WHITE PAPER
The Language of Eating Disorders: What the ED Professional Needs to Know
Addendum: Language Directed to Binge Eating Disorder (BED), Compulsive Overeating (CO) and People of Size

Purpose: the purpose of this addendum is to increase the awareness and educate the professionals who work with, treat, or educate, patients with BED, CO, and people of size on the "language" appropriate for this population.

Note: The above diagnoses are clearly defined and the professionals working with these patients should be aware of and understand these clinical parameters when using terminology within the patient conversation with insurance reviews, general writing, article submission and presentations at all levels.

Intro
 Binge eating disorder (BED), compulsive overeating (CO), represent the largest population within the eating disorder spectrum. The dialogue and conversations about weight and the associated food behaviors can evoke feelings of failure, shame, and judgment. Health care providers working with these individuals using improvised or uninformed discussions may disengage, stigmatize, or shame patients to the detriment of the provider-patient relationship, treatment goals, and patient outcomes.

Anyone, regardless of their age or sex can experience the negative consequences of weight stigmatizations. Strong weight disapproval attitudes continue to exist in our Western society due to the belief that there should be an inherent controllability factor associated with one's body size. Research has established that people correlate obesity or being fat with laziness and a lack of self-control whereas thinness is viewed as evidence of one's superior motivation and self-discipline. (*Greenleaf et al, 2004*)

The responsibility of the healthcare professional is to treat the eating disorder as a disease as described under the DSM-5 and not a behavioral choice. Maintaining this primary focus will redirect language more appropriately while also assisting the patient in establishing an identity outside of the eating disorder. This conversational lexicon allows the integration of the most important and fundamental principle of "people-first" language.   This means avoiding the use of the disease term as an adverb or noun to describe the individual or group of people. For example, avoid reference as a "diabetic" or "anorexic".   Reference to an individual *"who has"* cancer, diabetes, anorexia, bulimia, obesity, binge eating

disorder, etc., is clear recognition of the diagnosis and the recommended language to use when discussing those afflicted with an illness. Equally important is the skillful use of re-scripting and the integration of symbols and metaphor by the ED professional to further enhance meaningful dialogue.

General Guidelines
The following are important considerations when working with this population:

Avoid Assumptions:
Those who have a high body weight:
May or may not binge
May or may not overeat
May or may not be addicted to food
May or may not have a negative body image
May or may not under exercise
May or may not desire to change their weight

Those with BED or CO:
May or may not have high body weight
May or may not have a negative body image

Become Familiar With and Recognize:
Subjective vs. objective binge eating
Current media terminology that directly impacts this population
Current advancement in the scientific understanding of the inter-related relationships among multifaceted elements that affect health (e.g., the effect of microbiota, stress, sleep, hormonal changes, etc.)
Assessing the readiness to change which may affect their openness to conversation and the "language" that is acceptable
Recognize your own weight bias and reaffirm that you are comfortable and competent to work with this population

Focus of language:
Emphasis on health not appearance
Sensitivity towards an "obesogenic" (obesity causing) environment
Avoidance of extreme reactions to formation or details of behaviors disclosed by the patient
Validation of the concerns or emotions expressed regarding their behaviors in order to strengthen the provider-patient relationship
Based on the medical/behavioral definitions of the diagnosis
Based on the current research of what conversational terminology has been identified to reduce stigmatization and lead to improved outcome
Initiated by listening and allowing the client to discuss his/her weight and invite him/her to define the nature of their weight issues or associated health concerns

Specific Terminology

The following information has been summarized from referenced research articles and experts in the field. It is important to note that medial terms such as *overweight* and *obese* have changed definitions over time. These medical terms also have been associated with the assumption of *overeating*. The medical term "obese" has evolved into a word that has a negative social meaning, implying a sense of disgust. The medical term "overweight" conveys the idea that there is some "correct" weight a person should weigh. Inversely, words such as *underweight* and *normal weight* have precise meanings in relation to body mass index (BMI), yet do not have the negative stigma that *overweight* and *obese* invoke. Language and word choice are a "social action" which is influenced by societal and interpersonal factors and thus has communal as well as relational consequences. Language not only reflects but, in fact, often determines, reality. What is said is not necessarily what will be interpreted or heard. A person hearing the term "fat" may not think of fat *shape.* But, rather hear *unworthy, lack of respect, lack of acceptance.* These words may become part of an internal self -language. To this end, it is important for professionals to use their knowledge and understanding of eating disorders to tailor acceptable conversational language while motivating a behavior change.

The following is a summary of recommendations from the literature as well as experts in the field on the language and terms to use in working with the eating disorders population. It is important to tailor the message to the audience to whom you are speaking that may include other professionals, a treatment session with an individual or group, readers of your professional or community writing, policy makers or journalists, and public conversation in general. Continuous effort on the part of the healthcare professional will be required to hone these skills and integrate them into practice as leaders in the field

Less Desirable	*Currently Found to be Acceptable*
Overweight, obesity, fat, chubby, full figured, plus size, curvy, voluptuous, large frame, heavy set, heaviness, obesity, large size, excess fat, fatness	*People of size, people at the higher/upper end of the continuum of size, people in larger bodies*
Morbidly, severely, super obese (Class I, II, and III obese)	*Statistical extremes of BMI*
Exercise, fitness	*Joyful movement, activity empowerment active lifestyle, physical wellness, physical activity, sense of well-being*

Diet (*in relationship to weight*)	*A non-diet approach*
Diet (*in relationship to food intake*)	*Mindful eating, eating habits, attuned eating, intuitive eating, balanced eating, conscience eating*
Weight loss	*Size (body) acceptance, support improved health benefits for people of size where weight loss may or may not be a side effect*
Weight loss, BMI, % body fat, Ideal Body Weight, Height and Weight Charts	*Weight neutral, reducing intra-abdominal (visceral fat), unhealthy weight, healthier weight, healthier body, whole person's health*
Confirmation bias	*Once a belief is in place, people screen information in a way that ensures their beliefs are proven correct*
Evidenced Based/ False Assumptions	*People judge science by whether or not it agrees with what they believe to be true*
Anyone can lose weight if they have the right strength of character, try hard enough and put their mind to it	*Long term weight loss for people of size is elusive and unattainable for the vast majority of people*
Thin privilege	*Receiving unjust advantages at the expenses of others, privilege*
Makeover	*Signature Strengths, Image empowerment*
Do not assume fat is a marker for health risks or an eating problem	*Weight neutral, proven medically necessary*
Misplaced compassion	*If you have not experienced being a person of size: You cannot represent nor truly understand what it is like to live in their body; it is not okay to define their experience*
Fat phobia, Stigmata, Discrimination, Shaming, Prejudice	*This attitude caused disparity and pain for people of size, creates eating disorders and fears of becoming fat (dignity and equality)*

Quick weight loss	*Slow and steady habit change*
Attractive; Thin Ideal: Slim; Slender; Beautiful	*To change the way you look, you need to change the way you see...and to change the way you see, you need to change the way you feel...which changes the way you describe yourself and changes the way you behave and experience your body*
Perfection	*-Achievement*

Understanding the complexity of BED, CO, and working with people of size is an important prerequisite for any productive dialogue with a patient or audience. Personal bias or misconceptions on the part of the professional or expressed by the professional can lead to shame or stigmatization and may undermine productive conversation or audience engagement.   Language education and compassionate interaction requires attention and review both clinically and socially to maintain productive conversations in the eating disorder field.

References:

Carson RE. Binge Eating Disorder Chapter in Michael G Steelman and E Westman (EDS) Obesity: Evaluation and Treatment Essentials (CRCPress), 2016.

Dietz WH, S Kahan. STOP Obesity Alliance. George Washington University and Chandler Chicco Agency: 2014. www.stopobesityalliance.org.

Golden NH, Schneider M, Wood C. Preventing Oesity and Eating Disorders in Adolescents. American Academy of Pediatrics. 2016, 138(3).doi: 10.1542/peds.2016-1649.

Gray CM, Hunt K, Louriner K, Anderson AS, Benzeval M, Wyke S. Words matter: A qualitative investigation of which weight status terms are

acceptable and motivate weight loss when used by health professionals. BMC Public Health. 2011, 11:513.doi: 10.1186/1471-2458-11-513.

Greenleafa C, Starksa M, Gomezb L, Chamblissc H, Martina S. Weight-related words associated with figure silhouettes. Body Image 1: 2004, 373-384.

Lilienfeld SO, Sauvigne KC, Steven JL, et al. Fifty psychological and psychiatric terms to avoid: a list of inaccurate, misleading, misused, ambiguous, and logically confused words and phrases. Front.Psychol. 03 August 2015, 2/34-31/34.

Puhl RM, Peteron JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. Int J Obes (Lond). 2013 Apr; 37(4):612-9.

Volger S, Vetter ML, Dougherty M, et al. Patients' preferred terms for describing their excess weight discussing obesity in clinical practice. Obesity (Silver Spring). 2012 Jan;20(1):147-150.

Weissman RS, Becker AE, Bulik CM, Frank GKW et al. Speaking of that: terms to avoid or reconsider in the eating disorders field. Int J Eat Disord 2016. 49:349-353.