

EASO

European Association for the Study of Obesity

PERSON FIRST LANGUAGE GUIDE: ADDRESSING WEIGHT BIAS



EASO promotes person-first language and non-stigmatising images in all obesity-related written and verbal communications. EASO actively works to reduce weight bias and weight-based discrimination, urging researchers, healthcare professionals, policymakers, media professionals and others to use inclusive language, communications, and practices. This short guide aims to support the development of non-stigmatising research, project outputs and other communications.

Background on obesity as a chronic disease and weight bias

Obesity is a progressive, relapsing, chronic disease that affects a large portion of the global population.¹ Obesity is caused by a complex network of factors, including genetics, physiology, psychosocial factors and the environment.² Unfortunately, obesity is a highly stigmatised disease.³ This stigma is partially due to the oversimplification of obesity, framing it as the responsibility of the individual, or that having obesity is solely a 'lifestyle choice'. Oversimplification of obesity in research, medical practice, or policy may unintentionally perpetuate negative bias towards obesity and weight.⁴ Moreover, experiencing weight stigma has significant consequences for both wider health and socioeconomic well-being. Studies show that weight stigma can increase morbidity and mortality independently of a person's weight or BMI.⁵

People living with obesity experience bias and stigma throughout life and across various settings, including homes, schools, workplaces, media, public spaces, and healthcare environments.⁶ Obesity stigma manifests through social stereotypes, such as:

- People with obesity are lazy, unmotivated, lacking willpower, unsuccessful, ugly, and unintelligent.
- Patients with obesity are non-compliant with healthcare recommendations.
- Individuals with obesity do not exercise.
- Individuals with obesity do not eat healthily.

These stereotypes contribute to discrimination in school, workplaces, and healthcare settings. For example, teachers influenced by weight-based stereotypes may have lower expectations for students with higher weight and may provide fewer learning opportunities to children living with obesity ultimately affecting children's educational outcomes.

How can the obesity community – including researchers, policymakers, industry professionals and students – reduce weight bias in their work?

Use non-stigmatizing and person-first language

To avoid the perpetuation of weight bias in research, healthcare and policy, international obesity associations, including EASO, advocate for effective communication based on the fundamental values of respect, compassion, and person-centred healthcare and research.

The language used with, and also about, research participants living with obesity can influence their engagement in health care interventions and research studies. Implicit weight bias can be expressed in words such as describing persons as objects (e.g. a 500 pounder) or through negative attributes about people with obesity (e.g. non-compliant patient). Alarmist terminology (e.g. obesity framing as a burden to society can lead to blaming and shaming of people living with obesity).⁷

One way to enact these values of person-centred healthcare and research is the use of person-first language in all communications.⁸ Person-first language is the standard for respectfully addressing people with chronic diseases. Person-first language avoids labelling people by their illness and defining a person's identity by their health condition.

EASO urges all to adopt person-first language for chronic diseases such as diabetes, obesity, cancer, or hypertension. Researchers should urge media outlets to use person-first language when reporting on research.



Table 1. Examples of person-first and non-person-first language relating to obesity

| NON-PERSON-FIRST | PERSON-FIRST |
|---|---|
| Obese participants | Participants with obesity or participants living with obesity |
| Obese person | Person with obesity or person living with obesity |
| Morbidly obese patient | Patient with severe obesity or patient living with severe obesity |
| Hypertensive patient | Patient with hypertension or patient living with hypertension |
| Diabetics | People with diabetes or people living with diabetes |
| Demented individual | Person with dementia or individual living with dementia |
| Obese subjects | Participants with obesity |
| Overweight person | Person with overweight |
| Obese - BMI greater or equal to 30 kg/m ² | Obesity - BMI greater than or equal to 30 kg/m ² |
| Participants with healthy, overweight, or obese body mass index (BMI) category | Participants classified with healthy weight, overweight, or obesity based on body mass index (BMI) category. |
| Participants were stratified by sex/gender and BMI category (healthy “18.5 to 24.9 kg/m ² ”, overweight “25 to 29.9 kg/m ² ”, and obese “> 30 kg/m ² ”). | Participants were stratified by sex/gender and BMI category (healthy weight “18.5 to 24.9 kg/m ² ”, overweight “25 to 29.9 kg/m ² ”, and obesity “>30 kg/m ² ”). |
| Non-compliant patient | Treatment non-adherence was observed in XX number of patients... Patients had difficulty with treatment adherence... |
| Is this patient/client appropriate for X intervention (medical, surgical) | Is X (bariatric surgery, pharmacological, behavioural, etc) the most appropriate intervention for this patient/client. |
| A total of 30 patients failed to lose weight. | Treatment non-response was observed in 30 patients. |
| More than 50 patients did not respond to the treatment. | Treatment non-response was observed in more than 50 patients. |

Ensure sensitivity in communications on childhood obesity

Educating young children on obesity is particularly sensitive, because they may not yet understand the importance of or have concerns about health. Childhood obesity prevalence is rising across the world, and, therefore, many children in nurseries and schools may already live with overweight or obesity. The obesity community should discourage discrimination against children with obesity for being 'unhealthy' or 'bad' due to their weight. Messages around obesity should promote inclusivity and understanding by emphasising the importance of self-acceptance, body shape diversity and overall good health. Researchers and healthcare professionals should ensure messages to children promote balanced nutrition and regular physical activity for all, as well as other behaviours which support health like adequate sleep, not only children with obesity. Messaging should encourage positive self-image by highlighting factors that contribute to a person's well-being beyond appearance.

Use non-stigmatising images

Unfortunately, many public facing images portray people living with obesity in a negative manner. The European Coalition for People Living with Obesity (ECPO) offers an open access image bank that depicts individuals with obesity in ways that are positive and non-stereotypical. These images provide fair and non-biased representation of youth and adults living with obesity and can be found here: <https://ecpomediamedia.org/image-bank/>. Researchers and healthcare professionals are strongly encouraged to use non-stigmatising images in research activities and communications to help challenge harmful weightbased stereotypes, and encourage media professionals to use these images when reporting on research outputs.



Here is a short message template which can help encourage media professionals to use this image bank: *"I advocate for the use of person-first language and non-stigmatising imagery. Please use 'person with obesity' instead of 'obese person' when reporting on this research. Non-stigmatising images of people living with obesity can be found here: <https://ecpomediamedia.org/image-bank/>".*

Key messages to convey to avoid the perpetuation of obesity and weight bias

Researchers, healthcare professionals, policymakers and others in the obesity community can help dismantle stereotypes related to obesity and weight bias by conveying the following key themes in research and project outputs:

1. Key message: Obesity is a complex chronic disease

- a. **Use the medical definition of obesity**, which is “a complex chronic disease characterised by dysfunctional or excessive body fat that impairs health and/or wellbeing”⁹ In this context, “dysfunctional” body fat refers to the accumulation of excess fat in organs and tissues as well as changes in fat cell function, which can have major repercussions in other organs.
- b. **Emphasise diagnosis by qualified health professionals using medical screening and assessment tools beyond BMI and body weight.** Traditionally, BMI has been used as a surrogate measure of body fat, and thus an objective parameter to define obesity. However, BMI should serve as a screening measure for obesity when considered alongside other clinical indicators to help identify individuals who may benefit from obesity management interventions. Obesity should be treated as seriously as any other chronic disease, necessitating consultation with a healthcare professional to determine the most effective treatment.
- c. **Recognise the development of obesity is underpinned by a complex network of factors and avoid framing having obesity as entirely a personal choice or personal responsibility.** Research shows that health behaviours occur within the context of personal, social, and environmental factors¹⁰. Having obesity is not always rooted in making poor eating and physical activity choices. For example, if an individual has low socioeconomic positioning it may not be possible for that adult or child to make consistently healthy eating and physical activity choices. Choices around nutrition and exercise are small parts of the complex network of factors which, if addressed, could support obesity prevention/management. Encourage individuals to focus on their healthy eating and exercise plans as part of the overall comprehensive chronic disease management plan that they have developed in collaboration with their healthcare provider.

2. Key message: All deserve good health, dignity and respect, regardless of body weight or shape

- a. **Emphasise health and quality of life for people of all sizes, recognising that health can happen across a range of BMI levels.** Clarify that if individuals are not experiencing any health impairments due to their weight, they may not have obesity (the disease). Avoid encouraging weight loss unless medically necessary to support improved overall health.
- b. **Advocate improved overall health as the primary goal, avoiding exclusive focus on weight reduction for obesity interventions.** Acknowledge that obesity has numerous health impacts and can affect several organ systems, leading to poorer physical and psychosocial wellbeing. In severe cases, excess accumulation of body fat may lead to functional limitations (e.g. reduced mobility). Avoid recommending specific weight goals or ranges for individuals, focusing on improving healthy habits and quality of life rather than weight loss.
- c. **Avoid measuring the impact of healthy eating and physical activity behaviours in terms of weight loss.** Weight is not a behaviour and should not be a target for behaviour change – weight loss may or may not happen when individuals adopt healthy eating and exercise habits.

3. Key message: Researchers and other professionals in the obesity community should only disseminate evidence-based information about obesity and weight management

- a. **Dispel the oversimplified view that obesity is solely determined by unhealthy eating and lack of exercise, and highlight the complexity of obesity management.** A stereotype of obesity is that the amount of fat in your body is only determined by what you eat and how much you exercise. However, consistent obesity management over the long-term is much more complex than the outdated notion of 'energy in, energy out'. Genes play a major role in obesity. Genetic-environmental interactions drive obesity; genes make a person more susceptible to the impact of the environment.
- b. **Do not recommend fad diets or exercise plans as they lack evidence-based support.** While short-term 'quick-fix' solutions can sound appealing, they are usually temporary and can be linked to high rates of weight regain.

REFERENCES

1. Ralston J, Brinsden H, Buse K, Candeias V, Caterson I, Hassell T, et al. Time for a new obesity narrative. *Lancet*. 2018 Oct 20;392(10156):1384–6.
2. Wharton S, Lau DCW, Vallis M, Sharma AM, Biertho L, Campbell-Scherer D, et al. Obesity in adults: a clinical practice guideline. *CMAJ*. 2020 Aug 4;192(31):E875–91.
3. Rubino F, Puhl RM, Cummings DE, Eckel RH, Ryan DH, Mechanick JL, et al. Joint international consensus statement for ending stigma of obesity. *Nat Med*. 2020 Apr;26(4):485–97.
4. Ramos Salas X, Forhan M, Caulfield T, Sharma AM, Raine K. A critical analysis of obesity prevention policies and strategies. *Can J Public Health*. 2017 Sep;108(5–6):e598–608.
5. Sutin AR, Stephan Y, Terracciano A. Weight Discrimination and Risk of Mortality. *Psychol Sci*. 2015 Nov;26(11):1803–11.
6. Ramos Salas X, Forhan M, Caulfield T, Sharma AM, Raine KD. Addressing Internalized Weight Bias and Changing Damaged Social Identities for People Living With Obesity. *Front Psychol*. 2019;10:1409.
7. Kirk SF, Forhan M, Yusuf J, Chance A, Burke K, Blinn N, et al. Mapping changes in the obesity stigma discourse through Obesity Canada: a content analysis. *AIMS Public Health*. 2022;9(1):41–52.
8. Durrer Schutz D, Busetto L, Dicker D, Farpour-Lambert N, Pryke R, Toplak H, et al. European Practical and Patient-Centred Guidelines for Adult Obesity Management in Primary Care. *Obes Facts*. 2019;12(1):40–66.
9. World Health Organization. Health service delivery framework for prevention and management of obesity [Internet]. World Health Organization; 2023 May. Available from: www.who.int/publications/i/item/9789240073234
10. McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Educ Q*. 1988 Winter;15(4):351–77.