Management of Eating Disorders for People with Higher Weight

Summary Booklet

National Eating Disorder Collaboration
2025

NEDC acknowledges the traditional custodians of lands throughout Australia. We pay our respects to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander peoples, their cultures and customs across Australia.

NEDC acknowledges the individual and collective contributions of those with a lived and living experience of eating disorders, and those who love, have loved and care for them to both influence and drive change in the stepped system of care. Each person's experience is unique, and we value and uphold Lived Experience leadership and contribution in improving the system of care for people impacted by eating disorders.

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Introduction to the Guideline

This booklet provides a summary of the guideline and does not replace it. NEDC recommends practitioners read the full guideline and use this booklet as a reference guide.

The Management of Eating Disorders for People with Higher Weight: Clinical Practice Guideline addresses the issues that arise in the care of people experiencing eating disorders who are of higher weight. These individuals represent over half of all people experiencing an eating disorder in Australia with rates of eating disorders increasing most in people with higher weight [1].

The issues affecting people with eating disorders who are of higher weight are complex and important. These issues include delayed identification, misdiagnoses in assessment, subsequent inappropriate and inadequate treatment, widespread stigma, and the introduction of new disorders (i.e., anorexia nervosa without low weight). Weight stigma is a major factor contributing to these shortfalls.

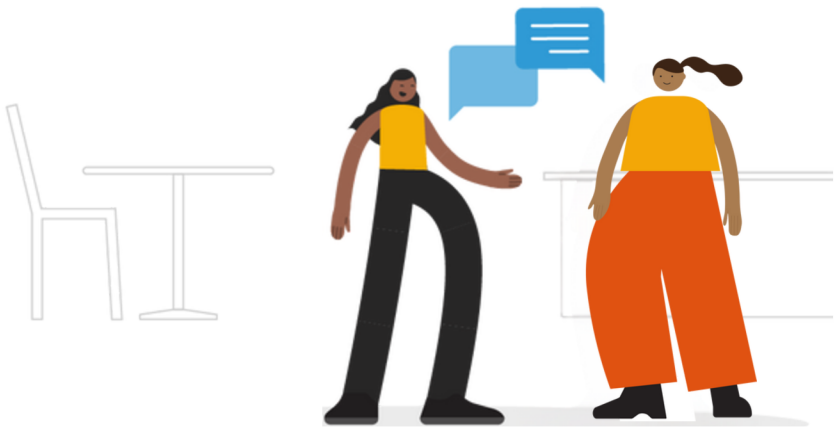
Aim and rationale for the Guideline

The aim of the Guideline is to synthesise the current best practice approaches to the management of eating disorders for people who are of higher weight, based on the premise that every person with an eating disorder is deserving of equitable, safe, accessible, and evidence-based care regardless of their body size. The focus is on the treatment of the eating disorder, with consideration of higher weight. The aim is not to address weight loss or treatment of obesity. The Guideline also provides advice on assessment.

Intended audience

The Guideline is intended for all health care professionals and does not present specialist information for any specific discipline. This encompasses, but is not limited to psychological, pharmacological, nutritional, medical, family and activity interventions. Management should address all aspects of an eating disorder, thus interprofessional collaborative practice (ICP) is recommended, with each clinician practicing within the scope of their profession.

It is hoped that the Guideline will assist health care professionals in all relevant fields to understand the needs of people in their care who have an eating disorder who are of higher weight and support the clinician in providing appropriate management of the eating disorder. Moreover, it is hoped that clinicians are more aware of, and responsive to, the adverse effects of weight stigma on the lives, health and treatment seeking of people with eating disorders who are of higher weight.



Prevention

Weight Stigma

Weight stigma is the disparaging association of higher weight with negative personal characteristics [2]. 'Weight stigma' in this guideline is used to mean the occurrence of discrimination against or stereotyping of a person based on their weight, size or shape [3].

Internalised weight stigma occurs when an individual upholds these disparaging associations towards their own body weight. Stronger internalised weight stigma predicts greater eating disorder psychopathology, higher levels of body dissatisfaction and poorer quality of life [4] and is common among people seeking bariatric surgery [5].

Weight stigma has serious adverse impacts on the lives, health and treatment seeking of people with higher weight. Experiences of weight stigma, body shame or other negative emotions such as guilt are traumatic and may contribute to the onset of eating disorders and increase disordered eating in those with eating disorders [6-8]. Perceiving and experiencing a health care provider as weight stigmatising is associated with disengagement from treatment or health care [9,10]. Thus, understanding and addressing weight stigma is crucial to the care of people with higher weight.

An important aspect in addressing weight stigma is in the use of language that avoids stigmatising terms for someone experiencing weight stigma. For this reason, this guideline uses the phrases 'people with higher weight' and 'living in a larger body'. 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.

It is recommended that health professionals adopt a weight-inclusive or weight-neutral stance, advocating for increases in health behaviours and decreases in disordered eating, instead of a focus on weight loss, which can be perceived as inherently weight stigmatising. To examine levels of internalised weight bias in people of higher weight, the Modified Weight Bias Internalisation scale [WBIS-M; [11] may be used to document links with eating disorder psychopathology.

The Academy of Eating Disorders recommends that all health professionals evaluate their own weight stigma with an online tool.

Limitations of Body Mass Index (BMI), language and definition of key terms

The terms larger bodied and higher weight includes people with high body mass index (BMI; kg/m2) through low adiposity and high muscle density (i.e., muscle building/athletes in larger bodies), as well as those with high adiposity. It may also include people with high adiposity but normal metabolic health indices and no physical health co-occurring conditions [12] although these may develop in the future. Thus, this guideline does not define higher weight by a BMI cut off but rather focusses on a conceptualisation of a larger body that includes people who may be impacted socially and by the health system by standard BMI cut off points.

Historically BMI has been and continues to be widely used as an indicator of risk relating to physical health status. However, it is acknowledged that there are limitations to sole reliance on BMI [13] Body composition can be highly variable in people with the same BMI and is influenced by many factors such as age, sex, race and muscularity. In individual assessment, other anthropometric, biochemical and behavioural measures may include waist circumference, blood pressure, blood glucose and lipid profiles. In children and adolescents, the height and weight growth velocity is preferred to the BMI. For all people it is more useful, if possible, to consider the person's pre-illness growth trajectory as likely to be close to their 'normal' or 'natural' body habitus. This trajectory should be used to guide assessments of nutritional repletion and physical recovery.

Physical co-occurring conditions and consequences

Physical co-occurring conditions in people experiencing an eating disorder, with or without a high body weight, are common. The consequences of eating disorders are similar regardless of BMI.

- People with eating disorders who restrict their dietary intake and/or engage in other behaviours such as purging may experience malnutrition resulting from poor dietary quality leading to altered body composition and body cell mass, and diminished physical and mental function and impaired clinical outcome.
- The severity of the eating disorder in anorexia nervosa (without low weight) is more closely related to the amount and rapidity of weight loss and weight suppression (which may be seen also in BED and bulimia nervosa) than the actual admission weight or BMI in adolescents and physical consequences are similar to low weight anorexia nervosa [14,15]
- Purging can affect the skin, teeth, eyes/ears and nose, throat, gastrointestinal tract, electrolytes, heart, a possible increased risk of miscarriages, and a rare risk of aspiration pneumonia [16]

Identification

Warning signs

Early intervention provides the best chance of recovery when an individual is experiencing an eating disorder. Eating disorder symptoms need to be identified and intervention offered as soon as possible [17] to all individuals experiencing eating disorder symptoms regardless of weight status.

When people living in larger bodies seek primary or mental health care for weight loss, assessment of eating disorder symptoms should be made. All services recommending or providing weight loss advice or programs (including bariatric surgery) should screen for disordered eating, risky behaviours such as use of unregulated weight-loss pills/supplements or laxatives, and body image concerns. All positive screens should be discussed with the individual and a more extensive eating disorders assessment should be undertaken.

Physical warnings signs	Psychological warning signs
• Recent body weight fluctuations (increases or decreases) [18]. However, clinicians should not wait for body weight changes to occur before considering an eating disorder assessment. • Loss of menstruation or fertility in women (not due to fluctuations with puberty onset or menopause) [18]. • Risk for or diagnosis of type 2 diabetes (e.g., impaired glucose tolerance, signs of metabolic syndrome) [19]. • Insulin misuse in diabetes (type 1 or 2) [20,21]. • Presentation with nutritional (e.g., iron) deficiency/ies[18].	• Body image concerns, especially where size and shape are influencing self-esteem (overvaluation) [18]. • Requests for weight loss interventions [22]. • Dietary changes or severe dietary restrictions for medical (e.g., coeliac disease, allergy) or non-medical reasons (e.g., sport, veganism) [23,24]. • Presence of food insecurity [25]. • Using food consumption or restriction to help regulate emotions [26]. • Increases in or driven/compulsive exercise, especially where there are musculo-skeletal injuries limiting active exercise [18]. • Depression, anxiety or substance misuse [27]. • Muscle building behaviours in males or females (i.e., intense weight training, use of sports/protein supplements, anabolic steroid use) [23,28]. • Participation in elite sports or aesthetic-based industries [23,29,30].

Initial Response

Assessment of eating pathology in people with higher weight

A comprehensive assessment of the individual and their circumstances should be undertaken to confirm an eating disorder diagnosis and any co-occurring psychiatric or medical diagnoses, to evaluate medical and psychiatric risks, and to develop a biopsychosocial formulation.
In some people with eating disorders, weight loss treatment may be contraindicated or may exacerbate their eating disorder. Communication of diagnosis, medical and psychiatric risk to other relevant treating professionals is therefore essential, especially where there are prescriptions for weight-loss treatments and/or plans for bariatric surgery.

Assessment Instruments

The ANZAED practice standards [31] recommend use of a psychometric assessment tool suitable for the assessment of eating disorders (e.g., Eating Disorders Examination Questionnaire; EDE-Q) and session by session review of progress (e.g., the shorter ED-15). The Binge Eating Scale (BES) is useful for the assessment of binge eating severity and BED in people with higher weight and may be administered as an adjunct to the EDE-Q which does not assess for all diagnostic criteria for BED.

Note, there is a paucity of high-quality instruments that have been validated for the full range of eating disorders among people with higher weight.

For a full summary of assessment instruments, please see Table 4 of the *Management of eating disorders in people with higher weight* guideline (pages 42-44).

Box 1: Anorexia nervosa (without low weight)

Anorexia nervosa (without low weight; also referred to as 'atypical anorexia nervosa') is a diagnosis under OSFED which requires all criteria for anorexia nervosa are met 'except that despite significant weight loss, the individual's weight is within or above the normal range.' People with anorexia nervosa (without low weight) may be just as physically compromised and experience similar or higher levels of psychopathology compared with their peers with low weight anorexia nervosa [14, 32, 33]. All people who have lost a significant amount of weight, either recently or in total, should be assessed for an eating disorder regardless of their weight. Clinicians should be cognisant that weight gain, regardless of BMI range, may be necessary as a part of recovery. Furthermore, the use of the broader ICD-11 diagnosis of anorexia nervosa without weight criterion (as is used in this guideline) is encouraged.

Treatment

Treatment encompasses, but is not limited to psychological, pharmacological, nutritional and activity interventions. Please find a summary of key recommendations here.

Management overview

For all, it is important that management addresses all aspects of an eating disorder and thus will be, for the majority of people, multidisciplinary and requiring practitioners to work together as a formal or 'virtual' team through inter-professional collaborative practice (ICP) with each clinician practicing within the scope of their profession. ICP occurs when healthcare workers from different professional backgrounds work alongside the person experiencing the health condition, their supports, and communities to deliver collaborative care underpinned by teamwork, effective communication, and shared values [34].

Recommendation	Grade
All treatment should be provided in the context of interprofessional collaborative practice.	A

Box 2: Trauma-informed care

A relationship between trauma and eating disorders is well established. Adverse experiences (e.g. emotional/physical/sexual abuse, crime victimisation, bullying) across the lifespan, but particularly in childhood are risk factors for the development of eating disorders [35-38]. Moreover, people who are at a higher weight are at greater risk of adverse experiences such as bullying and weight-related victimisation from peers, friends, parents and teachers than their peers without higher weight [39, 40]. Eating disorder treatment, in and of itself, may be traumatising for the person experiencing an eating disorder, especially when there is a lack of collaborative care and the misuse of power relations [41]. Components of eating disorder management such as weighing in a professional's office may provoke intense anxiety, distress, and erode feelings of safety and trust.

Thus, a crucial consideration for health professionals working with people with eating disorders who are of higher weight is to practice trauma-informed care through understanding the effects of actions that may be perceived as abusive, traumatic and/or triggering of previous trauma and moderating these actions as appropriate [42]. For a detailed discussion of treatment principles for trauma informed care for eating disorders see Brewerton [42,43,44] and Trim et al., [45]. In addition to trauma-informed care, due to the high prevalence of co-occurring trauma and eating disorders, mental health professionals working with people with eating disorders who are of higher weight should also assess the need to incorporate specific trauma specific interventions (such as trauma-focused cognitive behaviour therapy or prolonged exposure) with eating disorder treatment.

Psychological therapy for adults

Recommendation	Grade
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
Consider using therapies utilising non-dieting principles and interventions to reduce disordered eating.	D
Therapies with demonstrated efficacy for the treatment of anorexia nervosa 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

At this time, there is no evidence to suggest that recommended evidence-based psychological treatments for eating disorders in adults of various weights are not appropriate for people of higher weight, however it is possible that they may benefit from adaptations or additions.

These psychological treatments include:

- Cognitive behaviour therapy-enhanced (CBT-E), interpersonal psychotherapy and dialectical behaviour therapy (DBT) for adults with bulimia nervosa or BED
- Cognitive behaviour therapy (CBT), Maudsley model of anorexia nervosa treatment for adults (MANTRA), specialist supportive clinical management (SSCM) and focal psychodynamic therapy (FPT) for anorexia (without low weight).

There are some important issues specific to the treatment of people with eating disorders who are of higher weight that clinicians should be aware of:

- Resumption of menses has been identified as an important treatment goal for females with restrictive eating disorders as it is a factor contributing to improved bone mineral density [46]. Restoration to pre-morbid weight, even if this is at a relatively high BMI, may achieve the most complete and long-lasting recovery [47].
- When working with people with eating disorders who are of higher weight, the value of in-session weighing should be carefully considered, and the benefits evaluated against the risks of any possible negative consequences.

Psychological therapy for children and adolescents

Recommendation	Grade
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	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

There is no evidence to suggest that current evidence-based treatments for eating disorders in children and adolescents are not appropriate for people with higher weight.

FBT is the first line treatment for anorexia nervosa and bulimia nervosa for this age group, with second line treatments for anorexia nervosa being adolescent focused therapy (AFT) and CBT-E. CBT-E is also considered a second line treatment for bulimia nervosa. For BED, adult treatments are recommended [48] and for Avoidant Restrictive Food Intake Disorder (ARFID) there is no recommendation, but CBT is noted as promising [49]. An evidence base for specific psychological interventions or modifications to current evidence-based treatments for those with higher weight does not exist.

Modification of current evidence-based treatment for young people with and eating disorder and who are of higher weight is not yet indicated and treatment directives such as weighing the person experiencing the eating disorder in session should be followed. However, clinicians should proceed with sensitivity and judgement mindful of the potential for increasing shame and the impact of weight stigma and how this may impact on the young person's and family experience.

Pharmacotherapy

Recommendation	Grade
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

There are no medications developed for the treatment of people experiencing an eating disorder who are of higher weight where the primary outcome is improvement in eating disorder symptoms and/or behaviours. There are also no medications recommended in current general guidelines [48,50] as first line in the treatment of an eating disorder.

Medications that may be used for people with eating disorders:

Lisdexamfetamine: This is a stimulant approved in Australia for treatment of BED. It is not approved for appetite suppression but has this effect. It is cautioned and is a relative contraindication in people with histories of substance use disorder and/or who are in the underweight range, in a state of weight loss or weight suppression.
Anti-depressants: The majority of evidence for efficacy of antidepressants for people of a high BMI and an eating disorder is confined to BED and is of low to very low quality. Antidepressants may be considered for bulimia nervosa and BED where there is co-occurring depression or difficulties accessing psychological therapy.
Anticonvulsants: There is limited evidence for the use of topiramate in bulimia nervosa and BED. It is poorly tolerated with several adverse effects including weight loss, sedation and neurological symptoms [51].
Antipsychotics/Mood regulating agents: All antipsychotics and mood regulating agents, but particularly second- generation medications such as olanzapine, may cause increased appetite, weight gain and exacerbate conditions associated with a high BMI such as metabolic syndrome and type 2 diabetes [52].
The weight loss medication **orlistat** has been trialled in people with BED who are of higher weight but it has poor tolerability and there have been reports of its abuse in people with bulimia nervosa [53]. It has not been approved for use in BED in Australia.
Medications such as **metformin, insulin and semaglutide** may alter food consumption and consideration of this, and potential for non-prescribed use needs to be applied in the care of a person living with a higher body weight and an eating disorder.

Physical activity

Recommendation	Grade
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

While there has been much research on exercise interventions for people of higher weight, few studies directly examine physical activity in the treatment of eating disorders among people with higher weight. However, a range of physical and psychological benefits (e.g., improved self-perception, body image and mood) have been found in studies involving structured and tailored exercise interventions in eating disorder populations. Meta- analyses have consistently found that driven exercise for predominately weight and shape reasons is likely to be associated with the onset and/or exacerbation of an eating disorder [54-56].

Primary treatment goals in this population should be psychotherapeutic and focus on self-acceptance, and the development of a healthy relationship with exercise [57]. Emphasis should be placed on the physical and mental health benefits of regularly engaging in exercise [58], and more importantly, improvements in self-perception and positive wellbeing [59,60] rather than a narrow focus on weight. Clinical judgement should be utilised when dealing with vulnerable populations. For people with eating disorders exercise can be pathological or unhelpful in nature or frequency, thus exercise interventions for those people with higher weight need to take a different approach.

Family and other interventions for adults, adolescents and children

Recommendation	Grade
Include families and other carers when indicated for anyone with an eating disorder	C
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

The evidence-base for family interventions specific to people with an eating disorder who are of higher weight is extremely limited and no interventions developed for children and adolescents with eating disorders note any specific treatment adjustments for young people with higher weight. Further, none of the adult family interventions reported above specifically address or recommend an augmentation for people with eating disorders who are of higher weight.

Clinicians should implement evidence-based treatment interventions for people with eating disorders who are of higher weight as recommended and continue to involve families in treatment. At the least, psychoeducation of families and supports are needed. This may include how families manage their own weight stigma and conflicting advice from health professionals regarding the desirability of weight loss.

Structured support from family/supports to facilitate regular and adequate eating will assist with eating disorder cognitions and returning a normal eating pattern. This may include the responsibility of purchasing of food, preparing of meals, and support at mealtime. Families should be encouraged to check in with their own assumptions about body shape and size so their loved one can focus on recovering from the eating disorder, rather than on a fear of returning to or maintaining larger body size. Families should be encouraged to use body neutral and body positive talk.

Health professionals reflecting on their own use of body negative talk and overvaluation of shape and size is important. Changing our own language and thoughts can model body image acceptance and a focus on health in recovery.

Nutritional and medical management

Recommendation	Grade
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

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 registered dietitian.

The nutritional and medical management of a person 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, and the nutritional needs of physical and mental health co-occurring condition.

Malnutrition

Addressing malnutrition is essential for preventing life-threatening and longer-term complications in those with a restrictive or other eating disorders [14,61]. Intentional weight loss or being in a state of 'weight suppression' (i.e., a discrepancy between one's highest adult weight and current weight), should not preclude a diagnosis of malnutrition in someone with an eating disorder, and identifying malnutrition beyond current weight, with assessment of percentage of weight loss is recommended [62-64]

Micronutrient deficiencies

People experiencing eating disorders with higher weight may have micronutrient deficiencies (e.g., zinc, iron, vitamin D, B-group vitamins, etc.) due to low diet quality and potentially reduced bioavailability [65,66], dietary restriction and eating disorder behaviours (e.g., vomiting).

Other medical problems

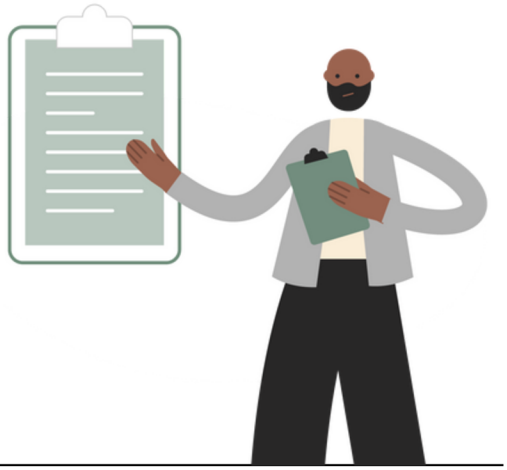
Eating disordered behaviours in people with higher weight may also lead to a range of medical complications that require intervention. These conditions often require specific dietary restriction and modification. Although traditional dietetic interventions for people with higher weight with such medical conditions have promoted the primary goal of specific dietary modification for weight loss [67-69], these effects appear short-term, and may bring unhelpful consequences such as weight regain, binge eating, body dissatisfaction, eating disorders and low self-esteem [70,71].

Further, health gains may be achieved with improved diet quality alone [72,73]. Nutritional guidance on management of such medical complications therefore needs to be aware of language and avoid messaging that can reinforce poor self-worth, feelings of failure and stigmatisation, which can all contribute to worsening eating disorder behaviours rather than reducing the medical complications. Individualised nutrition counselling and dietary adaptations to manage medical co-occurring conditions are important.

The presence of binge eating, purging and other eating disorder behaviours complicates the management of diabetes. Goebel-Fabbri [74] has written a practical guide to management of eating disorders and type 1 diabetes, some of which is also relevant for management of type 2 diabetes. A clinical guideline for disordered eating and eating disorders in adults with type 1 diabetes (aged 16 years and over) produced by Queensland Health is also available [75].

Bariatric surgery

It is important to assess for an eating disorder in people with higher weight attending for bariatric surgery assessment, as the prevalence is high [76]. Additionally, although binge eating and psychological conditions like anxiety and depression may improve in the short-term following bariatric surgery, they may restart over the longer term [77,78]. Continuing psychological support may improve outcomes in the longer-term from bariatric surgery [79].



Cultural consideration

Evidence-based knowledge of cultural considerations in the management of eating disorders is in its infancy. The following sections are derived from research pertaining to cultural considerations for the treatment of eating disorders (at any weight) as well as lived experience and clinical expertise. The below groups were chosen as salient groups that are under-represented in the eating disorders literature and treatment services within the Australian context, however such considerations may be relevant for similarly under-represented and disadvantaged groups across the international context.

Men with eating disorders

While there has been an under representation of males in eating disorder research [80], it is estimated that one third of people reporting eating disorder behaviours in the community are male [81]. Men are less likely to report a loss of control over eating, despite having similar rates of objective binge eating to women and are more likely to engage in compulsive exercise for emotion regulation [82]. For additional information on considerations for psychological therapy when working with men with eating disorders see Bunnell [83].

Aboriginal and Torres Strait Islander Peoples

Owing to the limited evidence for the treatment of eating disorders for Aboriginal and Torres Strait Islander people, health professionals working with people experiencing eating disorders and their families, should apply caution when applying this guideline to Indigenous peoples and recognise there may be a need to customise or tailor current treatment and communication approaches to accommodate their culturally diverse needs, resources and expectations.

When making recommendations for treatment health professionals should be aware that Indigenous peoples often face multiple access barriers (e.g., cost, transport, limited range of service for rural and remote communities) especially when needing to access multiple and ongoing health care as is required for eating disorder treatment.

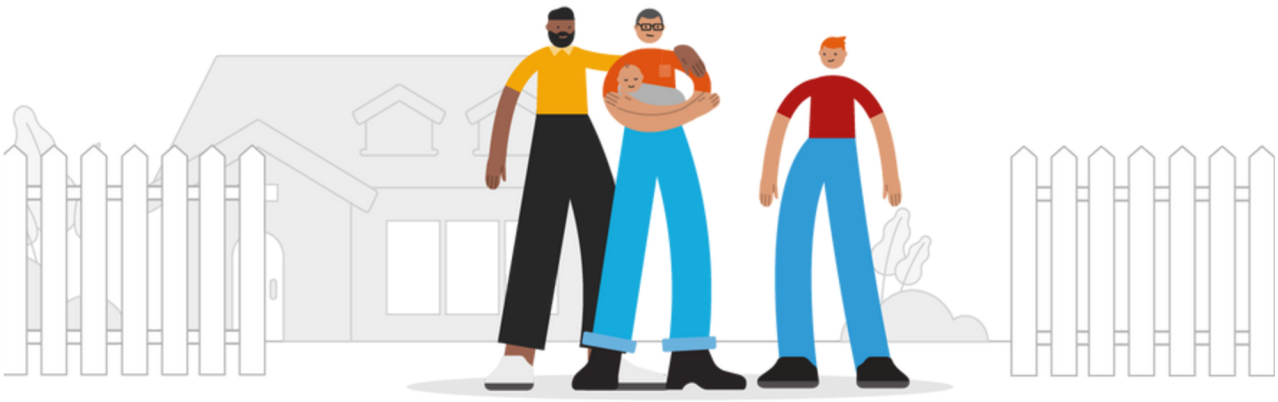
It is also recommended that health professionals practice and provide trauma-informed care due to the ongoing and intergenerational trauma, grief and loss consequential to colonisation and its continual impact on contemporary Aboriginal and Torres Strait Islander peoples [84]. Practicing cultural reflexivity (i.e., critically examining one's own attitudes, values and biases) is a step towards cultural competency.

LGBTIQA+ individuals

Research on the prevalence of eating disorders in gender and sexual minority people is limited, however, emerging research suggests higher rates of eating disorders in LGBTIQA people compared to their heterosexual and cisgender peers [86,87]. Health professionals may need to hold in mind additional considerations and tailor aspects of management and communication when working with LGBTIQA+ people with eating disorder who are of higher weight.

Body image dissatisfaction is a core symptom and stressor for sexual and gender minorities and a significant risk factor for the development of an eating disorder [88]. This is especially true for the transgender population where higher levels of incongruence between biological and assigned sex and gender identity are related to higher levels of body image dissatisfaction [89].

Finally, clinicians are encouraged to expand their perspective of what constitutes a family and support system to include 'chosen and created families' (i.e., non-nuclear supports) who may provide vital support throughout the treatment journey for people with an eating disorder who are of higher weight.



See a recent systematic review by Acle et al. [90] for empirically derived guidance on how to effectively address culture in eating disorder treatment among racial/ethnic minorities.

Conclusion

The Guideline has compiled a series of recommendation for the approach and care of people with eating disorders who have higher body weight. This guideline has been written from the perspective of the adverse effects of weight stigma and the complexity of causes of eating disorders across people of all sizes. The readers are referred to the full Guideline and other literature for the management of specific medical and other psychological disorders that are often experienced by people with an eating disorder who are living in a larger body.

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