidence of an adverse effect: A report from the NHLBI-sponsored WISE study. *Journal of the American College of Cardiology* 36(5): 1565–1571.

O'Reilly C (2011) *Weighing in on the Health and Ethical Implications of British Columbia's Weight-Centered Health Paradigm*. Victoria, BC: Simon Fraser University.

O'Reilly C and Sixsmith J (2012) From theory to policy: Reducing harms associated with the weight-centered health paradigm. *Fat Studies: An Interdisciplinary Journal of Body Weight and Society* 1(1): 97–113.

Parker I (2002) *Critical Discursive Psychology*. London: Palgrave.

Parr J and Rasmussen N (2012) Making addicts of the fat: Obesity, psychiatry and the "fatties anonymous" model of self-help weight loss in the post-war United States. In: Netherland J (ed.) *Advances in Medical Sociology: Critical Perspectives on Addiction*, vol. 14. Bingley: Emerald Group Publishing Limited, pp. 181–200.

Patton GC, Selzer R, Coffey C, et al. (1999) Onset of adolescent eating disorders: Population based cohort study over 3 years. *British Medical Journal* 318: 765–768.

Petersen A and Lupton D (1996) *The New Public Health: Health and Self in the Age of Risk*. Thousand Oaks, CA: SAGE.

Potter J (2003) Discourse analysis and discursive psychology. In: Camic PM, Rhodes JE and Yardley L (eds) *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. Washington, DC: APA, pp. 73–94.

Puhl RM and Heuer CA (2010) Obesity stigma: Important considerations for public health. *American Journal of Public Health* 100(6): 1019–1028.

Rice C (2007) Becoming "the fat girl": Acquisition of an unfit identity. *Women's Studies International Forum* 30: 158–174.

Rice C (2009) How big girls become fat girls: The cultural production of problem eating and physical inactivity. In: Malson H and Burns M (eds) *Critical Feminist Approaches to Eating Dis/orders*. London: Psychology Press, pp. 97–109.

Rice C (2015) Rethinking fat: From bio- to body-becoming pedagogies. *Cultural Studies ↔ Critical Methodologies* 15(5): 387–397.
Rich E, Monaghan LF and Aphramor L (2011) *Debating Obesity: Critical Perspectives*. Houndmills: Palgrave Macmillan.
Rothblum E (1999) Contradictions and confounds in coverage of obesity: Psychology journals, textbooks, and the media. *Journal of Social Issues* 55: 355–369.
Rothblum E and Solovay S (eds) (2009) *The Fat Studies Reader*. New York: New York University Press.
Saguy AC and Riley KW (2005) Weighing both sides: Morality, mortality, and framing contests over obesity. *Journal of Health Politics, Policy and Law* 30(5): 869–923.
Schwartz MB, O'Neal H, Brownell KD, et al. (2003) Weight bias among health professionals specializing in obesity. *Obesity Research* 11(9): 1033–1039.
Teachman BA and Brownell KD (2001) Implicit anti-fat bias among health professionals: Is anyone immune? *International Journal of Obesity* 25(10): 1525–1531.
Teachman BA, Gapinski KD, Brownell KD, et al. (2003) Demonstrations of implicit anti-fat bias: The impact of providing causal information and evoking empathy. *Health Psychology* 22(1): 68–78.
The British Psychological Society Obesity Working Group (2011) *Obesity in the UK: A Psychological Perspective*. Leicester: The British Psychological Society.
Tischner I (2013) *Fat Lives: A Feminist Psychological Exploration*. New York: Routledge.
Touster LO (2000) Fat oppression: The complicity of psychology. *Dissertation Abstracts International* 61(4–B): 2225.
Willig C (2001) *Introducing Qualitative Research in Psychology*. Buckingham: Open University Press.
World Health Organization (WHO) (2000) *Obesity: Preventing and Managing the Global Epidemic*. Singapore: WHO.
World Health Organization (WHO) (2014) Controlling the global obesity epidemic. Available at: http://www.who.int/nutrition/topics/obesity/en/
Young LM and Powell B (1985) The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behavior* 26: 233–246.
Ziauddeen H, Farooqi IS and Fletcher PC (2012) Obesity and the brain: How convincing is the addiction model? *Nature Reviews Neuroscience* 13(4): 279–286.

Author biographies

Amy Brown-Bowers received her PhD in Clinical Psychology from Ryerson University and has primary research interests in critical psychological approaches to understanding health, gender, and sexuality.

Ashley Ward is a doctoral student in Psychological Science at Ryerson University. Her current research interests include critical and anti-oppressive research and practice, Foucauldian-informed discourse analysis, disciplinary ethics, criminalization processes of youth and women, and madness.

Nicole Cormier is a doctoral student in Clinical Psychology at Ryerson University. Her research interrogates how heterosexism, neoliberalism, and postfeminism impact the sexual and gender subject positions made (un)available in pornography, erotic literature, and popular media.