CEDO COLLABORATIVE OF EATING DISORDERS ORGANIZATIONS

OPPOSING NEW CLINICAL GUIDELINES FROM THE AMERICAN ACADEMY OF PEDIATRICS

January 13th, 2023

American Academy of Pediatrics
345 Park Boulevard
Itasca, IL 60143

As the Collaborative of Eating Disorders Organizations (CEDO), we strongly oppose the new clinical guidelines introduced by the American Academy of Pediatrics. We do not support intentional weight loss in children via the methods included in the guidelines, especially the recommendation of bariatric surgery and pharmaceutical products for children. The eating disorders community is on the frontline responding to the harm that is done when children's relationship with food and body is disrupted. We are very concerned about the message this aggressive approach to childhood and adolescent "obesity" sends to the healthcare community, parents and guardians, and young people. Additionally, we believe it is irresponsible to call for ending weight biases while simultaneously perpetuating weight stigma through medical guidelines that put children at increased mental and physical health risks.

We stand firmly against the new American Academy of Pediatrics "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity." The statements made throughout these guidelines are problematic at best, and at worst, put American children and adolescents at serious risk for developing eating disorders, disordered eating, and other mental and physical health issues.

Eating disorders affect more than 29 million Americans and cause more than $400B/year in combined financial costs and loss of well-being to our country (Harvard STRIPED, Academy for Eating Disorders, Deloitte Access Economics, 2020). They are one of the deadliest mental illnesses, second only to opioid abuse. And, there has been a 100% increase in adolescent hospitalizations for eating disorders since the onset of the COVID-19 pandemic (Otto, et al., 2021).

We have highlighted several problematic excerpts from these guidelines below, and urge the American Academy of Pediatrics to reconsider and rescind these harmful recommendations.

"Comprehensive obesity treatment may include nutrition support, physical activity treatment, behavioral therapy, pharmacotherapy, and metabolic and bariatric surgery"

The guidelines speak extensively about “complex genetic, physiologic, socioeconomic, and environmental contributors” to “obesity,” yet all suggested interventions focus on individual behavior changes within an “obesogenic” environment. Acknowledging that factors such as racism, poverty, and cultural variances play a role in “obesity” while still pressuring individuals to change behavior does harm to children and further contributes to the misconception that “obesity” is based on individual choices. The AAP expresses its concern about weight bias while simultaneously publishing recommendations based on, and very likely to exacerbate, weight bias.

Individuals who are labeled as “obese” are shamed, stigmatized, and told that their body is diseased; then they are told all of this is their own fault. These new guidelines support this bias. It is difficult to imagine the trauma children will experience when they are told their body is not only diseased because of its form, but that they need invasive medication or surgery to fix it. Children in larger bodies are looking to parents or guardians to mediate their interactions with medical professionals. With the AAP guidelines, parents will receive and likely listen to harmful medical advice, which includes the constant berating of their children by physicians and their aggressive approaches to "fixing" their body size. Additionally, the guidelines treat “obesity” as an all-or-nothing concern, instead of on the spectrum of health, which exists in all sizes. It is reductive of other factors that can influence health such as weight stigma, racism, and poverty.

The medical field tends to overestimate the “risk” of “obesity” and maintains that the negative side effects of weight loss treatment outweigh the risk(s) of "obesity." Research does not support this assessment in children. The negative health consequences associated with “obesity” (i.e., type 2 diabetes, heart disease, etc.) do not have a high mortality rate among adolescents.

If we are operating under the assumption that weight loss leads to improved health outcomes, it’s also important to note that studies assessing the efficacy of diets do not show evidence of health improvements and are ineffective at “obesity” prevention (Mann et al, 2007; Fildes et al., 2015). The new class of “obesity” drugs, GLP-1 agonists, do not have a long track record in adults, much less in growing children. We are concerned that the AAP is putting a large amount of trust into short-term studies of new drugs.

To assume that those in larger bodies should accept the health risks associated with weight loss treatment (i.e., GLP-1 agonists and/or surgery) is evidence of the damaging weight stigma that is pervasive in “obesity” prevention and treatment efforts.

“Evidence-based treatment delivered by trained health care professionals with active parent or caregiver involvement has no evidence of harm and can result in less disordered eating.”

Weight normative approaches to working with clients and patients (e.g., dieting and calorie restriction) have been shown to lead to health consequences such as weight cycling and increased risk for eating disorders (Bacon & Aphramor, 2011). Furthermore, weight-based approaches to health exacerbate weight stigma, a correlate of adverse health and well-being (Tylka et al., 2014). As such, there are considerable ethical considerations of promoting treatment that may be damaging and excluding approaches to health and well-being that have no known negative health impacts.

The evidence-based treatments discussed in the AAP guidelines are reminiscent of past approaches to higher weight children that led to significant harm for individuals who now, as adults, are dealing with disordered eating/eating disorders and associated lack-of-wellness. We are very concerned when those approaches of decades past are now intensified with new tools that can take the level of harm to new heights both physically and mentally.

"Physicians should offer adolescents ages 12 years and older with obesity weight loss pharmacotherapy, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment."

The AAP promoting pharmacotherapy in the context of weight-loss, without evidence of safety for children, creates the false impression that a pill will "fix" the problem. This allows the reckless market of over-the-counter (OTC) diet pills and weight-loss supplements to thrive. Youth who use OTC diet pills are six times more likely to be diagnosed with an eating disorder within 3 years, compared to non-users. Further, there are more than 23,000 emergency room visits per year (in the U.S.) that are due to harmful dietary supplements – 25% of which were sold for weight loss. These supplements can result in organ failure, heart attack, stroke, and death. We see the abuse of these medications by concierge physicians who are prescribing GLP-1 agonists to their patients who are not higher weight but want to lose a few pounds. The likelihood of abuse is great, and based on the experience with dietary supplements and medications for weight loss in the past, these guidelines will contribute to an increase in eating disorders.

"Teens aged 13 and older with severe obesity (BMI ≥120% of the 95th percentile for age and sex) should be evaluated for metabolic and bariatric surgery."

Bariatric Surgeries have significant risks, including ulcer development, bowel movement issues or obstructions, nausea after eating or drinking, vitamin and mineral deficiencies, surgery complications, PTSD, and death. Adolescents do not have the emotional or cognitive capacity to navigate the complex medical, nutritional, and life changes that bariatric surgery involves, such as the mandatory, restrictive lifestyle and eating behaviors that would be necessary for the rest of their lives.

Bariatric surgery is not recommended for people experiencing eating disorders, and yet, up to 53% of bariatric surgery candidates meet criteria for binge eating disorder (BED), with an even greater number reporting subthreshold symptoms (Tess, Maximiano-Ferreira, Pajecki, & Wang, 2019). While not all individuals who have binge eating disorder are in larger bodies, BED is one of the most common psychiatric disorders in patients presenting for weight loss surgery (Sarwer et al. 2004). The eating disorders treatment community is on the front lines of adults with BED who have had these surgeries and those who have developed eating disorders post-surgery. We see the fall-out and cannot fathom these problems in young people with bodies that are still growing and developing.

With regard to using BMI as guidance for surgery, the BMI calculation is based on a child's weight. Children are expected to fluctuate in weight during pre-pubescent and pubescent years where, naturally, the body and brain need increased fuel to safely develop into adolescent, teenage, and adult body types. According to World Health Organization (WHO) growth charts, it is normal for children to gain 11-15 pounds each year until early adulthood when their weight can plateau. Manipulating childhood weight via pharmacotherapy and/or bariatric surgery can not only damage a child's physical development, but damage their cognitive and psychological development as well.

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The AAP's guidelines for childhood "obesity" are harmful, may increase or exacerbate eating disorders or disordered eating, significantly contribute to medical weight stigma and fat phobia, and are not in the best interest of children. We strongly ask the AAP to please reconsider the guidelines, and engage with the eating disorders community to reduce the potential for harm to children.

With regards,
Collaborative of Eating Disorders Organizations

Alaska Eating Disorders Alliance
Amy's Gift
Be Real USA
Beyond Rules Recovery
Body Equity Alliance
Carolina Resource Center for Eating Disorders
Colibri Education Services
COPE: Community Outreach to Prevent Eating Disorders
Eating Disorders Coalition of Iowa
Eating Disorder Foundation
Manna Fund
Michigan Eating Disorders Alliance
Missouri Eating Disorders Association
Multi Service Eating Disorders Association
National Alliance for Eating Disorders
National Association of Anorexia Nervosa and Associated Disorders
One Hope Project
Project Heal
Realize Your Beauty
Rock Recovery
Stay Strong Virginia

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