National Eating Disorders Collaboration

Evidence Experience Expertise

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

Summary of key recommendations

Recommendations for the management of eating disorders for people who are of higher weight	Level of evidence[1]
Management overview	
All treatment should be provided in the context of interprofessional collaborative practice	C
Psychological therapy for adults	
Psychological treatment should be offered as first-line treatment approach for bulimia nervosa or binge-eating disorder (BED)	A
Cognitive behaviour therapy (CBT) for an eating disorder either in standard form or therapist guided self-help should be considered as first-line treatment in adults with bulimia nervosa or BED	B
Other psychological treatments with evidence such as interpersonal psychotherapy (IPT) and dialectical behaviour therapy (DBT) should be considered as second-line treatment options in adults with bulimia nervosa or BED	B
Other feeding or eating disorder (OSFED), unspecified feeding or eating disorder (UFED) or subsyndromal eating disorders should be treated with treatment recommended for the most similar disorder	C

[1] 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.

Consider using therapies utilising non-dieting principles and interventions to reduce disordered eating	D
Therapies with demonstrated efficacy for the treatment of anorexia nervosa[2] in general, that is cognitive behaviour therapy-enhanced (CBT-E), specialist supportive clinical management (SSCM), Maudsley model of anorexia nervosa treatment for adults (MANTRA) and focal psychodynamic therapy (FPT) should be considered as treatment options	D
Psychological therapy for children and adolescents	
Psychological treatment for an eating disorder should be offered as first-line treatment approach	A
Family based treatment should be considered as first-line treatment for children and adolescents with bulimia nervosa and anorexia nervosa[2]	B
Other psychological treatments with evidence such as adolescent focused therapy (AFT) and CBT for an eating disorder should be considered as second-line treatment options in children and adolescents with anorexia nervosa (AFT, CBT) or with bulimia nervosa (CBT)	B
Other psychological treatments with evidence such as CBT for an eating disorder should be considered as second-line treatment options in children and adolescents with bulimia nervosa	B
Children and adolescents with higher weight should be offered a first line evidence-based treatment approach for eating disorders as those who do not have higher weight	C
OSFED, UFED or subsyndromal eating disorders should be treated with treatment recommended for the most similar disorder	C
Pharmacotherapy	
Consider using psychotropic medications with evidence in the treatment of eating disorders	B
Monitor for any non-prescribed use of medication in the context of an eating disorder	D

[2] In this guideline, the ICD 11 terminology for anorexia nervosa is adopted rather than the DSM-5 criteria. That is, anorexia nervosa (code 6B80) is used as a broad term to include all people at all body weights and without specifying the underweight criterion (sub coded in ICD-11 as 6B80.0, anorexia nervosa with significantly low body weight). See 2.2 for more detail.

Physical activity	
Physical activity interventions should focus on physical activity for positive physical and mental health benefits and away from exercising for weight or shape change	C
If compulsive exercise is present, referral to an exercise physiologist experienced in working with larger-bodied people and eating disorders populations is desirable	D
Family and other interventions for adults, adolescents and children	
Include families and other carers when indicated for anyone with an eating disorder	B
Family psychoeducation around impacts of body and eating conversations should include modelling body image acceptance, weight stigma and a focus on health in recovery	D
Nutritional and medical management	
Nutritional/medical guidance should minimise language that can reinforce poor self-worth and contribute to worsening eating disorder behaviours	C
Irrespective of body size, addressing malnutrition and poor diet quality is essential	C

Guideline access

Access the full guideline here or go to:
nedc.com.au/eating-disorder-resources/clinical-practice-guideline/