

# From Division to Dialogue: Uniting Paradigms to Advance Obesity and Eating Disorder Treatment

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## Key words

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## Abstract

Obesity is a complex, multifaceted phenomenon that intersects with biological, psychological, and sociocultural dimensions of health. In recent years, three major frameworks have proposed divergent definitions of obesity: the Health at Every Size (HAES) model, the 2024 European Association for the Study of Obesity (EASO) framework, and the 2025 Lancet Commission classification. HAES promotes a weight-neutral, behavior-centered approach grounded in well-being and the reduction of stigma—principles that have been formally endorsed by leading eating disorder organizations. In contrast, the EASO framework defines obesity as a chronic, relapsing disease requiring personalized, multidisciplinary care, while the Lancet Commission conceptualizes clinical obesity through the lens of adiposity-induced functional impairment, distinguishing between preclinical and clinical states. These models reflect deeper tensions in how obesity and eating disorders are defined, diagnosed, and treated. Yet, rather than treating these paradigms as mutually exclusive, this commentary argues for a synthesis that bridges their strengths. In the context of eating disorder prevention and treatment—where weight stigma, body image disturbance, and medical risk often coexist—integrating these frameworks offers an opportunity to build more person-centered, ethically sound, and clinically effective models of care. Uniting obesity paradigms in dialogue, rather than division, may enhance our capacity to deliver inclusive, evidence-based treatment that addresses the full complexity of weight-related health challenges.

## Introduction

Obesity is one of the most complex and multifaceted public health challenges of our time. But what, precisely, is obesity? Is it a numerical threshold? A chronic disease? A consequence of dysfunctional food systems? Or a socially constructed category imbued with stigma and blame toward individuals living in larger bodies? These questions are not merely academic—they shape how bodies are assessed, treated, and judged in clinical and social contexts, including in the field of eating disorders.

Recent years have witnessed increasing recognition of the ways obesity discourse intersects with eating disorder prevention, diagnosis, and treatment. Weight stigma—

often embedded in institutional definitions of obesity—has been shown to contribute to disordered eating, treatment avoidance, and poorer health outcomes (Phul, 2017).

Simultaneously, clinical paradigms continue to struggle with how to distinguish or integrate obesity and eating disorders within care models that are ethically sound, person-centered, and grounded in evidence (Camacho-Barcia et al., 2024; Golden et al., 2016; Hay & Mitchison, 2019).

In this context, three distinct and conceptually divergent approaches have emerged to define and address obesity:

1. Health at Every Size (HAES): A paradigm critical of weight-based medicalization and stigma (Bacon & Aphramor, 2011; Robison, 2005).

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2. The EASO Obesity Framework (2024): A multidimensional, personalized clinical model (Busetto et al., 2024).
3. The Lancet Commission Definition (2025): A functional reclassification based on pathological effects of adiposity (Rubino et al., 2025).

This commentary compares these frameworks with particular attention to their relevance for eating disorder care and prevention. It analyzes their strengths, limitations, and broader implications—especially considering growing efforts to build inclusive, stigma-free approaches to health that account for the full spectrum of body diversity and disordered eating experiences.

## Health at Every Size (HAES)

HAES is a public health and clinical framework that promotes a weight-neutral approach to health. It challenges the conventional view that weight loss is inherently linked to improved health, instead advocating for well-being through sustainable behaviors regardless of weight status (Bacon & Aphramor, 2011). The HAES model does not recommend weight loss as a necessary goal for health improvement. Instead, it encourages individuals to engage in health-promoting practices such as intuitive eating, enjoyable physical activity, and body acceptance while actively opposing weight stigma and discrimination in healthcare and society. Proponents of HAES argue that focusing on weight loss can lead to adverse outcomes, including weight cycling, disordered eating, and psychological distress, particularly given the poor long-term success rates of most dieting interventions (Mann et al., 2007).

### Historical Context and Philosophical Foundations

The origins of HAES can be traced to the fat acceptance movement of the late 1960s. Influential works, such as Louderback's article "More People Should Be Fat!" helped spark a public dialogue around the harms of diet culture and weight-based discrimination (Louderback, 1967). In response, advocacy organizations like the National Association to Advance Fat Acceptance (NAAFA) were founded to promote size diversity and resist the pathologization of fat bodies.

By the 1980s and 1990s, scholars and practitioners began to articulate a more formal framework around non-diet and weight-inclusive approaches to health. The concepts of intuitive eating (Tribble & Resch, 2020) and set-point

theory (Keesey & Hirvonen, 1997) gained traction, highlighting the body's biological resistance to sustained weight loss and the psychological harms associated with restrictive dieting. These principles ultimately coalesced into the HAES model, formally named and popularized by Linda Bacon in the early 2000s.

### Core Principles of HAES

The HAES model is grounded in five key principles, as outlined by the Association for Size Diversity and Health:

1. **Weight Inclusivity:** Health and well-being are accessible at all sizes; there is no ideal body weight that guarantees health.
2. **Health Enhancement:** Focus on holistic approaches to physical, emotional, and social well-being.
3. **Respectful Care:** Recognition of and action against weight stigma, bias, and discrimination.
4. **Eating for Well-being:** Support for intuitive, flexible eating based on hunger, satiety, nutritional needs, and pleasure.
5. **Life-Enhancing Movement:** Encouragement of enjoyable physical activity rather than exercise for weight loss.

This movement has also contributed to the development of inclusive language around body size and weight, favoring neutral terms such as "higher weight" or "larger-bodied" individuals. It often prioritizes identity-first language over person-first language, which some individuals prefer. Ultimately, the choice between these approaches reflects individual preferences and the norms of specific communities.

### Strengths

Growing evidence supports the efficacy of HAES-based interventions in improving various health outcomes without emphasizing weight loss. Clinical trials have demonstrated that HAES approaches can lead to improvements in blood pressure, cholesterol levels, eating behaviors, and psychological well-being while avoiding the harmful effects commonly associated with dieting (Bacon & Aphramor, 2011; Clifford et al., 2015). Unlike conventional weight-loss programs, HAES does not result in weight cycling, a phenomenon linked to increased cardiovascular and metabolic risks (Montani et al., 2015; Rossi et al., 2019).

HAES also fosters greater treatment adherence, body satisfaction, and resilience to stigma (Tylka et al., 2014). By reducing the emphasis on weight as a primary health indicator, HAES provides a more equitable and sustainable

approach to care, especially for individuals with a history of disordered eating or weight-based trauma.

The Health at Every Size (HAES) framework has gained increasing recognition as a foundational approach to treating eating disorders. Prominent professional organizations, such as the Academy for Eating Disorders, the Binge Eating Disorder Association, the Eating Disorder Coalition, the International Association of Eating Disorder Professionals, and the National Eating Disorders Association, have formally endorsed HAES principles within their clinical guidelines and policy initiatives (Bacon & Aphramor, 2011).

### Criticisms

Despite its contributions, the Health at Every Size (HAES) framework has received substantial critique from clinicians, researchers, and policymakers. A key concern is that by decentering body weight in health discussions, HAES may underplay the well-established risks associated with excess adiposity—particularly visceral fat, which is strongly linked to metabolic syndrome, cardiovascular disease, type 2 diabetes, and certain types of cancer (Blüher, 2010; Haslam & James, 2005). While not all individuals with high BMI are metabolically unhealthy or have a functional or psychological impairment, population-level data show consistent dose-response relationships between BMI and morbidity/mortality, particularly above 35 kg/m<sup>2</sup> (Flegal et al., 2013; Hu et al., 2004).

Obesity is also associated with functional impairments that reduce quality of life and daily functioning. These include mobility limitations, fatigue, and difficulty with routine activities, often compounded by comorbidities such as osteoarthritis and sleep apnea (Vincent et al., 2010). Cognitive and psychosocial effects, including impaired executive function, depression, and social withdrawal, further exacerbate this burden (Smith et al., 2011).

Some critics argue that certain HAES advocates adopt an anti-scientific stance by dismissing epidemiological evidence linking obesity to chronic disease or by framing all weight-focused interventions as inherently harmful (Camos et al., 2006). This polarization may hinder the development of integrated models that promote body respect while acknowledging the health implications of obesity.

HAES has also been criticized for being difficult to implement at a population level. Unlike traditional weight management programs, HAES emphasizes subjective outcomes—such as body image and intuitive eating—that are harder to standardize and measure (Clifford et al., 2015). (Clifford et al., 2015). Its applicability across diverse cultural and socioeconomic contexts is also limited, as

much of the evidence supporting HAES comes from high-income Western populations (Bombak, 2014).

Another concern is that HAES may unintentionally overlook the experiences of individuals who face genuine physical or emotional challenges related to their weight. While HAES emphasizes body acceptance and challenges weight stigma, it may not fully address the needs of those seeking weight loss for legitimate health or personal reasons, especially when such efforts are supported by evidence-based interventions (Courcoulas et al., 2014; LeBlanc et al., 2018). In contrast, international organizations such as the Global Obesity Patient Alliance (GOPA) and the European Coalition for People Living with Obesity (ECPO) focus on reducing stigma through education and advocacy while simultaneously recognizing obesity as a chronic disease that warrants evidence-based medical treatment (ECPO, 2023). Finally, the National Institutes of Health (NIH) recommends using terms like “higher weight individual” or “person with a larger body” primarily in non-clinical settings, while retaining “overweight” and “obesity” in scientific and clinical contexts (NIH, March 4, 2025). The NIH emphasizes that language should be context-specific: public health messaging may differ from personal narratives. Individuals often have personal preferences for how their bodies are described, and it is respectful to ask. For instance, some may reclaim the term “fat” as a neutral descriptor.

### The EASO Framework (2024)

In 2024, the European Association for the Study of Obesity (EASO) introduced a comprehensive framework for the diagnosis, staging, and management of obesity in adults. This framework was developed through a structured Delphi process involving three rounds of voting among 29 international experts, resulting in the formulation of 28 consensus statements (Busetto et al., 2024).

#### Definition of obesity

According to the EASO Framework, obesity is a multifactorial, chronic, relapsing, and non-communicable disease characterized by abnormal and or excessive body fat, which poses significant health risks. A person is considered to have obesity if they meet either of the following:

- BMI  $\geq 30$  or
- BMI  $\geq 25$  and WtHR  $\geq 0.5$ , plus medical, functional, or psychological complications

## Core Principles

A key innovation in the EASO framework is the shift from relying solely on BMI to incorporating assessments of adipose tissue distribution and function. Specifically, it highlights that abdominal (visceral) fat accumulation is a significant risk factor for cardiometabolic complications, even in individuals with BMI levels below the standard obesity threshold. This approach aims to reduce the risk of undertreatment in patients who may not meet traditional BMI criteria but still face substantial health risks.

The framework also draws inspiration from the Edmonton Obesity Staging System (Sharma & Kushner, 2009) which considers the severity of obesity-related complications, including medical, functional, and psychological impairments. This stratification enables personalized treatment plans that align with management strategies employed for other chronic diseases, prioritizing long-term health outcomes over short-term weight loss goals.

In terms of treatment, the EASO framework recommends a comprehensive, multidisciplinary approach. This includes behavioral modifications such as nutritional therapy, physical activity, stress reduction, and sleep improvement, alongside psychological support, pharmacotherapy, and, when appropriate, bariatric surgery. Notably, the framework suggests that treatment decisions should be based on a thorough clinical evaluation rather than solely on anthropometric measurements.

## Strengths

The framework's formal recognition of obesity as a chronic, relapsing condition aligns with global calls from medical and public health bodies, helping to reduce stigma and promote long-term management approaches akin to those used for conditions like diabetes or hypertension (WHO Consultation on Obesity, 2000). This reframing highlights the biological and environmental complexity of obesity, shifting the focus away from viewing it as solely a result of personal failure or lifestyle choice.

Rather than relying solely on BMI, the EASO framework incorporates measures such as the waist-to-height ratio and adipose tissue function, which better reflect obesity-related health risks (EASO, 2024). This helps identify individuals with central adiposity who may be at high risk for cardiometabolic diseases, even at lower BMIs, thereby addressing the previous limitations of BMI-centric classification systems.

The framework introduces a staging system that categorizes the severity of obesity based on medical, functional, and psychological complications. This enables more tar-

geted and individualized interventions, shifting the focus from weight loss alone to enhancing overall health and quality of life. It also facilitates shared decision-making between patients and clinicians.

The EASO framework advocates for a multidisciplinary management strategy that combines nutritional support, physical activity, behavioral therapy, pharmacotherapy, and bariatric surgery when appropriate. It places the patient at the center of care and encourages the development of treatment plans that are tailored to individual needs and preferences.

By acknowledging the biological and systemic drivers of obesity, the framework supports efforts to combat weight stigma and improve clinical attitudes. It aligns with international patient advocacy organizations, such as the European Coalition for People Living with Obesity (ECPO), in promoting dignity, respect, and access to equitable care for individuals living with obesity (ECPO, 2023).

The framework supports a life-course approach, emphasizing prevention, early intervention, and long-term support. It recognizes the role of environmental, genetic, and socioeconomic determinants of health, consistent with the latest public health frameworks that advocate for systemic change alongside individual support (WHO Consultation on Obesity, 2000).

## Criticisms

While the 2024 EASO framework represents a meaningful advancement in acknowledging the complexity of obesity, several limitations may hinder its implementation, inclusivity, and clinical effectiveness—particularly in settings that intersect with eating disorder prevention and treatment.

First, the development of the EASO framework was led primarily by professionals in endocrinology, internal medicine, and nutrition, with limited representation from primary care physicians, psychologists, eating disorder specialists and patient advocacy groups. This disciplinary imbalance may result in a clinical paradigm that insufficiently addresses psychological complexity, fails to detect co-occurring eating disorders—particularly in higher-weight individuals—and excludes insights from lived experience. Such omissions are especially concerning given growing recognition of how obesity and eating disorders overlap, including the high prevalence of binge eating disorder and atypical anorexia among individuals with elevated BMIs (Dalle Grave, 2023; Ricca et al., 2000).

Second, although the framework acknowledges the shortcomings of BMI as a diagnostic tool, it retains a BMI  $\geq 30$  as a threshold for defining obesity. While this offers a standardized population-level measure, its continued use risks

reinforcing a disease label based solely on size, regardless of metabolic health, functional capacity, or psychological distress. This can inadvertently pathologize body diversity, exacerbate weight stigma, and lead to diagnostic overshadowing—a well-documented phenomenon in which eating disorders in higher-weight individuals go undetected or untreated because disordered behaviors are misinterpreted as appropriate weight control efforts. For example, restrictive eating, or compulsive exercise may be overlooked or even encouraged in individuals classified as “obese.”

Third, although the framework endorses broader treatment objectives—enhancing mental well-being, physical function, and quality of life—it remains entrenched in a weight-centric medical paradigm. Furthermore, while it briefly acknowledges the need to screen for depressive symptoms and eating disorders, it overlooks the complex, bidirectional interplay between obesity and disordered eating. In particular, binge-eating disorder—a condition highly prevalent among people with obesity—demands a tailored therapeutic approach that diverges from standard obesity management. Research has shown that interventions emphasizing weight loss—even when well-intentioned—can precipitate or exacerbate disordered eating behaviors, especially among adolescents and those with a history of dieting or body dissatisfaction (Neumark-Sztainer et al., 2006). Without safeguards grounded in harm-reduction principles, the EASO approach may increase the risk of iatrogenic harm in a subgroup of people. A truly integrated framework should offer differentiated guidelines for individuals whose primary clinical concern is an eating disorder.

Fourth, despite its goal of promoting a more nuanced clinical understanding of obesity and reducing weight stigma, the EASO framework inadvertently reinforces the equation of obesity with disease by systematically anchoring it to medical, functional, and psychological assessments. This approach risks entrenching weight stigma for several reasons:

- Universal pathologization: Labeling obesity as a disease “regardless” of individual health status can render healthy higher-weight individuals invisible—those without medical or psychological dysfunction are nonetheless deemed ill.
- Institutional validation of bias: Without a critical examination of systemic stigmatization (in healthcare, education, or the media), the disease label can legitimize discriminatory attitudes, even when framed as concern for health.
- Anthropometric gatekeeping: Restricting screenings, treatments, and diagnostic pathways to those who

meet specific anthropometric cut-offs sends the implicit message that a fat body is always “abnormal” or “at risk,” even in the absence of symptoms.

- Pathologizing natural variation: Treating normal variations in body size as inherently pathological can foster helplessness among individuals who feel they lack control over their weight.
- Reinforcement of essentialism: Framing higher body weight as a fixed medical condition may promote essentialist beliefs—viewing people with obesity as fundamentally different. This deepens social divides and mirrors the stigma often directed at those with mental illness (Rathbone et al., 2023).

In sum, in attempting to combat stigma, the framework may paradoxically reinforce it—shifting bias from moral judgment to clinical diagnosis.

Fifth, the document explicitly endorses obesity pharmacotherapy for individuals with a BMI  $\geq 25$ —even in cases of overweight—so long as complications are present. This broader drug indication, alongside disclosed conflicts of interest with pharmaceutical companies, raises serious ethical concerns. It risks shifting the therapeutic emphasis from holistic patient care to systematic medicalization, despite a lack of evidence for clear long-term benefit.

Finally, the EASO framework introduces a paradigm shift that may not align seamlessly with existing care guidelines in eating disorder treatment. Providers trained in evidence-based eating disorder therapies face difficulties integrating weight-focused goals with the weight-neutral and body-trusting principles central to eating disorder recovery. This discordance could result in fragmented or contradictory care, particularly for individuals whose treatment plans span multiple specialties.

## The Lancet Commission Definition (2025)

*The Lancet Diabetes & Endocrinology* proposed a revised clinical taxonomy of obesity based on the pathological effects of adiposity on bodily functions rather than purely anthropometric measures (Rubino et al., 2025). The primary goal of the Commission was to establish objective criteria for diagnosing clinical obesity, thereby supporting clinical decision-making, treatment prioritization, and public health strategies.

The Commission highlighted that current methods of assessing obesity, particularly those relying on BMI, can be imprecise. BMI may underestimate or overestimate actual fat

accumulation and, therefore, may provide misleading information about an individual's health status. This can hinder both clinical decisions and the development of effective health policies. The Commission sought to redefine clinical obesity as a pathological condition characterized by the direct effects of excess adiposity on tissue and organ function—similar to how other chronic diseases are defined in medicine.

### **Definitions provided by the Commission**

*Obesity:* A condition characterized by excess adiposity, with or without altered fat distribution or dysfunction in adipose tissue. The causes are multifactorial and not yet fully understood. Diagnostic pathways include:

1. BMI  $\geq 30$  with elevated waist circumference or waist-to-hip/height ratios.
2. Two elevated anthropometric measures, regardless of BMI.
3. Direct fat mass measurement (e.g., via DEXA scan).
4. BMI  $\geq 40$ .

*Preclinical obesity:* A state of excess adiposity where tissue and organ function remains preserved but with a generally increased risk of progressing to clinical obesity and other chronic non-communicable diseases, such as type 2 diabetes, cardiovascular diseases, certain cancers, and mental health disorders.

*Clinical obesity:* chronic and systemic disease marked by dysfunction of tissues, organs, or the whole body—or a combination thereof—caused by excess adiposity. This condition can result in severe organ damage, manifesting as:

- Dyspnea from cardiopulmonary effects,
- Metabolic abnormalities,
- Joint pain and reduced mobility,
- Dysfunction in renal, neurological, or reproductive systems.

### **Core principles**

People with clinical obesity should have timely access to evidence-based treatments aimed at improving—or, where possible, resolving—the clinical manifestations of the disease and preventing progressive organ damage. The goal is not merely to achieve weight loss but to address measurable clinical outcomes (e.g., cardiovascular, metabolic, or musculoskeletal improvements). Treatment intensity and the degree of required weight reduction may vary.

Choice of therapeutic intervention (e.g., lifestyle, pharmacological, psychological, or surgical) should be based on:

- Individual risk-benefit assessment
- Available clinical evidence demonstrating intervention efficacy
- Reasonable likelihood of improving clinical manifestations
- Improved quality of life
- Reduced disease progression and mortality risk

Those in a state of preclinical obesity should receive evidence-based counseling, regular health monitoring, and targeted interventions as needed to prevent progression to clinical obesity or related diseases.

The Commission also emphasizes that weight stigma and bias remain significant barriers to effective prevention and treatment. Addressing this issue requires dedicated training and education for both healthcare professionals and policymakers.

### **Strengths**

The Lancet Commission presents a major step forward in redefining obesity as a chronic, systemic disease. One of its key strengths is its inclusive and multidisciplinary approach. Drawing on input from 58 experts across medical fields and individuals with lived experience, the Commission developed evidence-based criteria that reflect both clinical and patient-centered perspectives. The recommendations were endorsed by 76 global organizations, underscoring their broad consensus and relevance (Rubino et al., 2025).

A key innovation introduced by the Commission is its decision to move beyond BMI as the sole diagnostic criterion for obesity, except in cases where BMI is equal to or greater than 40. Instead, it proposes a multifactorial framework incorporating anthropometric measures (e.g., waist circumference, waist-to-hip ratio, or waist-to-height ratio), direct assessments of body fat, and signs of functional or organ impairment. This enables more accurate and individualized diagnosis, thereby reducing the risk of both over- and under-diagnosis.

Another key strength of the framework is its clear distinction between preclinical and clinical obesity. This classification enables early identification of individuals at risk before complications arise, facilitating timely and targeted interventions. By incorporating quality-of-life measures and recognizing limitations in daily activities as clinically significant, the framework aligns obesity care with approaches used for other chronic diseases.

This distinction also has important implications for individuals with eating disorders and higher body weight, populations that frequently experience stigma related to obesity,

eating disorders, and mental health. Acknowledging obesity as a disease may help alleviate some of this weight-related stigma. For those categorized with "preclinical obesity" — characterized by higher weight without organ dysfunction or major functional impairments — it is crucial to avoid undue pressure for weight loss or premature medicalization. Instead, care should prioritize treating eating disorders, encouraging sustainable lifestyle changes, and preventing progression to clinical obesity. Conversely, individuals living with both eating disorders and clinical obesity require a comprehensive, multidisciplinary approach. Collaboration among endocrinologists, psychiatrists, dietitians, and other healthcare professionals is essential to address both the medical and psychological aspects of the condition without exacerbating it. This holistic, health-centered strategy aims to improve clinical outcomes and quality of life, moving beyond simplistic weight-loss goals.

Additionally, the Commission addresses weight stigma by advocating for respectful and inclusive care while emphasizing the need for training among healthcare professionals. It encourages public health policies that prioritize access to evidence-based treatments without moral judgment or bias.

### **Criticism**

While the Lancet Commission on Obesity presents a progressive redefinition of obesity as a chronic, relapsing, and multifactorial disease, it has faced several notable criticisms (EASO, 2024; Obesity Medicine Association, January 27, 2025). One key concern involves the Commission's reliance on adiposity measures beyond BMI, which, although intended to improve diagnostic precision, lacks widespread clinical validation and standardization. This limits their practical application and may result in inconsistent diagnoses across healthcare settings.

Furthermore, the introduction of "preclinical obesity" as a distinct stage risk delaying treatment for individuals who fall below clinical thresholds but still experience health impairments, potentially worsening disease progression. However, it may also increase the risk of over-medicalization of preclinical states.

Another critique focuses on the Commission's proposed diagnostic framework, which may inadvertently exacerbate healthcare inequities. By emphasizing organ dysfunction and adiposity distribution, the model may complicate access to treatments, especially in resource-limited settings where advanced diagnostic tools (e.g., DEXA scans) are not readily available. Additionally, the framework's complexity could pose challenges for insurance coverage and reimbursement policies, potentially limiting timely intervention.

There is concern that the Commission does not sufficiently address the psychosocial dimensions of obesity, which can affect health independently of body fat. While weight stigma is acknowledged as a significant issue, the focus on clinical and biological factors—and the classification of obesity as a disease—may inadvertently reinforce that stigma. As noted in critiques of the EASO framework, this can happen by pathologizing natural variations in body size or by promoting essentialist beliefs that portray individuals with obesity as inherently different. Such perspectives risk deepening social divisions and perpetuating stigma, as has been observed in the case of mental illness.

From an eating disorder perspective, the Lancet Commission approach can lead to missed or delayed diagnosis of disordered eating in people with higher BMI, as symptoms may be wrongly attributed solely to obesity. This medical focus can also worsen weight stigma, which is a known risk factor for disordered eating and body dissatisfaction, making prevention and recovery harder. Additionally, without proper screening and care for eating disorders within obesity treatment, patients may face fragmented care and unmet mental health needs.

Finally, the Commission's emphasis on biological mechanisms risks underappreciating the broader social determinants of health, including socioeconomic status, the food environment, and cultural factors, which contribute to obesity risk and treatment outcomes. This narrow biomedical framing may limit the effectiveness of public health policies aimed at preventing and controlling obesity.

### **Toward an Integrated Understanding: An Opportunity for the Eating Disorder Field**

The comparison among these three paradigms—HAES, the EASO framework, and the Lancet Commission definition—reveals significant conceptual tensions, yet also complementary strengths and limitations (see Table 1) that, if integrated, could inform a more holistic approach to obesity and its related conditions, including eating disorders. While the HAES model centers on dignity, autonomy, and psychological well-being through weight-neutral care, the EASO and Lancet frameworks offer clinically actionable tools for identifying when excess adiposity contributes to medical risk, enabling evidence-based interventions.

These perspectives need not be mutually exclusive (Dalle Grave, 2025). A combined model is particularly essential in the context of eating disorder prevention and treatment. Overemphasis on weight as a health indicator has long

**Table 1.** Comparison of the three main definitions of obesity: HAES, EASO Framework, and Lancet Commission

Approach	Focus	Definition of Obesity	Strengths	Criticisms
<b>HAES</b> (Health at Every Size)	Health behaviors, inclusivity, anti-stigma	Rejects BMI as a health marker; does not define obesity as a disease; emphasizes health-promoting behaviors regardless of body size.	Reduces weight stigma; promotes mental and physical well-being; shifts focus to sustainable health behaviors.	May underestimate health risks of excess adiposity; lacks clinical criteria; some interpretations dismiss any disease link.
<b>EASO Framework (2024)</b>	Medical staging, individualized care	Defines obesity as a chronic, multifactorial disease. Diagnosis includes BMI $\geq 30$ or BMI $\geq 25$ with waist-to-height ratio $\geq 0.5$ plus medical, functional, or psychological complications.	Supports tailored treatment; considers functional and psychological impacts; broadens diagnostic tools.	Still relies partly on BMI; resource-intensive; risks over-pathologization and inconsistent implementation across systems. May not sufficiently integrate eating disorder screening, risking missed diagnoses. May unintentionally increase weight stigma.
<b>Lancet Commission (2025)</b>	Functional impairment from adiposity	Defines obesity based on dysfunction caused by adiposity. Distinguishes between preclinical and clinical obesity using measures like organ impairment, body fat distribution, and anthropometry.	Shifts focus to the impact on organ systems; reduces reliance on BMI; improves clinical relevance and early detection.	Requires complex tools (e.g., imaging); may delay diagnosis or access to care; unclear implementation in routine practice. Biomedical focus may unintentionally reinforce weight stigma and overlook psychosocial/behavioral factors, including eating disorders.

been associated with the onset and exacerbation of disordered eating, particularly among youth and marginalized populations (Neumark-Sztainer et al., 2006). Weight-centric approaches may inadvertently reinforce body dissatisfaction, dieting behaviors, and compensatory practices that drive the development or worsening of eating disorders (Stice, 2002). Conversely, ignoring the potential health consequences of adiposity may delay needed care.

The integration of weight-inclusive principles with clinically informed risk stratification allows for a person-centered approach that supports both psychological resilience and physical health. This approach acknowledges the complex coexistence of obesity and eating disorders, which often overlap but require distinct treatment foci.

All three frameworks implicitly or explicitly acknowledge that obesity is not merely a result of individual behavior, but a multifaceted condition shaped by the dynamic interplay of genetic, environmental, psychological, and societal factors. This systems-level understanding echoes the findings of the 2019 Lancet Commission on the Global Syndemic of Obesity, Undernutrition, and Climate Change, which

identified shared root causes—such as inequitable food systems, urban design, and socioeconomic disparities—across public health challenges (Swinburn et al., 2019).

To respond effectively, healthcare must move beyond binary framings of obesity and eating disorders as separate, unrelated conditions. Instead, it must recognize their frequent overlap, shared risk factors, and the complex ways in which weight stigma, body image concerns, and sociocultural pressures influence both. This shift calls for integrated assessment tools, interdisciplinary treatment approaches, and training that equips providers to address disordered eating behaviors across the weight spectrum—acknowledging that individuals in larger bodies can experience restrictive eating, and those in smaller bodies can face metabolic risks. A more nuanced, unified perspective allows for care that is both clinically appropriate and psychologically safe, reducing missed diagnoses and improving outcomes across diverse populations.

## Conclusion

Defining obesity is not a neutral act. Each framework entails specific clinical, social, and political implications. The way obesity is defined shapes not only diagnostic criteria and access to healthcare but also influences public discourse and the lived experiences of millions affected by this condition. In a world still grappling with profound health disparities and cultural inequities, there is an urgent need for a more precise, ethical, and non-stigmatizing medical language. Such language must acknowledge the complexity and individuality inherent in living with a larger body, avoiding reductionist approaches that rely solely on biomedical metrics, such as BMI.

This need is especially urgent in the field of eating disorders, where weight-centric frameworks can unintentionally reinforce stigma, undermine body trust, and delay or obstruct care—particularly for individuals in larger bodies. Many people with eating disorders do not fit traditional stereotypes, and narrow definitions of obesity can both pathologize and overlook those most at risk. A more integrated model is essential to ensure that care is sensitive to both metabolic and psychological dimensions of health.

Integrating the clinical rigor and pathophysiological insight of the EASO and Lancet Commission frameworks with the compassionate, weight-neutral, and behavioral emphasis of the HAES approach could foster a more holistic and humane model of care. This combined perspective would not only enhance treatment effectiveness but also promote respect, dignity, and empowerment for individuals across the weight and diagnostic spectrum. Ultimately, obesity should be understood not only as a matter of body size but also as a complex, multifaceted condition embedded within broader social, environmental, and systemic contexts. Addressing it requires comprehensive strategies that prioritize systemic change, equitable access to care, and sustained psychosocial support—putting human lives, mental health, and well-being at the heart of every intervention.

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