Management of eating disorders for people with higher weight: clinical practice guideline

Considerations regarding language

This resource outlines the rationale for the language chosen regarding 'high weight' within this Guideline and NEDC's approach to language on this topic.

Summary

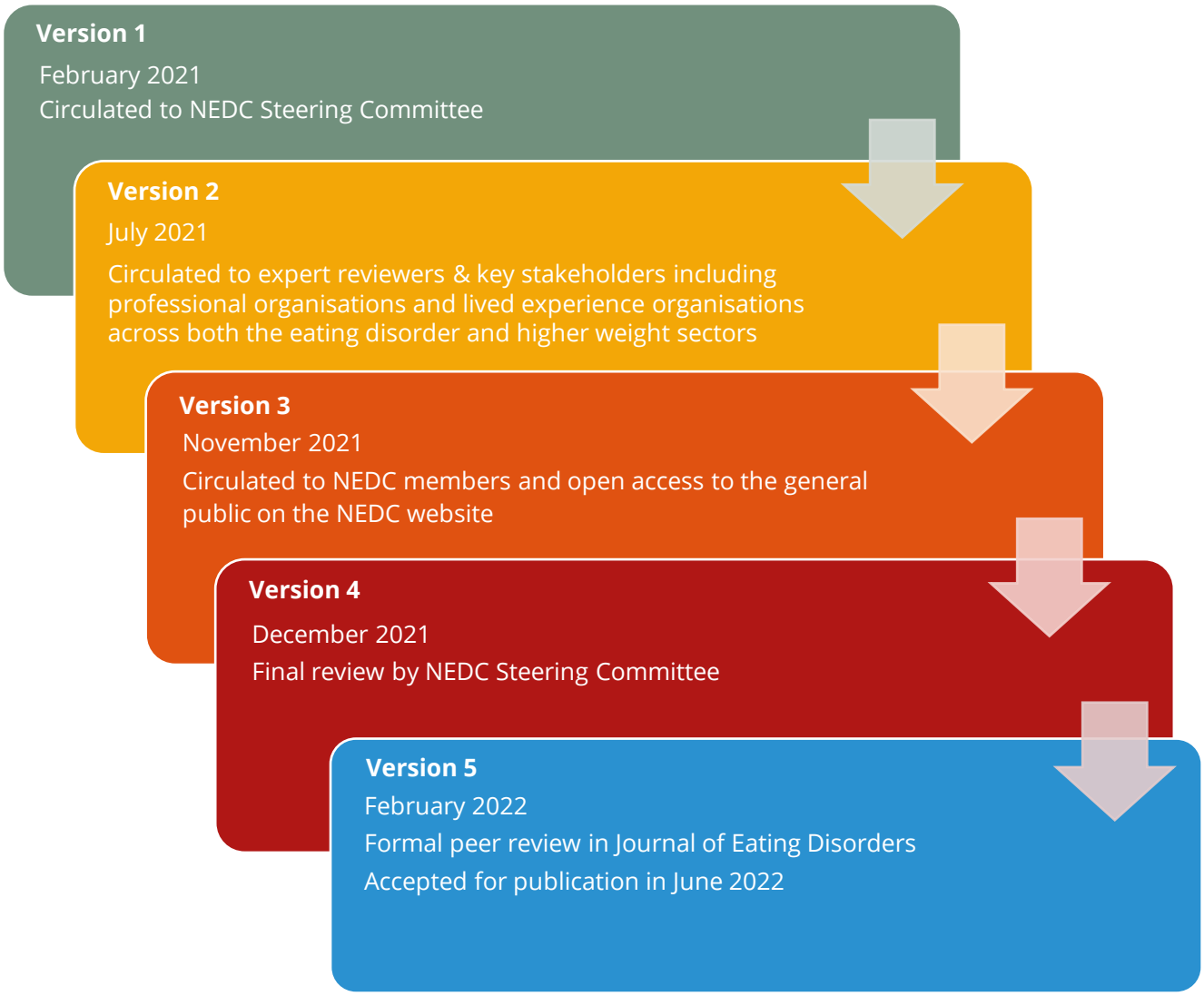
- Weight stigma **[LINK TO COME]** is common and causes harm
- One important aspect of addressing weight stigma is the use of language that is affirming and inclusive for a person with higher weight
- There is not one universally preferred term for people with higher weight and health professionals should discuss preferred language with each person
- The Guideline uses the phrases 'people with higher weight' and 'living in a larger body'
- These terms were chosen based on consultation with people with lived experience of eating disorders and higher weight, as well as research literature in this area

Brief background to the Guideline:

The aim of Management of eating disorders for people with higher weight: clinical practice guideline is to synthesise current best practice approaches to the management of eating disorders in people who are of higher weight, based on the premise that every person with an eating disorder is deserving of equitable, safe, accessible, and evidence-based care regardless of their body size. The Guideline accords with the role and function of the National Eating Disorders Collaboration (NEDC) to bring together research evidence, clinical expertise and lived experience in national standards to improve the system of care for all Australians.

In 2019, the NEDC Steering Committee auspiced this Guideline and a Guideline Development Group was formed comprising academic, clinical, and lived experience from diverse disciplines. Modelled on the 'Guidelines for Guidelines' process outline by the National Health and Medical Research Council (NHMRC), the Guideline was not only informed by recent systematic reviews, meta-analyses and primary trials, but also clinical expertise and lived expertise. This guideline has undergone extensive peer review and consultation over an 18-month period involving reviews by key stakeholders, including experts and organisations with clinical and/or academic expertise and/or lived experience. This process is outlined in the figure below.

The Guideline has undergone five stages of review and consultation:



Use of language

An important aspect in addressing weight stigma is in the use of language that is affirming and inclusive for someone with higher weight. For this reason, the Guideline uses the phrases 'people with higher weight' and 'living in a larger body'. These terms were chosen based on consultation with people with a lived experience of eating disorders as well as existing literature in this area (e.g., Hart et al., 2021; Puhl, 2020). Notwithstanding this approach, it is important to emphasise that there is not one universally preferred term for people living in larger bodies and health professionals should discuss preferred language with each person.

Cognisant of weight stigma and other considerations in this Guideline, the terms *larger bodied* and *higher weight* include people with high body mass index (BMI; kg/m^2) through low adiposity and high muscle density (i.e., muscle building/athletes in larger bodies), as well as those with high adiposity. It also includes people with high adiposity and normal metabolic health indices and no physical heath co-occurring conditions (Zembic et al., 2021). Thus, this Guideline does not define higher weight by a BMI cutoff but rather focuses on a conceptualisation of a larger body that includes people who may be impacted socially and by the health system by standard BMI cutoff points.

Examples of phrases to avoid	Alternative language and considerations
Obese/overweight person Obese/overweight child Obese/overweight subject/participant	Neutral phrases such as "person with higher weight", "larger-bodied", "person living in a larger body"
Unhealthy weight/healthy weight Unhealthy BMI/healthy BMI Excess weight	Weight and BMI are poor indicators of the health of a person and assumptions should not be made about a person's health based on their weight

Note: There is not one universally preferred term for people with higher weight and health professionals should discuss preferred language with each person. For example, some people may prefer the term 'fat' as a reclaimed neutral descriptor, but this term should not be used without consent.

Limitations of BMI

Historically BMI has been and continues to be widely used as an indicator of risk relating to physical health status. However, it is acknowledged that there are limitations of BMI and it should not be relied upon as a sole measure. As noted above, body composition can be highly variable in people with the same BMI and it can be influenced by many factors such as age, sex, race, and muscularity. BMI has utility as a chronic disease risk marker in a population but should be used with other indicators of health status for a person. In individual assessment, other anthropometric, biochemical, and behavioural measures may include waist circumference, blood pressure, blood glucose and lipid profiles. In children and adolescents, height and weight growth velocity are preferred to the BMI. For all people it is more useful, if possible, to consider the person's pre-illness growth trajectory as likely to be close to their 'normal' or 'natural' body habitus. This trajectory should be used to guide assessments of nutritional repletion and physical recovery. It is also important to note that people living in larger bodies may have been engaged in weight suppression strategies for many years (in some instances, since childhood), and prior to the eating disorder, and thus their pre-illness BMI may yet be weight-suppressed rather than 'natural'.

Recommendations

In addition to in-depth discussion of clinical considerations and recommendations, the Guideline contains 21 recommendations which are graded according to the National Health and Medical Research Council evidence levels.

There is one recommendation specific to use of language:

Nutritional and medical management	Level of Evidence*
Nutritional/medical guidance should minimise language that can reinforce poor self-worth and contribute to worsening eating disorder behaviours	C

* NHMRC grades range: A. Body of evidence can be trusted to guide practice e.g., meta-analyses of randomised controlled trials (RCTs) low risk of bias; B. Body of evidence can be trusted to guide practice in most situations (RCTs or other controlled studies, low risk of bias); C. Body of evidence provides some support for recommendation(s) but care should be taken in its application (moderate risk of bias in trails); and D. Body of evidence is weak and recommendation must be applied with caution (high risk of bias in trails). Full criteria in Appendix C.

Access to Guideline

Access the full guideline here or go to: https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-022-00622-w

References

Hart, L. M., Ferreira, K. B., Ambwani, S., Gibson, E. B., & Austin, S. B. (2021). Developing expert consensus on how to address weight stigma in public health research and practice: A Delphi study. *Stigma and Health*, *6*(1), 79.

Puhl, R. M. (2020). What words should we use to talk about weight? A systematic review of quantitative and qualitative studies examining preferences for weight-related terminology. *Obesity Reviews*, *21*(6), e13008.

Zembic, A., Eckel, N., Stefan, N., Baudry, J., & Schulze, M. B. (2021). An empirically derived definition of metabolically healthy obesity based on risk of cardiovascular and total mortality. Journal of the American Medical Association Network Open, 4(5), 1-14.