


## ORIGINAL RESEARCH ARTICLE

# “I don't want them to think that what they said matters”: How treatment - seeking adolescents with severe obesity cope with weight-based victimization

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## Summary

Adolescents with severe obesity are subject to a high prevalence of weight-based victimization that may lead to pervasive mental health symptoms. However, different coping strategies could potentially modulate these psychological consequences. This study aims to explore how treatment-seeking adolescents with severe obesity cope with weight-based victimization. This was a qualitative research study using an interpretive phenomenological analytic approach. One-on-one semi structured interviews were completed with 19 adolescents (63% female) enrolled in a weight management program. The interviews were transcribed and sequentially analysed until data saturation was attained. The majority of participants (89.5%) described being a victim of weight-based victimization and highlighted a significant emotional toll. Two key themes were identified that captured the various coping strategies used by participants. Over half (52.9%) described approach coping strategies where they acted on the source to invoke change by standing up for themselves, helping others in similar situations or becoming a bully themselves. Whilst the majority (94.1%) used avoidant coping strategies such as feigning a strong exterior façade, denial, isolation and self-harm. Nearly half (47.1%) used both strategies. Treatment-seeking adolescents with severe obesity commonly use avoidant coping strategies to deal with weight-based victimization. These strategies are associated with negative mental health outcomes and should be evaluated when counselling adolescents with obesity who have experienced weight-based victimization.

## KEYWORDS

adolescents, bullying, coping strategies, obesity, youth

## 1 | INTRODUCTION

Adolescence is known as a particularly challenging time during which

a young person must learn to cope with dramatic changes in their

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physical, cognitive and psychosocial environments. Compared to normal weight peers, there is a much higher prevalence of weight-based victimization (ie, weight-based teasing or bullying) among adolescents affected by overweight or obesity.<sup>1,2</sup> This is a chronic stressor with

potential long-lasting psychological consequences, including low self-esteem and depression.<sup>3-7</sup> However, their ability to adaptively cope with weight-based victimization can have an important impact on their mental health.<sup>8</sup>

Coping is defined as “cognitive and behavioural efforts to manage external and/or internal demands that are appraised as taxing or exceeding the resources of the person” and is an important mediator between negative life events and psychological well-being.<sup>9</sup> The literature suggests that how one responds to a stressful situation depends on one's cognitive review of the situation and on their emotional status at that time,<sup>10</sup> highlighting the intricate web that makes up one's coping response. Several different coping models have been developed which define broad categories of coping styles.<sup>11-13</sup> Common to many of these is a delineation between active/approach and avoidance strategies.<sup>13</sup>

The first style, approach coping, is defined as efforts to act on the source to change it. This includes problem solving, cognitive restructuring, emotional expression and social support. The second style, avoidant coping, is defined as efforts to regulate emotions due to the stress.<sup>9,14</sup> This includes problem avoidance, wishful thinking, self-criticism and social withdrawal.<sup>15</sup>

Whereas approach coping strategies are associated with more positive adjustment and have fewer symptoms of depression,<sup>16,17</sup> research has demonstrated that adolescents who use maladaptive and avoidant coping styles are less likely to successfully negotiate challenges and more likely to have mental health symptoms, including negative body image and self-esteem.<sup>16,18</sup>

A systematic review of qualitative studies examining adolescents' views on obesity reveals a stigmatizing and stressful world.<sup>19</sup> However, there is scarce literature focusing on the growing population of adolescents with severe obesity.<sup>6</sup> There is even more limited qualitative research that provide narrative into how these adolescents respond to and cope with physical, verbal and social weight-based victimization. Furthermore, there is poor understanding of the importance of teaching effective coping strategies when counselling these treatment-seeking adolescents. This is the first qualitative study to explore how they cope with weight-based victimization.

## 2 | METHODS

### 2.1 | Study design

Qualitative research methodology using an interpretive phenomenological analytic (IPA) approach was used. IPA aims to offer insights into how a given person, in a given context, makes sense of given phenomena, which usually relate to experiences of personal significance.<sup>20</sup> Furthermore, IPA is valuable in understanding emotionally laden topics such as weight-based victimization and bringing to light under-researched phenomena or perspectives.<sup>21,22</sup> Research Ethics Board approval was obtained from the Hospital for Sick Children (SickKids) in Toronto, Canada. (REB # 1000057114).

### What is already known about this subject?

- Weight stigmatization and discrimination are chronic stressors among adolescents with obesity and have a profound effect on their psychological well-being.
- Adolescents' ability to adaptively cope with perceived weight stigmatization and discrimination has an important and long-standing impact on their mental health.
- A systematic review of qualitative studies examining views on obesity among adolescents paints a picture of a stigmatizing and stressful world.

### What does your study add?

- This is the first qualitative study to explore how treatment-seeking adolescents with severe obesity cope with weight-based victimization.
- Treatment-seeking adolescents with severe obesity commonly use avoidant coping strategies to deal with weight-based victimization.
- Avoidant coping strategies are associated with negative mental health outcomes and should be evaluated when counselling treatment-seeking adolescents with obesity who have experienced weight-based victimization.

### 2.2 | Study population

Adolescents aged 16 to 19 years enrolled in the SickKids Team for Obesity Management Program (STOMP), a 2-year intensive program that serves adolescents with severe obesity (BMI >99th percentile or >97th percentile with medical or psychiatric comorbidities), were approached by a research coordinator. Approximately 150 adolescent patients participate in STOMP at any given time, with approximately 70 new intake consultations per year. Purposeful sampling was used to identify individuals from the clinic that provided variable information across gender, age and length of time in the program. This form of sampling was employed as it is intended to include participants that have particular knowledge that can help inform the in-depth exploration of a subject area. Since the goal of the study was to get rich information from each individual, a large sample size was not necessary. A research coordinator invited selected adolescents to participate and informed consent was obtained for those interested.

### 2.3 | Data collection

Semi-structured interviews were conducted privately one-on-one and in-person by a female clinician-researcher (Ó. W.), who was a doctor outside of STOMP with experience in qualitative research methods.

The interviewer did not have an established relationship with the participants nor did she have any biases or assumptions prior to the study. The interview guide included a broad range of topics including weight-based victimization, friendships, home life, body image, mood, substance use, dating and sexual health. The principal author was experienced with adolescent counselling strategies in case of emotional distress and psychologists or psychiatrists were immediately accessible if required. Interviews lasted approximately 1 hour and were audio-recorded with permission. Participants received a \$25 gift card and a certificate for volunteer hours as a token of appreciation. Baseline demographic information, comorbid mental health diagnoses and anthropometry were obtained from the participants' medical chart.

## 2.4 | Data analysis

Using the framework developed by Saldana, we performed our analysis in a stepwise and iterative process from the generation of codes to the development of themes.<sup>23</sup> Recordings were transcribed verbatim and shared with the research team, including the lead researcher's field notes. To ensure rigour and reliability, more than one investigator (Ó. W., J. C.) reviewed the first five transcripts independently, and then shared their perceptions of the interviews. Based on patterns they identified, a coding framework was developed to capture the different categories of information. The broader research team (Ó. W., J. C., A. T., J. H., E. D., A. R.) subsequently met regularly to review the transcripts and coding of data, and from these discussions, common themes were identified across the experiences of participants. The coding framework was modified as new concepts were identified. All transcripts were then reviewed using the coding framework by the principal author (Ó. W.) and a software package (N-Vivo 10) was used to organize the data. Interviews were conducted until the research team determined that saturation had been reached.<sup>24</sup>

Our analysis was also reflexive consisting of multidisciplinary clinicians and researchers, which allowed discussion of our personal biases throughout data analysis.<sup>25</sup> Regular meetings were held with the research team to review the transcripts to ensure agreement in the coding of data. Where there was discrepancy in coding, the research team discussed their understanding until consensus was reached. From the collective review and discussions of the coded data, common themes were identified across the experiences of participants. A journal was kept by the principal author (Ó. W.) to document the context of each interview, including an audit trail of key analytic decisions, after each team meeting which supported the data analysis process.

Demographic, mental health diagnoses and anthropometric data were analysed descriptively using Microsoft Excel (version 16.19).

## 3 | RESULTS

In total, 27 adolescents were approached and 8 declined to participate (3 males and 5 females). 19 interviews were conducted. Those who participated were mainly female ( $n = 12$ , 63%) with a mean age of

**TABLE 1** Baseline demographic characteristics of the study cohort

	Study participants ( $n = 19$ )
Mean age (years)	16.8 ± SD 1.0
Mean BMI ( $\text{kg}/\text{m}^2$ )	43.9 ± SD 8.6
Race ( $n, \%$ )	
White	9 (47%)
Black	3 (16%)
Mixed race/other	7 (37%)
Biological sex ( $n, \%$ )	
Male	7 (37%)
Female	12 (63%)
Sexuality	
Heterosexual	15 (80%)
Other (homo/pan/bi/asexual)	4 (20%)
Mean duration in STOMP (months)	17.9 ± SD 15.8
Family household income ( $n, \%$ )	
>\$100 K	5 (26%)
\$50-100 K	7 (37%)
<\$50	7 (37%)

Note: The baseline demographic characteristics of the study cohort including mean age, mean BMI, race, biological sex, sexuality, mean duration in STOMP and family household income are expressed in terms of percentages in Table 1.

Abbreviation: STOMP, SickKids Team for Obesity Management Program.

**TABLE 2** Comorbid mental health diagnoses of the study cohort

	Study participants ( $n = 19$ )
Numbers of comorbid mental health diagnoses ( $n, \%$ )	
0	3 (15.8%)
1	5 (26.3%)
2	3 (15.8%)
≥3	8 (42.1%)
Types of mental health disorders ( $n$ ) <sup>a</sup>	
Anxiety and/or depression	23
Self-harm and/or suicidality	5
Binge eating disorder	5
Attention deficit and hyperactivity disorder	4
Other (oppositional defiant, borderline personality, post-traumatic stress disorder)	5

Note: The comorbid mental health diagnoses, divided into total numbers and different types of mental health disorders are expressed in terms of percentages in Table 2. Different types of mental health disorders include anxiety and/or depression, self-harm and/or suicidality, binge eating disorder, attention deficit and hyperactivity disorder and other (oppositional defiant, borderline personality, post-traumatic stress disorder).

<sup>a</sup>Total >19 as many had >1 condition.

16.8 years and mean BMI of 43.9. See Table 1. for the baseline demographic characteristics of the participants. A high proportion (n = 16, 84.2%) of participants had comorbid mental health diagnoses with anxiety, depression and self-harm and/or suicidality being most common (Table 2). All but 2 participants (n = 17, 89.5%) had been a victim of weight-based victimization and many (n = 15, 78.9%) highlighted its significant emotional impact. See Table 3 for related themes and quotes.

Participants described various forms of weight-based victimization, both verbal and physical, by their peers at school and family at home. Some described how it escalated over time.

Some participants highlighted names they had been called, while others described being physically “poked”, beaten up or being denied

food which negatively impacted their self-esteem. One participant described significant weight-related psychological abuse. Others described less overt forms of weight-based victimization where they were intentionally left out of activities or made to feel like the odd one out.

Through these described experiences, two identifiable key themes captured the various coping strategies used in an attempt to deal with the emotional impact of the weight-based victimization.

### 3.1 | Avoidant coping strategies

Most participants described using avoidant coping strategies (n = 18, 94%), where they tried to regulate their own emotions without

**TABLE 3** Themes and quotes pertaining to weight-related victimization and its emotional impact

Theme	Quote
Weight as the source of the bullying	“I feel like whenever, you're a chubby person and you're being bullied, your weight always comes in it even if you're not even that big, even if you're just a little chubby.” (Participant #1, female)“Throughout elementary I was bullied about my size, I went through pretty horrific experiences actually, but I learned to laugh about it. Like just address the elephant in the room and make jokes about it. Once I found out that it was Comedy Gold, I never went back, so yeah.” (Participant #17, male)
Names they had been called	“fatso, elephant” (Participant #9, male, aged 16)“fat city whore” (Participant # 6, female)
Escalation of bullying over time	“When I was little it was mostly continuous teasing or completely leaving me out and kind of making me the odd one out... And then once I got to high school it was a lot more physical. It was food being thrown at me: apples, poutine, orange peels, oranges, being pushed in the halls... once I got older the bullying was centred around my sexuality and my weight gain” (Participant #15, female)
Bullying both at home and at school	“It happened at home too sometimes, and that hurt me the most because it's bad enough to get it at school and then to go home and have your parents do it, that was difficult for me, but I guess I've gotten over that as well.” (Participant #7, female)
Weight related psychological abuse	“it would start off with small things like, “You should go on a diet and you should do this”, and then it moved up to they would only give me the bare minimum of food a day, and then if I wanted second they'd then make comments about my weight and like, “Oh are you sure you actually want to eat that.” (Participant 6, female)
The emotional impact of the bullying	“when I was younger I think it impacted my life, a lot, I was bullied, in elementary school and like also the reason why I have my, depression or whatever, because I just never thought I was good enough...Yeah, I don't really try to think about that much but sometimes, I'll get the memory of it and I'll feel down...” (Participant #1, female)“It made me feel awful, it made me feel like I was the size of an ant, because they would untie my shoe laces, they'd get me to tie them back up and they'd tip me over calling it a “cow tipping” and that seemed pretty cruel.” (Participant #17, male)

Note: The themes generated by the research team, and examples of illustrative quotes pertaining to the weight-related victimization and its emotional impact experienced by the study participants are outlined in Table 3.

tackling the source of the stress. These included the development of a public/exterior self, the denial of their trauma, avoidance or isolation and self-harm.

Many described how they managed the emotional and physical impact of the weight-based victimization throughout the years through the portrayal of a strong exterior. Participants often described the public portrayal of confidence despite having low self-esteem to distance themselves from the impact of the weight-based victimization:

“Most of the times, I like to think that I'm pretty confident. Is it always true? Not really, but I try. Like, I'm a firm believer in, like, if you say or do something enough, it just kind of becomes true” (Participant #12, female).

Another participant described how he tried to lessen the impact of weight-based victimization by doing so in isolation:

“Before, when I was younger, I would be really shook by it. I could cry. I would try to find a place to cry in peace. But now, I don't know. I think I'm more confident. I get upset, obviously, but I wouldn't show it... Because I don't want them to think that what they said matters.” (Participant #9, male).

All but one male participant described weight-based victimization. One of them described always joking about their weight prior to others commenting in order to lessen the impact:

“It does put up a shield, because it doesn't let people come in with their own jokes, because they're like, oh well, I'm not going to go and insult him, it won't affect him, because he's already like acknowledging it and stuff, he's already laughing about it. They won't get the satisfaction from me.” (Participant #17, male).

This participant also described that they did not care about the weight-based victimization, however, like other participants he contradicted this by describing the effect it truly had on him:

“I try to keep the attitude of, I don't care, I'm not going to know them in 10 years, but that only gets you so far really, because right now my world is school. What people think of you is kind of a big deal, because everybody, like my parents and everybody tells me, it's not a big deal what people think of you, well it is.” (Participant #17, male).

The emotional effects were often downplayed by participants as something that they previously let impact them but that they are no longer affected by:

“when I was younger it used to bother me a lot, but now I'm kind of numb to the fact so if somebody says something, I won't care...If you hear something enough times, eventually it's not going to mean anything to you. So, the words, 'You're fat' doesn't mean anything to me anymore” (Participant #7, female).

Some participants described withdrawing from peers or social situations as a means of coping:

“I remember being alone a lot which led me to isolate myself later instead of going and seeking help... I try not to pay attention... I don't have to care about them anymore and I don't see a point to letting them make me feel miserable.” (Participant #15, female).

Interestingly, some chose to “lose themselves” in an online world where they did not have to interact with individuals in-person:

“I like playing games for that because you can just lose yourself, and just you know, not think about anything else, you can just have fun and, just explore, be happy... I think that it's definitely a coping mechanism for some people, to lose themselves in the game, and just forget about everything.” (Participant #5, female).

Whilst others purposefully pushed people away by choosing to be unpleasant:

“It was a strategy I adapted to. Getting people to not talk to me, by doing something like that, specifically, if they just start messing with me... so they would just never mess with me again. It was very quiet, so that was nice.” (Participant #11, male).

Some participants described not engaging in relationships as they had difficulty trusting people:

“I still have a lot of trust issues around everything really. One of my biggest downfalls is that I don't trust people- I've never been given a reason to trust anyone...” (Participant #6, female).

Despite some of the individuals indicating that the weight-based victimization no longer impacted them, some described self-harming behaviours to cope with the trauma, including bingeing or restricting food intake:

“I still get the judgements, and I still feel like the past judgements get to me... I think that's why I have like a hard time... with my self-esteem so much... And I think, that was probably why I started bingeing when I was a

kid... I've been bingeing and... now it's just bingeing and restricting.” (Participant #2, female).

Others used substances and cutting behaviours:

“I had been to the Emergency Room about three times for attempted self-harm... I didn't want to hurt myself, but I didn't know what to do, how to have an outlet for my emotions. So it was my way of calming down.” (Participant #15, female).

The weight-based victimization was extreme in some cases where their peers even provided the tools to facilitate the self-harming behaviour:

“People started sending me notes that had razor blades attached to them. They taped the razor blades on and they told me to go kill myself with them, and so before that I didn't even think about self-harm and then all of a sudden, I was doing it every single day and I just had to do it.” (Participant #6, female).

### 3.2 | Approach coping strategies

Just over half of the participants described approach style coping strategies (n = 10, 52.9%), defined as efforts to act on the source to change it, including standing up for themselves, the evolution of selves into either a “saviour” or becoming a bully themselves.

A small number of participants described how they stood up for themselves:

“I'd just walk by him. I don't know the dude and he would just say, 'Ew.' And then I just went and told on him. But then he hates me more now because I told on him... But I usually don't stand for it. Like if you're going to talk about me, I'm going to talk about you.” (Participant #9, male).

Some indicated that they would not tolerate others treating them badly:

“That's one thing with people- I find ironic about people is that they always thirst for someone's approval, like okay that's good for them, I'm not gonna do s\*\*\* that I don't want to do for someone. If they actually like me then I'm pretty sure that they'd respect my boundaries.” (Participant #6, female).

From their lived experience with weight-based victimization, some participants described a concerted effort to assist those that may be victims themselves.

In a few instances, female participants described a desire to pursue careers in sectors intended to help others as a direct consequence of their experiences, including social work and counselling:

“My end goal is to go up north onto different First Nations reservations and opening chains of counselling services that run 24 hours and employs people and gives people opportunities. (Participant #6, female).

While some attempted to help others that experienced similar experiences, others ultimately became the bully themselves:

“I think I was a victim, but I'm pretty sure I did bully other people, I probably can't name it off the top of my head, because I wasn't always noticing it at the time. I was just doing it to make myself feel better.” (Participant #17, male).

## 4 | DISCUSSION

The vast majority of participants described experiences of emotional and physical weight-based victimization at the hands of peers and family. The majority also had comorbid mental health diagnoses. The main study finding is that just over half of the participants used approach focused strategies such as standing up for themselves or others, while the vast majority used avoidant strategies, such as isolation and self-harm. Nearly half used both strategies. These coping strategies in response to weight-based victimization have not been previously described in this population.

Tobin et al examined the structure of coping using a hierarchical factor analysis comprised of eight primary factors, four secondary factors and two tertiary factors. The primary factors identified were avoidant coping strategies including problem avoidance, wishful thinking, self-criticism and social withdrawal and approach coping strategies including problem solving, cognitive restructuring, emotional expression and social support.<sup>15</sup> These primary factors identified dimensions of coping found in previous empirical research and theoretical writing.<sup>15</sup> Tobin et al's analysis also resulted in the emergence of higher-order strategies which unified several hypotheses about the structure of coping. The second-order factors were categorized into two types of problem-focused coping activities (problem engagement and problem disengagement) and two types of emotion-focused coping activities (emotion engagement and emotion disengagement). At the tertiary level, coping strategies were broadly organized into activities that allow an individual to engage or disengage with the stressful situation.<sup>15</sup> Our study explored these concepts in greater detail by asking participants to describe in detail the stigmatization they suffered, and their coping methods.

Examples of avoidant strategies used included the development of a public/exterior self, which the research team named “the mask”, and the denial of their trauma at the time. Participants also withdrew socially and used self-harm. Approach strategies described less frequently included



standing up for themselves and others. Becoming a bully is an example of emotional expression and the evolution of selves into either a “saviour” of others could be seen as a form of problem solving.

The reported experiences of weight-based victimization in this study are in keeping with other qualitative studies in the literature examining treatment-seeking adolescents' views on obesity.<sup>19</sup> In a similar study, Yufe et al examined the experience of weight-based victimization in young adult bariatric patients and also found that many coped through avoidance.<sup>26</sup>

Sikorski et al found elevated psychological risk factors in adolescents with obesity and concluded they may be a mediator between weight-based discrimination and mental health disorders.<sup>8</sup> It is well established that the relationship between obesity and mental health disorders is likely bidirectional.<sup>8,27</sup> The underlying mental health issues experienced by patients in this study may have had an impact on their perceived experiences compared to adolescents with obesity without mental health comorbid conditions. Himmelstein et al studied coping specifically in relation to obesity stigmatization and examined whether particular forms of coping were associated with adaptive or maladaptive psychological outcomes.<sup>17</sup> They found stigmatization was common and related to more depressive symptoms, lower self-esteem and poorer physical health.<sup>17</sup>

It has also been well documented that stressful events, such as weight-based victimization are associated with emotional and behavioural problems in children and adolescents. Compas et al described how efforts to alter a source of stress and regulate the related negative emotions are important in reducing the subsequent negative effects.<sup>14</sup> Therefore, how an individual copes with the source of stress is an important mediator of their subsequent psychological well-being.

The majority of participants described behaviours that would be characterized as avoidant approaches which are associated with increased mental health disorders. Many studies have found that symptoms of anxiety, depression and somatic problems were high when there was a poor fit between appraisals and coping; for example, using an approach strategy when the stressor was uncontrollable.<sup>17,18,28,29</sup> It is possible that the study participants did not feel they had control over the weight-based victimization, and therefore, chose not to use approach coping styles.

Supporting the literature, our study found that many of the participants had a mental health diagnosis, with depression and anxiety being the most commonly cited. Herman-Stahl et al specifically looked at the relationship between coping style and depression in adolescents and found that those who could elicit support from others and engage in adaptive approach strategies including problem solving and cognitive restructuring were more likely to successfully negotiate challenges. They found that peer and parent relationships were important buffers of the stress.<sup>16</sup>

Approach strategies were less frequently described by participants and the majority did not describe a positive or open relationship with their peers or parents, with many of them wearing a “mask” to avoid revealing the true extent of the emotional impact of the weight-based victimization. Therefore, they were lacking important sources of support that could help them engage in an increased level of approach coping strategies.

In this study, a gender difference was noted in the description of weight-based victimization, its emotional impact and the coping strategies used to deal with it. Female participants provided more detailed descriptions of weight-based victimization and its emotional impact on them. They also were more likely to engage in self-harm and isolation than their male counterparts. The minority of females reacted in a more approach style of becoming the “saviour” of other victims of weight-based victimization.

Conversely, the male participants described significantly less weight-based victimization overall, or even denied it occurred despite giving examples of how they used self-deprecating humour and violence to cope with it. Both male and female participants who used avoidant strategies to cope spoke about feelings of sadness, low self-esteem and even fear of rejection.

Similarly, Puhl and Luedicke found gender differences in how overweight adolescents reacted to weight-based victimization when they systematically examined their affective reactions and coping strategies. Females were more likely to be affected, have negative affective reactions and have more avoidant coping strategies.<sup>18</sup>

Limitations of the study include the possibility of participant self-selection, whereby adolescents with severe obesity with negative experiences may have wanted to talk about their experiences more so than those who had not. Additionally, having a female interviewer may have impacted what participants, in particular the males, were willing to divulge. This is an important potential limitation to acknowledge in a qualitative study where self-reflection is critical in the interview process and analysis. Furthermore, the population is a clinical sample of adolescents with severe obesity already attending a treatment program, and therefore do not necessarily reflect the general population of adolescents with severe obesity. The potential difference between a treatment seeking population and a non-treatment seeking population warrants further exploration and study in future research. Lastly, since a significant number of participants used both avoidant and approach coping strategies, this study could not stratify participants into two dichotomous groups and determine differences in baseline demographics such as race, socioeconomic status and number of mental health conditions.

## 5 | CONCLUSION

It is known that weight-based victimization has a significant emotional impact on adolescents with obesity and can be associated with poor psychological outcomes. This study is the first to qualitatively explore how treatment-seeking adolescents with severe obesity cope with weight-based victimization. It explores the propensity towards choosing avoidant vs approach coping strategies and some factors that influence this behaviour. Future research could consider a mix methods approach to triangulate the data with quantitative methods (eg, established coping questionnaires like the Brief COPE<sup>30</sup>) along with qualitative interviews which maintain the rich voices of these youth. Doing so would help to further define the complexities of lived coping experiences of youth who experience weight-based victimization.

This study highlights the importance of the need for healthcare providers to discuss weight-based victimization with patients. In depth conversations are required to assess its severity and whether the adolescent has the required skills to help them cope effectively. The perception of control over the weight-based victimization is an important factor as this can help guide which strategies are more likely to be successful.

In order to provide comprehensive care, weight management programs must aim to improve not only the physical health but also the psychological wellbeing of adolescents who are known to be at risk of significant stigmatization. This should include counselling on effective coping strategies.

Engaging adolescents is essential to understanding their needs and experiences during this key transitional life stage. This study has demonstrated the value of peer relationships and integration into peer groups as a way to improve psychological well-being. This serves as a foundation for future research exploring how adolescents with severe obesity navigate social situations.

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## CONFLICT OF INTEREST

No conflict of interest was declared.

## AUTHOR CONTRIBUTIONS

Órla Walsh carried out all interviews. Órla Walsh and Jennifer Christian analysed all interview transcripts. Órla Walsh, Jennifer Christian and Alene Toulany contributed to the development of themes. All authors were involved in writing the article and had final approval of the submitted and published versions.

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