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ORIGINAL ARTICLE

Understanding the feasibility of integrating the eating disorders and obesity fields: the beyond obesity and disordered eating in youth (BODY) Study

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Abstract
Background Attention has been devoted to exploring ways to integrate the eating disorders (ED) and obesity (OB) prevention fields. Although research has revealed considerable overlap between the risk factors for ED and those for OB, collaboration between the two fields remains strained. Existing position papers focus mainly on discussions about the lack of collaboration and whether or not the two fields should merge their prevention efforts. However, no empirical study has yet addressed these questions. The beyond obesity and disordered eating in youth (BODY) Study is a qualitative study that sheds light on the relationship between the ED and OB fields.
Aim Using part of the BODY Study data and findings, this paper aims to further explore the costs and benefits of ED and OB collaboration/integration. Four models, or scenarios, proposed by Neumark-Sztainer to describe the interaction between the ED and OB prevention fields are used as a framework to guide the BODY Study findings' discussion.
Method Based on grounded theory methodology, the BODY Study used in-depth interviews and focus groups as data collection methods. A total of 61 participants took part in the study: 35 researchers/practitioners who work in either ED or OB; and 26 youths (aged 16–26 who attended six focus groups and 12 in-depth interviews).
Analysis Selected BODY Study themes, relevant to better understanding the four scenarios proposed by Neumark-Sztainer, presented in this paper are: (a) Two camps: understanding the relationship between the ED and OB fields; (b) Consequences for professionals and youths of the existence of two camps; (c) Root causes of the perceived tension: ideology and philosophy, power and knowledge, and gender.
Conclusion Findings from this study mirror existing theoretical papers that look at the relationship between the two fields—including Neumark-Sztainer's scenarios. At the same time, this empirical work further discusses the costs of a possible integration that, even if desirable, does not take into account the root causes of the tension between the two fields (e.g., power imbalance, gender neutrality).

Keywords Eating disorders · Obesity · Prevention · Grounded theory

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Introduction

Empirical studies suggest that eating disorders and obesity can coexist, and that individuals can cross over between these two conditions. In a community-based sample of women, a much higher percentage of women with bulimia nervosa had been overweight as children (40 %) as compared to the percentage who were "healthy" or who had "psychiatric conditions" (15 and 13 % respectively) [1]. Other studies found shared behaviours, attitudes, and beliefs among adolescents who developed eating disorders and/or obesity later in life. For example, Haines and Neumark-Sztainer [2] found that dieting, media use, body dissatisfaction, and weight-related teasing served as possible shared behaviours, thoughts, and experiences related to the development of obesity and/or eating disorders. Furthermore, Project EAT (Eating Among Teens), a longitudinal study of 2,516 adolescents from 1998/1999 to

2003/2004, identified weight-based teasing by family, personal weight concerns, and dieting/unhealthy weight-control behaviours (e.g., vomiting, use of diet pills, laxatives, and diuretics) as strong predictors of overweight status, binge eating, and extreme weight-control behaviours after 5 years [3]. Approximately, 44 % of girls and 29 % of boys in the study who identified as overweight had at least one of the three problematic weight-related outcomes (i.e., binge eating and/or extreme weight control). In clinical practices, the literature on weight suppression, which refers to a person's highest adult weight minus current weight, offers further evidence of the link between eating and weight problems [4, 5]. A number of studies have shown that weight suppression seems to be a robust predictor of binge eating spectrum disorders and it may be associated with the onset and maintenance of bulimia nervosa [4, 5]. Indeed, weight suppression may play a key role in the manifestation and course of the spectrum of eating and weight disorders [4, 5]. Although research reveals considerable overlap between the risk factors for eating disorders and those for obesity, collaboration between the two fields remains strained [6].

The 2010 International Conference on Eating Disorders held a panel entitled "What do Transdisciplinary Approaches Bring to the Integrated Prevention of Obesity and Disordered Eating?" As Sanchez-Carracedo and colleagues described:

> First, the lack of connections between the two fields is largely due to the types of professionals working in them, who see obesity and ED as separate problems. Those involved in obesity prevention tend to come from medical or public health backgrounds, while those working in the field of ED prevention tend to come from the mental health field. Few professionals have a background in both fields, and there is a need for much more communication between them. Second, some experts in ED are concerned about the fact that experts in obesity are unaware or show little interest in the potential negative repercussions of prevention with a strong weight focus (as opposed to a health focus) on the development of disordered eating. Third, a strategy for moving forward would be to make efforts to ensure that those working in each field have access to key information about the intersections between the two and the possible undesirable consequences of certain types of prevention aimed at one problem on the other. [7, p. 10]

Only a selected number of publications exist, mostly theoretical papers that speak to the integration of eating disorders and obesity prevention [2, 6–8]. In particular, Neumark-Sztainer published a paper entitled "The interface between the eating disorders and obesity fields: Moving toward a model of shared knowledge and collaboration" in *Eating and Weight Disorders.* This theoretical paper explored four potential models, or scenarios, of interaction between the eating disorders and obesity prevention fields. As the author explained:

> The first model is one in which the obesity field overpowers the eating disorders field. In the second model, the two fields have minimal opportunities for interaction and for cross-fertilization of ideas. In the third model, there is antagonism and a lack of respect for the other field. The fourth, and recommended model, is one in which the two fields share knowledge to enhance the difficult work of preventing and treating both eating disorders and obesity. [8, p. 51]

To date, published position papers focus mainly on discussions about whether or not the two fields should merge their prevention efforts and, if so, how; however, no empirical study has yet addressed these questions. The beyond obesity and disordered eating in youth (BODY) Study [9] is a qualitative project that sheds light on the relationship between the eating disorders and obesity fields. The BODY Study aimed at answering the following questions: What keeps the areas of eating disorders and obesity prevention apart? Can, and should, an integration between these two areas be implemented? Two groups of stakeholders took part in the study: (a) professionals, public health/health practitioners, members of interest groups or associations, policy makers and researchers involved in eating disorders and/or obesity prevention; and (b) youths and young adults from the general public, recipients of prevention interventions. BODY Study [9] generated two theoretical formulations: The first theoretical model described the root causes of the tension between the eating disorders and obesity fields; the second, called Corporeal Ethics, is a new ethical framework for eating disorders and obesity prevention practices based on critical reflexive knowledge collected through and within a person's bodily lived experiences. In this paper, using part of the BODY Study [9] data and findings, I turn to Neumark-Sztainer's scenarios to revisit the costs and benefits of this collaboration/integration.

Methodology

Study design

After reviewing study protocol, study consent forms for both youths and health practitioners, and assent forms for 16-year-old youths, the research ethics boards (REB) at the Hospital for Sick Children and University of Toronto granted ethical approval. Participants' first contact with the

research team was by phone or email. In almost all cases, the REB-approved consent form and audio consent form were sent via email to participants to review prior to the first interview or focus group. Prior to the start of the interview/focus group, the consent form was reviewed and signed by both the participant and the interviewer (MF). Each participant received a copy of the signed consent form.

Sixty-one people took part in the study; data were collected across Canada through interviews conducted with 35 researchers/practitioners who work in either eating disorders or obesity (for a total of 55 in-depth interviews), and through six focus groups and 12 in-depth interviews conducted with 26 youths (aged 16–26). Two interviews were recommended to all practitioners interested in taking part in the study; this was to allow the practitioner to feel more comfortable expressing his/her personal perspective, as well as to provide an opportunity for reframing/adding/correcting content, if needed, during the second interview. However, this was not always feasible. In 16 cases, only one long interview (between 1 and half to 2 h), rather than two, was conducted with the professional.

Grounded theory

A grounded theory approach, informed by Charmaz [10], guided the data generation and analysis presented. Developed by Barney G. Glaser and Anselm L. Strauss [11], grounded theory methods locate the emerging theory in the data collected from one (or more) empirical studies and not in pre-existing theory—this is how this methodology gets its name—although a theoretical sensitivity may inform the initial research. This is one element that characterizes grounded theory research as an inductive process, as the theory developed from patterns found in empirical data, rather than a deductive process where a hypothesis is generated according to existing theories and is tested through empirical research. The second element that characterizes grounded theory is the constant comparison between codes and their conceptualization or constructs, which informs the development of the emergent theory, and new data. The theoretical constructs are confirmed through constant comparison across and between data samples, data coding, and conceptualization, which drives the collection of additional data until the researcher feels that the new theory is fully developed and, as defined by some, theoretical saturation has been reached.

Over the years, grounded theory, as a methodology of enquiry, has grown, developed, and split into two schools: Glaser's views versus Strauss and Corbin's views [12] of grounded theory. Grounded theory reconciled, or found a third dimension, within the postmodern paradigm [10, 13]. The grounded theory method shifted from a post-positivist tradition, where the aim was to provide a basis for predicting cause and effect relationships, to a constructivist paradigm, which argues that multiple constructions comprise reality and that the knower is subjectively linked to what can be known [10]. This method was brought into the twenty-first century approaches to reality by the work of Clarke [13] and Charmaz [10]. Clarke and Charmaz saw grounded theory as a set of principles and practices, not a rigid prescription of tasks, that allows flexibility. In this sense, people's experiences are theorized by the researchers in what is a construction of reality.

The BODY Study was conducted in the Charmaz grounded theory tradition using a feminist perspective. Charmaz's grounded theory and post-structuralist feminist theory guided decisions regarding which people needed to be involved within the research process (researchers, practitioners, and youths—the last often being the excluded voice in other studies), and which issues were important to examine and how to do so (the meaning given to eating disorders and obesity and the unpacking of them through discourse analysis).

Sampling strategies

As per grounded theory methodology, participants were recruited through a variety of sampling strategies: conventional, purposeful, and theoretical samplings [8]. This study used conventional sampling, the beginning of the research process to recruit participants based on their "knowledge" and "expertise" with body dissatisfaction and weight- and shape-related issues—"knowledge" is also understood as lived experience, including youths' lived experience, of weight problems; followed by purposeful sampling, in which possible participants were identified through the first stages of data analysis; and ending with a more formal theoretical sampling, where participants were selected based on the emergent concepts and theory.

Conventional sampling included selecting professional participants from a variety of groups and areas: prevention intervention facilitators; health practitioners involved in prevention; researchers within the eating disorders and/or obesity prevention areas; public health practitioners; members of interest groups or associations. Names of individuals were drawn from participants at the *Obesity and Eating Disorders: Seeking Common Ground to Promote Health* symposium, well-established provincial and national eating disorders and obesity networks and associations (e.g., Ontario Community Outreach Program for Eating Disorders, National Eating Disorder Information Centre) and public health agencies. An email containing information about the study was sent through networks and associations inviting prospective participants to be involved in the study.

Youth participants were recruited through a variety of methods (e.g., flyers, website information). Study flyers were posted in buildings around the University of Toronto. The University of Toronto campus offered an ideal setting to recruit individuals within the targeted age group with diversity in body weight/size, cultural and racial background, socio-economic status, sexual orientation, and abilities. Furthermore, the National Eating Disorder Information Centre offered to post the study information on their website and also sent an email through their listserv. The snowball technique was also used with the youth participants. At the end of each focus group, participants were provided with study flyers to share with friends who they thought might want to participate in the study.

Purposeful sampling was used to capture data that otherwise might have been missed in other means of sampling. This included (a) public health practitioners, policy makers, and professionals working in obesity prevention; (b) other professionals from across Canada (including Ontario, Quebec, Alberta, and British Columbia). Following the generation of the first theoretical framework, the interview and focus group process became less intense and more specific. After realizing that the sampling lacked professionals working in the obesity field, I liaised with members of the Canadian Obesity Network—a procedure which utilized both purposeful and theoretical sampling. In addition, the snowball technique was used to enhance study recruitment. At the end of an interview, especially one conducted with a professional working in obesity, I requested additional names for purposes of recruitment.

In terms of the recruitment process for youth participants, the availability of male participants was minimal. I invited different community organizations to be involved in the study (e.g., YMCA House in Toronto). Similarly, the data analysis process brought to light the need to recruit youths who had experienced formal eating disorders or obesity/weight-management treatment. Sheena's Place, a drop-in day facility which offers support to people struggling with eating disorders, posted information about the study, both at the centre and on their website. Sick kids team obesity management program (STOMP) supported the recruitment process by inviting youths who had completed their program to take part in the study. Focus groups were implemented at both facilities.

Data Collection

Data collection methods included in-depth interviews with both professionals and youths, and focus groups with youths. The initial interview guide focused on the following topics: career development; professional experience in developing and/or implementing eating disorders, obesity, and/or weight-related problems prevention interventions; perspectives of eating disorders and obesity generated through disciplinary/interdisciplinary knowledge, and/or practical knowledge, and/or personal experience; and the relationship between the eating disorders and obesity prevention fields. The first interview explored career development and professional experience in prevention to contextualize the professional's work, whereas the second interview covered the relationship between the two fields of prevention. As mentioned, grounded theory is based on comparison between data samples, data coding, and initial conceptualization, which drives the new data collection. In this sense, data analysis and data collection go hand-in-hand and early data analysis shapes the subsequence data collection process. Following grounded theory practices, the initial interview was modified to include emerging themes and concepts identified though the early stage of data analysis—for example, asking professionals, "Could you tell me about your recent experiences working in the prevention field?" Gender differences in relation to eating and physical activity habits started to emerge through the participants' narratives. This prompted me to start to explore gender differences during the professional interview process.

An attempt was also made to organize focus groups to be homogenous based on sex and age, but in three instances it was not feasible. In two focus groups, a 16-year-old girl and boy attended a young woman's and a young man's focus group, respectively, with youths between the ages of 20 and 25. The STOMP focus group was conducted with both boys and girls together. Focus groups were concentrated on the following topics: youths' perceptions of current messages, campaigns, and interventions aimed at promoting a healthy lifestyle and positive body image; youths' ideas about effective ways to promote healthy lifestyle choices and positive body image; youths' needs regarding weight- and shape-related issues and the type of interventions required to address those needs. Similarly, focus group questions were modified to include emerging concepts (e.g., adding a question related to youths' eating and physical activity practices when they were growing up and about possible gender differences).

Youths had a chance to participate in one-to-one, semi-structured interviews if they wished and 12 of them chose to do so. The same focus group questions were asked during these interviews. The one-to-one, semi-structured interviews offered the youths the possibility to express more personal experiences and unpack sensitive topics in a more private and comfortable environment. They also allowed the youths to confirm, clarify, and redefine the content discussed during the focus groups and, in some cases, comment further on other focus group participants' opinions and stories.

Participant demographics

Participants were asked to provide basic demographic information by completing the Demographic Information Form. This information was collected to ensure representation of study participants from across diverse social classes and ethnocultural backgrounds. Tables 1 and 2 include specific demographic information on the two participant groups.

With regard to practitioners work experience, the number of years working in the field ranged from less than 1 to 40 years of work experience (the average was 11 years). Practitioners received primary and secondary training across a variety of disciplines. Looking at their primary training, seven identified having an academic background in psychology (20 %), seven in dietetics and nutrition, six in public health and epidemiology (17 %), four in medicine, three in kinesiology or physical activity, and three in social work and five "other" disciplines. The majority of professionals identified their secondary area of academic training as public health, psychology, nutrition, or movement sciences. Other identified secondary disciplinary trainings were women's studies and education.

Table 1 Practitioners demographics

Variable	*n*	%
Sex		
Male	6	17.0
Female	29	83.0
Age		
≤35 year old	9	26
36–45 year old	9	26
46–55 year old	12	34
56–65 year old	4	11
Missing data: one person skipped this question	1	3
Income		
≤$30,000 CD	2	6
$30,000–$49,999 CD	6	17
$50,000–$74,999 CD	7	20
$75,000–$89,999 CD	6	17
≥$90,000 CD	13	37
Missing data: one person skipped this question	1	3
Born in Canada		
Yes	26	74
No	6	17
Missing data: three people skipped this question	3	9
First language		
English	29	82
French	3	9
Bilingual: English or French	1	3
Missing data: two people skipped this question	2	6

Table 2 Youth demographics

Variable	*n*	%
Sex		
Male	7	27
Female	19	73
Age		
16 year old	7	27
17–20 year old	10	38
21–26 year old	9	35
Income		
≤$30,000 CD	18	69
$30,000–$49,999 CD	1	4
$50,000–$74,999 CD	0	0
Missing data: seven people skipped this question/prefer not to answer	7	27
Education		
High school degree	9	35
Undergraduate degree	11	42
Graduate degrees (in progress)	4	15
Community college degree	2	8
Born in Canada		
Yes	16	61
No	8	31
Missing data: two people skipped this question/prefer not to answer	2	8
First language		
English	14	54
Bilingual: English and other	5	19
Other than English	5	19
Missing data: two people skipped this question/prefer not to answer	2	8

Several theoretical frameworks were identified as having had influence on their professional work: behavioural theories (e.g., cognitive behaviour therapy, motivational interviewing, social cognitive theory, self-determination), systems theory (e.g., family behavioural systems, systems thinking), ecological models and population-based approaches, and social and feminist theories. Professionals identified themselves as having varied and multiple roles: researcher, teacher, practitioner, clinician, policy advisor, activist, and advocate. They also identified, in the majority of cases, a variety of areas in which they were involved such as eating disorders prevention, disordered eating prevention, weight- and shape-related issues prevention, body image, health-at-every-size promotion, and obesity prevention. It is interesting to note that professionals who were involved in eating disorders prevention identified themselves as also being involved in obesity prevention work. The contrary was not found among those working in obesity prevention. Nine professionals (26 %) identified

themselves as being involved solely in the prevention of weight- and shape-related issues (weight management) and/or obesity prevention. Again, in the majority of cases, professionals identified themselves as being involved in multiple levels of preventions (e.g., primary prevention, secondary prevention, targeted prevention, universal prevention, selected prevention). It seems that people involved in primary prevention and universal prevention interventions were also involved in carrying out selected and targeted intervention work. To the contrary, those working in secondary, targeted, or selected prevention work (a much smaller group) did not cross over to the area of primary prevention.

Looking at the youths' profiles (see Table 2), nineteen (73 %) female and seven (27 %) male youths took part in the focus groups; the average age for the youth participants was 20 years old with an age range from 16 to 26 years. All but three youths identified as having an income of less than $30,000 CD. The majority of the participants, as mentioned, defined their status as students and some of them had work experience as well. Four of the young men who took part in the focus group were workers. Six of the youth participants identified themselves as immigrants and/or first-generation immigrants or refugees. Some of them identified themselves as bisexual, with a disability, or as a member of minority ethnic group. As the table shows, they also identified themselves as being part of a variety of ethnocultural groups, born in difference places (e.g., Togo, Japan, South Africa, China, Paraguay, Philippines) and able to speak different languages when they were growing up.

Data analysis

Grounded theory data analysis is a well-defined practice that is accomplished through a complex set of coding processes, basic descriptions of initial concepts, and an elaborate process that involves comparing and contrasting concepts to develop links between them, and concludes with theorization about the concepts [10]. The traditional transcription coding consisted of two phases: initial and focused coding. Broadly, during the coding process the researcher uses a short name to describe a segment of data and, as mentioned, attempts to define this code and/or category to give it a meaning. According to Charmaz, "coding is the first step in moving beyond concrete statements in the data to making analytic interpretations." [10, p. 43]

As mentioned, focused coding was the second part of the transcription coding process. In this stage, several analytic codes and concepts have already been identified as well as some of the links between them. It was easy in this way to review the data using the codes and categories to explore the adequacy of those codes and to refine them if needed. At this stage, axial coding was used to define concepts/categories and subcategories, as well as their properties and dimensions [10] and to create a cohesive picture of the data. N-Vivo software was used to facilitate the data management, storage, and analysis of qualitative textual data. Youths' names have been changed and some information omitted from the tables to ensure anonymity and confidentiality.

Results

This section presents the analysis and interpretation of the part of the BODY Study data related to the discourses that circulate about the relationship between the eating disorders and obesity prevention fields. Themes covered within this section are: (a) Two camps: understanding the relationship between the eating disorders and obesity fields; (b) Consequences of the existence of two camps for professionals and youths; (c) Root causes of the perceived tension: Ideology and philosophy, power and knowledge, and gender. These themes were selected as relevant to better understanding the four scenarios proposed by Neumark-Sztainer.

Two camps: understanding the relationship between the eating disorders and obesity fields

> P1: Well, I am sad to say that it is still two worlds… I wrote that… it's two worlds. All around the world it's like that, it's like that [here] and all around the world. You have the eating disorder business, conferences, experts, journals, books, and you have on the other side, the obesity "gang"…
>
> P2: Oh the current relationship … I think at this point they're miles apart. The way of thinking about eating disorders and obesity are very different between the two sectors.

Professionals often mentioned how the eating disorders and obesity fields mainly exist as two worlds, camps or gangs. As a professional described:

> P3: They're slowly starting to come together, but slowly. You know, honestly, I think [it is] just because there's an increased awareness of the two camps.

Professionals reported that the two fields have different research journals, conferences, and disciplines that inform their knowledge base, different languages, different meanings attributed to words (weight, fat, health, illness, etc.), different ways of understanding the health problems, and, as a result, often different prevention practices to resolve the problems—obesity prevention interventions

promote dieting to lose weight while eating disorders prevention discourages dieting because it is identified to be a risk factor for disordered eating and problems.

It appears to be a "war on weight," borrowing a practitioner's term, and each camp is trying to gain resources as well as public and medical recognition.

> P4: The first word that came to mind was adversarial … I would say that because some of the initiatives are actually diametrically opposed, the languages that we use are different and the meaning we even make of words are different in those fields. Oftentimes there's a feeling of needing to fight against, instead of working together it's almost like there's a war, there's a war on weight and, um, there's two sides and they're not agreeing on how to go about [it].

> P5: That's funny I never noticed that, I was not in the eating disorder gang but I was thinking mostly weight preoccupation but I was reading IJO (International Journal of Obesity)…

During her academic journey, this practitioner was actually interested in weight problems—she was not a member of the "eating disorder gang" but she was very close to their philosophy and practices, reading feminist works on women's bodies, fat prejudice, and, for example, Hilde Bruch's book, *The Golden Cage: The Enigma of Anorexia Nervosa.* At the same time, because of her interest in weight concerns, she was reviewing and accessing research and knowledge generated from the obesity field. She now recognizes herself as a member of the obesity camp because of her current work position, dealing with obesity prevention strategies, and she feels rejected by the eating disorders camp.

At different points during their professional journeys, practitioners encountered the tension between the two fields of prevention.

> P6: I was the only person from the [eating disorders] sector in amongst 30 other pediatricians who specialize in obesity, surgeons (who did the weight loss surgery), nurses, doctors, you know a whole range of professionals…they were very dismissive towards people with eating disorder experience—they didn't even want to hear anything I had to say…They were dismissive, they were saying things like…"Don't tell us about that, we don't want to hear that." I brought up the socio-cultural aspects to obesity, they said, "We don't want to hear about that."

All professional participants told how they were directly part of conflict situations, they witnessed the tension unfold during professional gatherings, conferences, and, in some cases, they saw it expressed in the lives of their clients during clinical practices (see next section).

Consequences of the existence of two camps

Often professionals, especially those working in eating disorders and body image areas, reported how conflicting messages, grounded in core philosophical differences, generated diametrically opposite prevention interventions delivered by the eating disorders and obesity fields to children and to the general public.

> P4: I think that people are incredibly confused. There are mixed messages… people hear one thing from one camp and another thing [from the other camp] and they're completely opposite. How do you put those two messages together?

The majority of the public health practitioners that I interviewed believed in and promoted a balanced approach to eating and physical activity, and they often incorporated it within their practices in schools or work settings. However, as the next practitioner described, a balanced approach and, more specifically, positive body image messages/initiatives are perceived in some schools as promoting obesity, pro-obesity initiatives, and/or initiatives that are against the anti-obesity initiative.

> P7: I do about 200 presentations a year and sometimes the school is completely on board with [my messages and philosophy],then other times…It's hard because they think that because I'm telling the kids to eat properly and that they shouldn't be on diets that I'm almost against the anti-obesity initiative that schools are taking … I don't want children to be obese, I don't want them to have an eating disorder, I don't want any problems…

At a clinical level, eating disorders clinicians, especially those working more on a psychosocial level and/or those who are not trained as medical physicians, feel frustrated about not being able to help their clients.

> P8: We have a client…her doctor's purpose is regulating the sugar level in her blood even though she's not diabetic…it is for weight loss purposes. And we have another client who visited a doctor who suggested the gluten-free diet. You know, it's very hard when they come in and say, my doctor suggested a gluten-free diet. We're not doctors to say: "This is a dieting mentality, this is not good." It's very hard for us to fight it.

It is one professional opinion against another professional opinion and, as I will describe further, they do not hold the same weight, status, and/or power.

During focus groups, youths talked about the consequences of opposite prevention interventions delivered in school by the eating disorders and obesity fields. For example, they discussed the negative effects of school BMI surveillance on themselves and other students. Many identified the practice of being weighed in school by a health care provider in front of their classmates as immoral. Here are some comments by young people currently in an obesity treatment program:

> Lucas: I think what they're doing, for example our district school board, they did a survey where they took everybody's height, weight, and they made us fill out a survey on how we live our daily lives, right?… But a lot of people are uncomfortable doing it and they felt really insecure. I think it could be a negative thing for us because we have to expose ourselves to somebody else.

Yuki, during a focus group in an eating disorders treatment centre, described the use of screening practices in Japan where kids are weighed and sent to special extracurricular activities if they were deemed overweight or obese.

> Yuki: So, uh, if you are too much above the average weight, you are sent to the special extracurricular for exercise but I didn't like that they had an average weight graph because I was pretty shocked when my weight was above the average. I felt that I was being criticized that I'm big by the society. In my understanding each person has their development speed in body and a bone framework varies like different kids.

Root causes of the perceived tension: ideology and philosophy, power and knowledge, and gender

Ideology and philosophy

All practitioners interviewed engaged in a variety of discourses that criticized, reinforced, redefined, or maintained the eating disorders and obesity definitions and status quos. When asked to define eating disorders and obesity, the majority of professionals referred to their formal knowledge, driven by their academic and/or disciplinary training. Professionals working in eating disorders referred to the DSM-IV to define eating disorders. Both eating disorders and obesity practitioners referred to BMI classification for adults, or percentiles for children and youths, to define obesity. Overall, several eating disorders practitioners were quite critical of both the terms *eating disorders* and *obesity*; they consider them sort of labels, and they are more concerned with preventing, decreasing, and/or eliminating the eating disorders/disordered eating symptoms (e.g., refusal to eat and denial of hunger, the intense fear of gaining weight, the negative or distorted self-image, excessive exercise, fear of eating in public, preoccupation with food, social withdrawal). Although obesity practitioners can be critical of the use of BMI classification, they are still very attached to it.

> P10: So in general, everybody [working in pediatrics] is using the same definitions … those definitions are based on the BMI percentile. Divide it up into three categories, less than the 85th percentile, 85th to less than the 95th, and 95th and above.

Power and knowledge

Power and knowledge are inextricably intertwined. I already described how practitioners working in the eating disorders field seem more aware of knowledge and practices related to the obesity field. At the same time, they spend time, energy, and resources to reach out to obesity practitioners. In contrast, obesity practitioners seem to have little knowledge and interest in what the eating disorders practitioners have to share and offer to the obesity field. Eating disorders practitioners experience the power relationship between the eating disorders and obesity fields in hierarchic form, as the obesity field seems to have power over the eating disorders field—as indicated by the prevalence of messages, overall practices, and knowledge about obesity. This was often captured by practitioners through metaphors, such as "the little fish attaches to the big fish."

> P11: We don't have any eating disorder prevention besides what we do here. A lot of what we're already seeing, prevention-wise, it's already being swallowed up and that's why I think, the little fish attaches to the big fish. If we just keep going this way, with this disconnect between eating disorder and obesity, then eating disorder prevention will eventually get lost because the obesity prevention is being done everywhere, it's being echoed by everyone … it's just going on, it's spinning out of control, and it's spreading its message, then eating disorders will, I think, eventually get lost if it doesn't, you know, almost leech on.

Gender

The previous section addressed the issue of the inequity of resource distribution, power, knowledge, and knowledge production as one of the root causes of tension between the eating disorders and obesity fields. Gender-based inequity in relation to the bodily lived experiences of girls and boys,

and also in relation to the dominant discourse of gender neutrality, generated and embraced by practitioners, is discussed here as another core cause of the tension between the two camps.

The gender neutral position informs the dominant discourse among practitioners, especially those working within the obesity field. Some eating disorders practitioners are aware of how gender, race, and class have an effect on body image and eating problems, and recognize the importance of developing prevention interventions able to meet the needs of people with diverse gender-based social experiences.

> P12: When we're talking about eating disorders as a women's issue, is the eating disorder the problem or [is] it the gender inequities out there that are creating the problem? Eating disorder has become one of the symptoms of the inequalities…

> P13: Asian women, African American women and Aboriginal women are subjected to it [Western norms] twice as hard because there's no way they're gonna even attempt to fit into that. The prevalence of body dissatisfaction among Aboriginal young girls increased in this community. It does present in a different perspective, I mean that there is that group of young girls that are really trying to fit, integrate themselves into the mainstream community of [name of the city], away from their reserve and First Nation community, as well as integrating themselves into the ideal beauty image of what a youth should look like. They're double whammed in that regard… I really think that has a lot to do with their struggle in fitting in. We find that the young Aboriginal women messages are a little bit different—they're more focused on being accepted as a woman versus an image of maybe what is beautiful. It's more around the acceptance of them period.

However, the current push to promote healthy eating, active living, and healthy weights seems to reinforce, instead of mitigate, forms of racist body-based harassment. Gender roles and gendered experiences seem to get lost in attempts to overcome the mixed messages generated by the eating disorders and obesity fields. The healthy eating and active living approach, however, grounded in the idea that health can be achieved regardless of body weight or size, acts as a shared vision and direction to integrate and find common ground between the fields. The healthy eating and healthy weights discourse not only reinforces individual responsibility for eating/weight problems, but also acts as a gender neutral discourse so that there is no acknowledgement and/or recognition of the sexist, racist, and classist machinery that has an influence on eating disorders or obesity.

Gender difference, and not gender neutrality, was always very present in each youth focus group and individual interview that I conducted. Young people clearly described gender differences in the school setting in relation to physical activity and eating behaviours.

> Sarah: I remember sometimes, boys and girls were separated in gym class…less was expected of the girls in gym class and more is expected of the boys. I felt as the years went on, especially in high school, more girls were dropping out of gym class and it was always the boys who would take it in, like, grade 11–12 especially. I dropped it as soon as grade 9 was over. I was like, I'm out! Grades 11–12, it was all boys, I think mostly boys especially like weight-lifting class and stuff like that…there'd be like one girl. I think boys are just expected to like gym class automatically and girls, it's more accepted that you sort of, they are not a big fan…

Young women often recall the internal struggle between, on the one hand, wanting/achieving physical freedom (e.g., play like a boy, be strong, get messy and sweaty) and proving themselves as good and successful athletes, and, on the other hand, conforming to the gender norms that require girls' bodies to look good, perfect, pretty, and, in several cases, to look "sexy."

Neumark-Sztainer's four scenarios

Scenario 1: the obesity field overpowers the eating disorders field

The BODY Study findings show how practitioners locate themselves in one of two "camps" or "worlds," which has shaped and transformed their professional identity. Each camp is defined by its knowledge, practices, philosophical understanding of the health issues at hand, and the language used to describe these activities. Based on the analysis performed, power is conceptualized in binary terms, where one camp is poised to win over the other. On the one hand, the obesity field seems to occupy more "space"—for example, a central position at eating disorders gatherings and conferences. The eating disorders field, on the other hand, is struggling to convince government and other stakeholders that these disorders are worthy enough to fund.

As Neumark-Sztainer [8] has pointed out, eating disorders professionals were the first ones to reach out and seek ways to integrate their work across the two fields. As professionals searched for ways to agree on common messages, some professionals working in the eating disorders field recognized how their language changed. This

analysis brings to light how the terms *weight stigma* or *weight bias*, and *obesity* are more and more entering into eating disorders language and practices. Ironically, putting the emphasis on weight as the way of defining the problem, within messages to the public or as a health outcome, has always been challenged by some eating disorders practitioners working in prevention as they sought to frame the problem under a gender-inequity lens (see Smolak and Piran [14]). In some instances, eating disorders practitioners resist the most powerful camp/players, authority, or dominant discourse, thereby facing severe consequences—I will further develop this position later in the paper.

Scenario 2: antagonism between the fields

In response to fighting for resources, status/knowledge, and power, antagonism exists between the two camps. Tension and animosity have emerged during cross-field discussions about how best to integrate the two fields. In today's society, the obesity epidemic messages and the fear of becoming fat act as dominant discourses. Practitioners who do not comply with mainstream obesity prevention messages are negatively perceived. In fact, those who claim a balanced approach to healthy living are often labelled as being pro-obesity. Weight loss messages, including claims that being fat is equated with being unhealthy, tend to overshadow the "health at every size" philosophy that some eating disorders experts base their prevention work on.

As a result, there is a feeling of distrust if not indifference that exists among the professionals from the two fields, leading to misunderstandings about each other's intentions or health-related goals. Rejection of each other's approaches (e.g., philosophy, ideology, language, practices) is common and ultimately leads to rejection of the Other/the person working within the opposite field. Boundaries are often established by staking claim to the unique classifications or criteria that are used to define each of the health problems.

Scenario 3: minimal interaction and sharing between the fields

According to Neumark-Sztainer [8], professionals who share similar points of view regarding the nature and prevention of weight-related problems tend to "hang" together, which can limit collaborations to a selected group of individuals or disciplines.

The findings from the BODY Study show how the uniqueness of one's academic or discipline-based training shapes the way in which she/he practices. Health practitioners who do not conform to the dominant weight loss messages face criticism from their peers who do. Some remain stuck in between the two fields, as they struggle to find new language or gain legitimacy for their more integrated approaches to prevention. Public health practitioners who are trying to promote different messages and practices that do not adhere to one or the other camp's ideology/message and/or that challenge the binary opposition are challenged and, in some cases, criticized. They seem to no longer belong to one camp or the other and they need to work hard to create their own space and give some legitimacy to their messages.

Scenario 4: coming together to learn from each other: a model of sharing and collaboration between the eating disorders and obesity fields

The model in which stakeholders from the two fields collaborate and share knowledge seems to be the most advantageous. However, in light of the BODY Study findings, it may not be the most desirable if the root causes of the tension between the two fields are not taken into account. In light of current unequal distribution of resources across the two fields, eating disorders practitioners seem to be extending themselves to the field of obesity in an attempt to make visible their work and to help find ways to minimize the potential for harm brought on by weight-focused interventions. This further takes focus away from the field of eating disorders which is already marginalized by poor funding and overall support. There is also the reality that by shifting the language of eating disorders and obesity to a more neutral shared language (e.g., weight-related issues) the topic of eating disorders might drop completely off people's radar—the opposite to the effect of, for example, the title of the journal, *Eating and Weight Disorders: Studies on anorexia, bulimia, and obesity*.

Several youths described how they were treated as obese persons and counselled to lose weight for reasons of health. However, they described their need for emotional support to help cope with the stress that might have influenced their eating behaviours. Furthermore, there appears to be a total disregard for the role of gender in explaining the nature of, or solutions for, weight-related issues such as obesity. Gender analysis appears to be more common among some eating disorders experts, who incorporate gender, race, and class into their understanding of what influences body image or eating problems. However, such analysis and, in fact, critical bodies of work on gender are largely ignored within the field of obesity prevention and applied work. It would appear that the shared focus on promoting healthy lifestyles offers a way to find common ground between the two fields but, in doing so, the integrated prevention work ignores the social contexts in which people live their lives. Through the youths' narratives, it is possible to capture

how their bodies have been socialized into gendered categories. For example, girls are torn between their desire to be physically powerful, which is considered socially inappropriate, or physically powerless, which is considered more socially appropriate, even though this requires them to control their body, their physicality, and their appearance. Unpacking gender construction is the point of departure to problematize the status quo of current knowledge.

Young people clearly described gender differences in the school setting in relation to physical activity and eating behaviours. Gender difference, and not gender neutrality, was always very present in each youth focus group and individual interview that I conducted. An important part of this social context is the way(s) in which gender interacts with experience. The fields run the risk of entirely ignoring individuals', particularly females', experiences with body-based harassment and its impact on their bodies and self-care. Overall, caution is advised when integrating the eating disorders and obesity fields.

Discussion

The BODY Study set out to investigate the discourses that take place around the relationship between the eating disorders and obesity prevention fields. Before revisiting the findings in light of existing theoretical frameworks, I would like to discuss research rigour and trustworthiness as well as limitations of the present study. Then, as mentioned, I will highlight how the findings from the present study extend knowledge on the subject area—in particular, the study's contribution to the current widespread debate concerning the feasibility of integrating the two fields to find common ground to promote health.

Trustworthiness and rigour seek to assist the value, meaning, credibility, and resonance of the research conducted, similar to the way that validity and reliability do under the positivist research paradigm. According to Lincoln and Guba [15], qualitative research cannot be judged on the positivist notion of validity and reliability, so different criteria must be used. This study embraces Charmaz's [10] criteria of evaluating grounded theory work, which are credibility, originality, resonance, and usefulness. Credibility looks at the quality of the data; methodological rigour was used to satisfy this criterion. Originality considers how the analysis provides a new conceptual rendering of the situation under investigation; as the "Results" section shows, this research produces several new insights into the matter under enquiry. Resonance looks at the link between large collectivities and individual lives; the systemic comparison within the data analysis process allowed me to move from individual lived experiences to more abstract terms of conceptualizing the enquiry. Usefulness considers how the analysis offers interpretations that people can use in their everyday worlds; the new model and recommendations generated through this analysis are aimed at satisfying this criterion.

Limitations of the present study are: First, in qualitative enquiry, the level of analysis is heavily influenced by the context. As such, it is important to appropriately locate the participants' experiences within a micro level of analysis to explore the interactions between the individual, the context, and the surrounding socio-cultural structures (e.g., class, gender, race). Second, although the aim was to provide a balanced analysis and interpretation of the narratives of both youths and practitioners, I recognize that this paper focuses more attention on practitioners. I decided to focus on the eating disorders and obesity fields' relationship, to explore unknown areas and promote constructive ways for the two fields to move forward. Furthermore, other scholars have already been working to explore the relationship between body, gender, embodiment, weight, shape, and eating problems (see Piran & Teall [16] and Rice [17]). Finally, this study makes use of qualitative methodology which aims to achieve an *in-depth understanding* of participants' experiences and the nature of social phenomena. The findings are not intended to be *statistically generalizable* to all, but are still *generalizable* to those who have had similar lived experiences to the participants in the study (see Morse [18]).

As mentioned, only a few theoretical papers have been published which speak to the lack of integration between the eating disorders and obesity prevention fields. The BODY Study offers empirical evidence to assess the value of those papers as well as an opportunity to revise their claims. Previously, Neumark-Sztainer's scenarios [8] offered the most comprehensive view of the current interaction between the two fields. The BODY Study's findings build on Neumark-Sztainer's scenarios [8], in particular the struggles of practitioners working in the two fields with issues related to problem definition, paradigms, discipline, and values that guide each field, and with ethical perspective. However, the BODY Study presents new challenges with respect to the possibility of integrating the two fields.

Although interactions seem desirable, this is not feasible and it may not benefit practitioners or, most importantly, youths if the root causes of the tension between the two fields are not taken into account. Each field is defined by its language and philosophical understanding of the health problems. The boundaries between the two camps are set by rigid classifications or criteria used to define each of the health problems (see Cuzzolaro [19]). There is a perceived "tension" between the two fields caused by some previously known issues, for example, ideology and philosophy

of the health problems, but also by new ones brought to light by the analysis conducted, such as the identity that each professional acquires, power and knowledge imbalance, and gender issues.

As described, the fields run the risk of entirely ignoring individuals', particularly females', experiences with body-based harassment and its impact on their bodies and self-care. Gender analysis is often overlooked within the field of obesity prevention and applied work (see Austin [20]). The BODY Study analysis of the youths' narratives revealed that there was fluidity between the experiences of having an eating disorder versus being obese. The open and unbounded bodily lived experiences of these youths did not appear to fit the pre-defined medical classifications for either eating disorders or obesity. Based on the data presented, eating disorders and obesity are anchored in lived experiences, which, by nature, are unique and individual to each person and are influenced by social context. This position further supports the notion that a thorough exploration of an individual's unique experience(s) should act as a point of departure to help them search for solutions. As Shildrick explained:

> Audre Lorde makes clear what is at issue when she writes: "It is not our differences which separate women, but our reluctance to recognise those differences and to deal effectively with the distortions which have resulted from the ignoring and misnaming of those differences" (1984:122). If, then, the real material differences between people are to be acknowledged, difference must be reconstructed as diverse, plural and in practical terms irreducible. It is not enough simply to avoid the false homogeneity of sameness, for simple difference (black/white, young/old, heterosexual/homosexual) is conceptually organised in equally homogenous and oppressive binary opposites. The notion of diversity, by contrast, embraces heterogeneity, sidesteps the devices of dualistic hierarchy, and allows differences and sameness to coexist and mingle. It takes on in short something of the indeterminacy of différance without losing touch with material circumstances. [21, p.127]

Merleau-Ponty [22], among others, conceptualized philosophical epistemologies in which the lived experience in the body, embodiment, is held in a central, valued position. He addresses the body as both object to others, and as a lived subjective reality. He moves us beyond the dichotomous pairings of mind/body, subjective/objective with his introduction of "perception" as a phenomenon that transcends a cognitive experience. According to Shildrick [21], conventional health practices are out of touch with the phenomenology of embodiment—referring to the work of Merleau-Ponty [22]. Shildrick [21] explains that the body can no longer be contained in any pre-defined categories, especially those defined by the certainties of binary thinking; the concept of "leakiness" is more appropriate to define the subject and the body. It is important for practitioners to capture the *différance*[1] of the lived experiences of youths so that a more comprehensive, meaningful, and ethical approach to care can be provided. This view and practice could also benefit practitioners who are currently operating "in between" the two fields, providing them with a new perspective on the health problems, a more fluid one, and the possibility to legitimize their practices.

Conclusion

The BODY Study aimed at answering the following questions: What keeps the areas of ED and OB prevention apart? Can, and should, an integration between these two areas be implemented? I turn to Neumark-Sztainer's scenarios [8] to revisit the costs and benefits of this collaboration/integration. I hope readers will think about and revisit them as discursive entities grounded in individual lived experiences. Ironically, rejecting homogeneity within each of the two camps could bring more light to the kind of problem we, as practitioners, are interested in preventing or treating, opening up a space for interaction and shared practices.

Moving forward: recommendations for practitioners

- If you are member of the obesity camp, take some time to explore the eating disorders world; try to gain more knowledge on risk factors common to both overweight/obesity and disordered eating/eating disorders.
- If you are member of the obesity camp, try to see obesity as more than a weight problem. Work toward the development of interventions that take into consideration the social context and have relevance for both fields.
- For practitioners in both fields, try to overcome possible negative experiences so that you can explore new, meaningful collaborations.
- For practitioners in both fields, consider moving away from thinking about the eating disorders and obesity fields as binary. Be aware of issues related to problem

[1] French philosopher Derrida [23] used the word *Différance* as a theoretical concept that tries to describe both the use of words and their specific meanings. The French word *différence* is intentionally misspelled by Derrida as *différance*; however, the two words are pronounced identically. Derrida argued that because each person has different ways of experiencing the physical worlds, a word would not conjure up the same idea to every person.

definition, paradigms, discipline, and values that guide each field. You can start by revisiting how these problems have been conceptualized in your professional training.

- For practitioners in both fields, try to be humble, open, and curious about individual lived experiences and take the time to learn from the youths or clients—see them as resources for your interventions and practices.
- For practitioners in both fields, consider publishing in open-access or hybrid open-access journals, knowing that open-access journals are effective knowledge-sharing and dissemination tools to reach policy makers and the general public.

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References

1. Fairburn CG, Welch SL, Doll HA, Davies BA, O'Connor ME (1997) Risk factors for bulimia nervosa: a community-based case-control study. Arch Gen Psychiatr 54:509–517
2. Haines J, Neumark-Sztainer D (2006) Prevention of obesity and eating disorders: a consideration of shared risk factors. Health Educ Res 21:770–782
3. Neumark-Sztainer D, Wall M, Haines J, Story M, Sherwood NE, van den Berg PA (2007) Shared risk and protective factors for overweight and disordered eating in adolescents. Am J Prev Med 33:359–369. doi:10.1016/j.amepre.2007.07.031
4. Van Son GE, van der Meer PA, Van Furth EF (2013) Correlates and associations between weight suppression and binge eating symptomatology in a population-based sample. Eat Behav 14:102–106. doi:10.1016/j.eatbeh.2012.11.003
5. Berner LA, Shaw JA, Witt AA, Lowe MR (2013) The relation of weight suppression and body mass index to symptomatology and treatment response in anorexia nervosa. J Abnorm Psychol 122:694–708. doi:10.1037/a0033930
6. Irving LM, Neumark-Sztainer D (2002) Integrating the prevention of eating disorders and obesity: feasible or futile? Prev Med 34:299–309
7. Sanchez-Carracedo D, Neumark-Sztainer D, Lopez-Guimera G (2012) Integrated prevention of obesity and eating disorders: Barriers, developments and opportunities. Pub Health Nutr: First View Artic. doi:10.1017/S1368980012000705
8. Neumark-Sztainer D (2009) The interface between the eating disorders and obesity fields: moving toward a model of shared knowledge and collaboration. Eat Weight Disord 14:51–58. doi:10.1007/BF03327795
9. Ferrari M (2012) Beyond obesity and disordered eating in youth. Dissertation, University of Toronto
10. Charmaz K (2006) Constructing grounded theory: a practical guide through qualitative analysis. Sage, Thousand Oaks
11. Glaser BG, Strauss AL (1967) The discovery of grounded theory: strategies for qualitative research. Aldine, Chicago
12. Strauss AL, Corbin JM (1990) Basics of qualitative research: grounded theory procedures and techniques. Sage, Newbury Park
13. Clarke A (2005) Situational analysis: grounded theory after the postmodern turn. Sage, Thousand Oaks
14. Smolak L, Piran N (2013) Gender & the prevention of eating disorders. In: McVey GL, Levine MP, Piran N, Ferguson HB (eds) Preventing eating-related and weight-related disorders: collaborative research, advocacy, and policy change. Wilfred Laurier University Press, Waterloo, pp 199–222
15. Lincoln YS, Guba EG (2000) Paradigmatic controversies, contradictions, and emerging confluences. In: Denzin NK, Lincoln YS (eds) Handbook of qualitative research, 2nd edn. Sage, Thousand Oaks, pp 163–188
16. Piran N, Teall T (2012) The developmental theory of embodiment. In: McVey GL, Levine MP, Piran N, Ferguson HB (eds) Preventing eating-related and weight-related disorders: collaborative research, advocacy, and policy change. Wilfred Laurier University Press, Waterloo, pp 169–198
17. Rice C (2014) Becoming women: the embodied self in image culture. University of Toronto Press, Toronto
18. Morse J (1999) Qualitative generalizability. Qual Health Res 9:5–6
19. Cuzzolaro M (2014) Eating and weight disorders: studies on anorexia, bulimia, and obesity turns 19. Eat Weight Disord 19:1–2. doi:10.1007/s40519-014-0104-9
20. Austin SB (2011) The blind spot in the drive for childhood obesity prevention: bringing eating disorders prevention into focus as a public health priority. Am J Pub Health 101(6):e1–e4. doi:10.2105/AJPH.2011.300182
21. Shildrick M (1997) Leaky bodies and boundaries: feminism, postmodernism and (bio)ethics. Routledge, New York
22. Merleau-Ponty M (1962) Phenomenology of perception. Routledge & Kegan Paul, London
23. Derrida J (1980) Writing and Difference. University of Chicago Press, Chicago