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

Short summary for medical practitioners

The Guideline

The National Eating Disorders Collaboration (NEDC) has developed a clinical practice guideline for the management of eating disorders for people with higher weight. Modelled on the 'Guidelines for Guidelines' process outline by the National Health and Medical Research Council (NHMRC)[1], the Guideline was not only informed by recent systematic reviews, meta-analyses and primary trials, but also clinical expertise and lived experience. The Guideline has undergone extensive review and consultation throughout 2021-22, involving reviews by key stakeholders, experts and organisations, with clinical and/or academic expertise and/or lived experience.

NEDC encourages all health professionals across varied disciplines and settings of practice to read and utilise the Guideline. This resource provides a short summary of key points for medical practitioners. To read more about medical and nutritional management of eating disorders for people with higher weight including clinical considerations, evidence supporting the recommendations and management in the context of co-occurring conditions, access the full Guideline here.

Key points

- Eating disorders are serious, complex and potentially life-threatening mental illnesses.
- Eating disorders can occur across a range of body weights, shapes and sizes and are common in people with higher weight.
- Eating disorders in people with higher weight are under-recognised and under-treated, this is often due to the effects of weight-stigma. More information about weight stigma is available here.
- Eating disorders in people with higher weight are just as serious and life threatening (from medical complications and self-harm) as eating disorders among people with lower weight [2-5].
- Eating disorders in people of any weight are associated with high levels of psychological distress and mental disorders [6].

- Early intervention is crucial and provides the best chance of recovery from an eating disorder. Many people with eating disorders and higher weight are not aware they have an eating disorder. These people frequently present for weight loss treatment [7].
- Medical practitioners should routinely screen for eating disorders and facilitate access to appropriate treatment. It is particularly important to do so in anyone, at any weight, who is presenting with weight concerns and anyone presenting for bariatric surgery as the prevalence is very high [8].
- Eating disorders are complex and multifaceted. Treatment encompasses, but is not limited to psychological, pharmacological, nutritional and activity interventions.
- For all people experiencing eating disorders, management should occur in the context of Interprofessional Collaborative Practice (multi-disciplinary care) to address all aspects of the eating disorder. While the minimum treatment team is a medical practitioner and a mental health professional, input from practitioners from a range of disciplines is often necessary for comprehensive care. Family and other supports are integral to the care team.
- Medical practitioners are vital members of the care team of a person experiencing an eating disorder and higher weight. The role of the medical practitioner is to provide treatment and management of the physical symptoms of the eating disorder. This includes medical monitoring and treatment of medical complications associated with eating disorders, monitoring medical status, and sometimes prescribing medications.
- Evidence-based psychological treatments for eating disorders experienced by people with higher weight exist and can be provided by mental health professionals. These may be rebated under Medicare.
- The nutritional and medical management of people with an eating disorder who are of higher weight must address both the eating disorder and any other health needs of the individual. This may include nutritional complications of the eating disorder including malnutrition and micronutrient deficiencies, and the nutritional needs of physical and mental health co-occurring conditions
- Management and treatment should be targeted to the person's eating disorder instead of person's weight (e.g., advising a medication for binge eating reduction rather than any appetite suppressing effects).

- Weight loss should not be "automatically" praised and reinforced. Eating disorders do not resolve with weight loss and require targeted, evidence-based treatment for the eating disorder.
- There is no evidence to support any dietary intervention as stand-alone care for treatment of an eating disorder. Nutritional assessment and management of nutritional care in larger-bodied people with eating disorders is best provided with the support of a dietitian. Dietetic care, may be rebated under Medicare.
- Weight stigma is common and causes harm. One 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., 9, 10]. 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.

Key recommendations for medical practitioners

The below table outlines key recommendations for medical practitioners, namely management overview, nutritional and medical management and pharmacotherapy. For a complete summary of recommendations including recommendations for physical activity, family interventions and psychological therapy for adults, adolescents and children click here.

Recommendations for the management of people with eating disorders who are of higher weight	Level of evidence[1]
Management overview	
All treatment should be provided in the context of interprofessional collaborative practice	C
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
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

[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.

Further resources/learning

Additional learning on eating disorders and higher weight is available including resources on weight stigma and use of language regarding higher weight.

Access the full guideline for Management of eating disorders for people with higher weight here, or go to nedc.com.au/eating-disorder-resources/clinical-practice-guideline/

For freely accessible, comprehensive foundational online eating disorder training go to NEDC eLearning. To view available treatment services in your local area, go to NEDC Support and Services.

References

1. National Health and Medical Research Council. Guidelines for Guidelines Handbook: National Health and Medical Research Council; 2016 [Available from: www.nhmrc.gov.au/guidelinesforguidelines].
2. Appolinario JC, Sichieri R, Lopes CS, Moraes CE, Veiga dGV, Freitas S, et al. Correlates and impact of DSM-5 binge eating disorder, bulimia nervosa and recurrent binge eating: a representative population survey in a middle-income country. Soc Psychiatry Psychiatr Epidemiol. 2022:1-13.
3. Whitelaw M, Lee KJ, Gilbertson H, Sawyer SM. Predictors of complications in anorexia nervosa and atypical anorexia nervosa: Degree of underweight or extent and recency of weight loss? J Adolesc Health. 2018;63(6):717-23.
4. Sawyer SM, Whitelaw M, Le Grange D, Yeo M, Hughes EK. Physical and psychological morbidity in adolescents with atypical anorexia nervosa. Pediatrics. 2016;137(4): e20154080.
5. Peebles R, Hardy KK, Wilson JL, Lock JD. Are diagnostic criteria for eating disorders markers of medical severity? Pediatrics. 2010;125(5):e1193-e201.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (5th ed.)2013.
7. Hart LM, Granillo MT, Jorm AF, Paxton SJ. Unmet need for treatment in the eating disorders: a systematic review of eating disorder specific treatment seeking among community cases. Clinical psychology review. 2011;31(5):727-35.
8. Piya MK, Chimoriya R, Yu W, Grudzinskas K, Myint KP, Skelsey K, et al. Improvement in eating disorder risk and psychological health in people with class 3 obesity: Effects of a multidisciplinary weight management program. Nutrients. 2021;13(5):1425-37.
9. Hart LM, Ferreira KB, Ambwani S, Gibson EB, Austin SB. Developing expert consensus on how to address weight stigma in public health research and practice: A Delphi study. Stigma and Health. 2021;6(1):79.
10. Puhl RM. 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. 2020;21(6):e13008.