
Speaking of That: Terms to Avoid or Reconsider in the Eating Disorders Field

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ABSTRACT

Inspired by an article on 50 terms that, in the interest of clarity in scientific reasoning and communication in psychology, psychiatry, and allied fields, “should be avoided or at most be used sparingly and only with explicit caveats,”¹ we propose a list of terms to avoid or think twice about before using when writing for the *International Journal of Eating Disorders (IJED)*. Drawing upon our experience as reviewers or editors for the *IJED*, we generated an abridged list of such terms. For each term, we explain why it made our list and what alternatives we recommend. We hope that our list will contribute to improved clarity in scientific thinking about eating disorders, and that it

will stimulate discussion of terms that may need to be reconsidered in our field’s vocabulary to ensure the use of language that is respectful and sensitive to individuals who experience an eating disorder. ©2016 Wiley Periodicals, Inc.

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Introduction

Seeking to improve clarity of scientific thinking and communication, Lilienfeld et al.¹ recently enumerated 50 psychological and psychiatric terms to avoid because these terms are either “inaccurate, misleading, misused, ambiguous,” or “logically confused words and phrases” (p. 1). Examples we found edifying and relevant include, “hard-wired” (a misleading description of genetically influenced traits or behaviors), oxymorons such as “stepwise hierarchical regression” (stepwise and hierarchical are two different types of regression), or pleonasm such as “latent construct” (constructs are hypothetical attributes and as such not directly observable). Lilienfeld et al. emphasized that this 50-term list is not exhaustive and they invited readers to generate their own list of least-favorite, problematic terms.¹ We highly recommend that *IJED* readers and contributors familiarize themselves with the Lilienfeld article.

From our vantage point as the current or former editors and associate editors of the *International Journal of Eating Disorders (IJED)*, this invitation resonated strongly. We decided to develop a list of terms that were not included on the “Lilienfeld list,” and yet are frequently misused in the scientific literature on eating disorders. We began by developing a list of problematic terms we commonly encountered in manuscripts submitted to or published in the *IJED* and realized (perhaps not surprisingly) that many of the terms found on the Lilienfeld list also could be found in the clinical

case reports, original research articles, and review papers submitted to *IJED*. Rather than duplicate the Lilienfeld terms here, we opted to focus our efforts on identifying nebulous or inappropriately applied terms or phrases that are specific to the field of eating disorders. The resulting list presented here is neither exhaustive nor comprehensive, but rather abridged and selective of terms with greatest relevance to *IJED* authors and readers. We hasten to emphasize that, in retrospect, we, too, have used terms improperly in our own scientific writing (e.g., Refs. 2–13). We recognize that, similar to numerous words or phrases in any language, the nuances and conventional usage of scientific terms evolve over time. Indeed, we view this linguistic drift as all the more reason for authors to strive toward clarity and precision in their writing. Although as editors, our emphasis here is on scholarly publications in the *IJED*, we believe that the rationale for including a term or phrase on our list applies regardless of the medium of communication. Therefore, we encourage our readers (and we challenge ourselves) to avoid these terms or think twice before using them, whether such usage occurs in a clinical or professional setting (e.g., a treatment session, communications with carers, a case conference, or a research presentation), when interacting with the general public (e.g., communications with policy makers or journalists, as well as in social media posts), or in scientific manuscripts. Clarifying our language will also contribute to bridging the research-practice gap by ensuring that the translation of concepts from research to clinical practice is not blurred by usage of terms with imprecise meanings.

We present our list of terms divided into four categories: (1) terms that need to be expunged from our vocabulary because they are imprecise or inaccurate; (2) terms that are frequently misused; (3) terms that should be used only when a definition is provided; and (4) terms that may need to be reconsidered in light of changing cultural norms or usage. For each term, we offer our rationale for why it is problematic and suggest a remedy. We acknowledge that our selections of terms for inclusion in this manuscript reflect our own particular experience and values as *IJED* editors (i.e., choosing usage that especially impedes clarity of communication or may have adverse social impact in the context of shifting cultural norms). As such, our decisions of which terms and phrases to include in or to exclude from our list are open to discussion, and we welcome feedback about the terms we have selected. Readers are invited to send letters to the editor (rweissman@wesleyan.edu) within 30 days

of the in print publication date of this article and not to exceed 250 words. We may select letters for online publication or write a brief follow-up article in which we summarize the feedback contained in the readers' letters.

Terms That Should No Longer Be Used

1. “Anorexic;” 2. “Bulimic;” 3. “Binge Eater”: Avoid referring to individuals by a label that implies that the person is defined by the diagnosis or symptoms that they experience. Every field has its shorthand terms for rapid communication of information. Use of such shorthand terms is especially tempting when brevity is valued or, in the case of *IJED*'s word limits, imposed. Yet, certain usage should be avoided. As has been editorial practice of other professional journals, we should not refer to individuals by using a diagnostic term.¹⁴ Individuals who meet diagnostic criteria for an illness or disorder do not become the disorder (e.g., anorexics or bulimics), they remain persons, participants, or patients and our scientific writing must reflect this fact. To refer to individuals by the name of a disorder is both inaccurate and, in the case of conditions that are associated with negative social evaluation, stigmatizing.

Relatedly, we should refrain from using the adjectives “anorexic (or anorectic)” and “bulimic” as nouns to describe our study populations. The adjectives “anorexic” and “bulimic” may be used when referring to a collection of symptoms of anorexia nervosa or bulimia nervosa (as reflected in these titles “Evaluating new severity dimensions in the DSM-5 for bulimic syndromes using mixture modeling”¹⁵ or “A latent profile analysis of the typology of bulimic symptoms in an indigenous Pacific population”¹⁶). We recommend that when referring to individuals who experience an eating disorder, authors should use terms such as “individuals” (or, if applicable, “patients,” “study participants,” “women,” “adolescents,” etc.) with anorexia nervosa, bulimia nervosa, or binge-eating disorder, respectively.

4. “Bulimic episode”: When referring to the behavior of binge eating, avoid using “bulimic episode.” Many studies have used the Eating Disorder Examination (EDE)¹⁷ or the EDE-Questionnaire (EDE-Q)¹⁸ to assess eating disorder symptoms, including binge eating. These instruments were developed well before the current editions of the ICD or DSM. The intention of the term “bulimic episode” was to capture eating behavior (i.e., binge eating). In these instruments, eating episodes

involving a sense of loss of control are referred to as “bulimic episodes” and such episodes are further characterized as “objective bulimic episodes” if they meet research criteria for an “objectively” large amount of food and as “subjective bulimic episodes” if the amount of food consumed is deemed as below the amount threshold. Now that bulimia nervosa has come to be defined as a syndrome characterized by both binge eating and inappropriate compensatory behaviors, and given that binge-eating disorder is also characterized by binge eating, we ask that authors replace the term “bulimic episode” with “binge-eating episode” when assessing or describing episodes of binge eating.

We further recommend that authors consider the use of “binge eating” rather than “binging” or “bingeing” because the latter terms have become linked to various other forms of behavioral disinhibition (e.g., “binge drinking” in the psychiatric literature¹⁹ or “binge watching” in colloquial speech²⁰). On a minor note, we advise readers of the proper spelling of binge eating when used as an adjective. For example, in the 5th edition of the DSM, a hyphen is now used in the name binge-eating disorder,²¹ reflecting the grammatical rule that when used adjectively (but not when used as a verb or a noun), “binge-eating” should be hyphenated.

5. “Gold standard”: Avoid using gold standard when describing an assessment tool or treatment. “Gold standard” is among the 50 terms to avoid on the Lilienfeld list. The rationale provided for its inclusion is that even well validated instruments are imperfect. We opted to include “gold standard” on our eating disorder specific list because of its common use in our field. Although in the broader psychiatric literature the term has been applied to a variety of instruments and treatments, in the eating disorders field it has evolved into a shorthand means of conveying that a treatment has been extensively validated or that an instrument has excellent psychometric properties (e.g., Refs. 3 and 13). We recommend that, if indeed applicable, authors describe instruments as “extensively validated” or describe treatments as “demonstrably superior to other treatments.” We note that even an extensively validated instrument or treatment may not perform well in a sample that notably differs from prior validation samples (e.g., Refs. 22 and 23). Therefore, authors are encouraged to provide information about the psychometric properties of the instruments and the outcomes of the treatments, as established in the study sample under investigation.

Frequently Misused Terms

6. “Anorexia”; 7. “Bulimia”: Avoid using abbreviated names for eating disorders. Widely used dictionaries such as Merriam-Webster define “anorexia” and “bulimia” broadly (but not precisely) consistent with the diagnostic criteria for anorexia nervosa or bulimia nervosa,^{24,25} which reflects the common use of the terms anorexia and bulimia in popular or lay communication when referring to the eating disorders. In scholarly communication, authors should refer to the names of eating disorders, as specified in internationally recognized classification systems for mental disorders such as the Diagnostic and Statistical Manual for Mental Disorders (DSM)²¹ or the International Classification of Diseases (ICD).²⁶ The reason for our recommendation is that both anorexia and bulimia (without nervosa) have additional, established clinical meanings (loss of appetite; an abnormal and constant craving for food) whereas anorexia nervosa and bulimia nervosa unambiguously refer to specific eating disorders.

As a term relating to bulimia nervosa, the single-word term “bulimia” has not been a diagnosis since DSM-III, when its features were far more limited. “Bulimia” therefore has a specific historical meaning as a diagnosis that will rarely be appropriate to use now. We advise authors to use “anorexia” only if the authors do indeed mean to refer to loss of appetite, as, for instance, in the literature on loss of appetite among physically ill or older individuals.²⁷

Terms That Should Be Used Only When Definitions Are Provided

8. “Spectrum” eating disorder; 9. “Subclinical” eating disorder; 10. “Subthreshold” eating disorder: Unless authors provide descriptive information accompanying the use of these terms, authors should avoid using “spectrum,” “subclinical,” or “subthreshold” eating disorder. A meta-analysis published under DSM-IV criteria found that investigators had used >30 terms to describe eating disorders that did not meet criteria for anorexia nervosa or bulimia nervosa.²⁸ Since then, the nomenclature has been clarified in DSM-5 by providing specific terms within the residual category, Other Specific Feeding or Eating Disorder (OSFED). These terms correspond to five named examples that illustrate presentations featuring relevant and

clinically significant signs and symptoms (e.g., atypical anorexia nervosa, purging disorder) while not meeting threshold criteria for full syndrome eating disorders. We therefore encourage authors to adhere to DSM or ICD terminology when applicable and, in the case of disordered eating that does not clear the bar for one of the full syndrome eating disorders or for OSFED, describe both inclusion criteria (e.g., signs or symptoms that encompass eating and/or body image disturbance and are associated with distress or impairment) and exclusion criteria (i.e., why they do not meet criteria for anorexia nervosa, bulimia nervosa, binge-eating disorder, or one of the other feeding or eating disorders?). Furthermore, because the term “subclinical” may be (mis)understood as referring to a condition that does not warrant a “clinic” or treatment, we recommend use of the more neutral term “subthreshold.”

Terms the Use of Which May Need to Be Reconsidered

Languages constantly evolve and a term that may have been neutral over time may take on a negative connotation or, conversely, a formerly valence-laden or “unspeakable” term may become part of common parlance without its historical negative ballast. Here, we introduce for discussion several terms that may unintentionally cause offense to or distress in the very population we wish to help and support.

11. “Sufferer”; 12. “Struggling with an eating disorder”: When describing a study sample of individuals with eating disorders, avoid referring to these research participants as “sufferers” or as people “struggling with an eating disorder.” Instead, describe the sample as suggested in the preceding paragraphs, according to the participants’ diagnostic status or study inclusion criteria. We do not mean to imply that individuals who experience an eating disorder may not be suffering or struggling. Yet, in the absence of demonstrable evidence or substantive reasons to do so, we have come to understand that to refer to study participants as “sufferers” or as “struggling” may be perceived by some readers and, perhaps most importantly, by the participants in question as pejorative. Since little is gained by using terms such as “sufferers” or people “struggling with an eating disorder,” using less emotionally charged terms is recommended. For example, with the benefit of hindsight, we would have described our study samples as “treatment-seeking,” “enrolled in a treatment pro-

gram,” or “exhibiting an eating disorder or related symptoms.”^{4,9,12}

13. “Refeeding”: For this final term on our list, after extensive debate amongst ourselves, we offer two (perhaps seemingly contradictory) recommendations. We recognize and endorse the continued use of the medical term “refeeding syndrome”²⁹ (or similar terms such as “refeeding hypophosphatemia”),^{30,31} a potentially life-threatening condition which may occur in severely undernourished individuals during nutritional rehabilitation following a prolonged period of starvation. Yet, we decided to include the verb “refeeding” as a term worthy of discussion for this reason: some people experience the term “refeeding” negatively, as it conjures up for them the image of an animal being fed, or of being a young child. In the medical literature, various alternative terms are already being used alongside the most commonly used term refeeding, including “renourishing” or “nutritional rehabilitation.”^{32–35} We recommend that authors review the context in which “refeeding” is being used and consider alternative terms when not referring to established medical procedures or conditions.

Conclusion

We have presented a short list of terms to avoid or reconsider their usage in hopes that these strictures or considerations will enhance communication, clinical thinking, and clinical/scientific writing. Our list is not exhaustive and reflects the particular demographic and cultural background, professional qualifications, experiences, and biases of the authors. We recognize that these terms will need to be refined and augmented over time, as knowledge and social/clinical cultures change.

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