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Contributing Factors to Eating Disorders in Sexual and Gender Minorities

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ABSTRACT: This review explores the disproportionately high prevalence of eating disorders (ED) in sexual and gender minorities (SGM) compared to their cisgender heterosexual (CH) peers. It first explains the main contributing factors leading to disordered eating behaviors in SGM, including minority stress, gender/ sexual dysphoria and body dissatisfaction, desire to pass, and barriers to affirming and inclusive care. It then separates the discussion into sexual minorities and gender minorities to explore the specific contributing factors of these communities. The review highlights the need to develop more inclusive treatment models to support SGM individuals, as well as future research that expands to include underrepresented groups within SGM.

KEYWORDS: Behavioral and Social Sciences, Clinical and Developmental Psychology, Eating Disorders, Sexual and Gender Minorities, Minority Stress.

Introduction

Sexual and gender minorities (SGM) face certain unique and heightened challenges compared to cisgender heterosexual (CH) individuals, contributing to a higher prevalence of eating disorders (ED) among SGM populations. Recent studies support the greater prevalence of ED among SGM populations. For example, in a nationally representative sample of 35,995 U.S. adults who participated in a diagnostic review from 2012 to 2013, ED prevalence rates were significantly higher among SGM than among heterosexual cisgender individuals (anorexia nervosa—1.71% versus 0.77%; bulimia nervosa—1.25% versus 0.24%; binge eating disorder—2.17% versus 0.81%).[1,2] Another literature review published in 2021 found that SGM adults have between 2–4 times greater odds of being diagnosed with anorexia nervosa, bulimia nervosa, or binge eating disorder compared to cisgender heterosexual adults.[3] However, the majority of studies concerning ED do not include the unique experiences of SGM individuals, leading to a limited understanding of risk factors specific to them. Furthermore, current ED treatment models designed for CH individuals do not attend to the specific needs and unique experiences of SGM, resulting in a lack of access to affirming and effective treatment.[4] Understanding why SGM communities have a higher chance of ED is crucial for healthcare providers to develop specialized interventions that provide effective and inclusive care.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), eating disorders are "behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotions."[5] They can lead to serious physical, psychological, and social consequences. The most commonly recognized types of EDs include Anorexia Nervosa (an intense restrictive food intake or starvation driven by the fear of gaining weight), Bulimia Nervosa (cycles of binge eating, usually with a loss of control, followed by episodes of intense compensatory behaviors, such as vomiting, excessive exercising, or fasting, to lose weight), Binge Eating Disorder (recurrent episodes of binge eating, consuming large amounts of food, without the following compensatory behaviors), Avoidant Restrictive Food Intake Disorder (avoidance of food or restricted food intake that results in nutritional deficiency), and Other Specified Feeding and Eating Disorder (eating disorders that do not fit in any of the above categories but still pose physical, psychological, or social consequences). The studies included in this review conform to this definition of eating disorders. Several studies use ED screening tools that reflect the criteria in the DSM-5-TR, which contains the most conventional understanding of mental disorders. This review includes studies of individuals who are diagnosed with ED as well as those with disordered eating behaviors. The latter indicates that these individuals may not meet the full criteria for an ED diagnosis, but still exhibit irregular eating behaviors that match the definition above.

This review focuses on sexual and gender minorities (SGM), which are relatively underrepresented in ED studies. SGM is an umbrella term for LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual) populations whose sexual orientation or gender identity doesn't conform to traditional social norms.[6] Specifically, this review discusses transgender, gender nonbinary, gay, lesbian, and bisexual individuals, with studies mostly based on demographics in the United States and the United Kingdom. This review argues that SGM communities have a greater prevalence of ED compared to CH peers due to factors including minority stress, gender dysphoria, desire for passing, and barriers to accessing affirming and inclusive care. By analyzing, comparing, and contrasting studies from different demographics and perspectives, this review aims to raise awareness of ED among SGM and the unique stressors and contributors, thus offering insights that may result in more effective and inclusive treatment programs for this population.

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Discussion

Minority Stress Model:

The minority stress model is based on the theory that marginalized populations face greater mental health challenges due to increased social stress that results from their stigmatized status.[7] Minority stress differs from general stress because the former is rooted in stigma and prejudice experienced by minority communities. Minority stressors can be separated into 2 categories: distal and proximal.[8] Distal stressors are external events that SGMs experience due to discrimination and prejudice, typically transphobia and homophobia. These can be discriminatory policies or everyday microaggressions, including acts of harassment and violence. For gender minorities, one study from Project AFFIRM compared transgender and gender nonbinary participants who met the criteria for current ED-related symptoms with transgender and gender nonbinary participants who didn't, and found that the former had higher minority stress scores along with higher BMI and lower transgender congruence.[9] In this study, minority stress scores were calculated based on 3 tests: a 10-item version of the Everyday Discrimination Scale measuring enacted stigma, evaluating aspects of discriminative experiences like frequency and prevalence; a 10-item version of the Stigma Consciousness Questionnaire for felt stigma, in which participants had to indicate their level of agreement with statements like "Most non-transgender individuals have a problem viewing transgender individuals as equals"; and the Transgender Identity Survey for internalized transphobia.

For sexual minorities, one study from Tennessee, USA, using the Eating Disorders Screen for Primary Care and other screening instruments, found that lesbian individuals have a 66.7% ED proneness, whereas gay individuals had a 47.6% ED proneness.[10] The study found that perceived stigma has a direct relationship with ED proneness in gay individuals and a significant indirect relationship with ED proneness in lesbian individuals. Similarly, a literature review conducted in 2021 showed that experiences like minority stress, heterosexism, and sexual objectification can lead to eating disorder behaviors and body dissatisfaction among lesbian and bisexual women.[3] It also found that sexual minority adults who have experienced discrimination based on their weight, a common experience of minority stress, had a greater risk of eating disorder behaviors compared to those who did not experience weight discrimination.

On the other hand, proximal stressors are internal responses to these external pressures. These include internalized stigma, an expectation of stigmatization, and hiding sexual orientation or gender identity. According to the minority stress model, SGM individuals face increased stress as they do not fit into the traditional social norms of heterosexuality and cisnormativity. In turn, these individuals might develop disordered eating behaviors as a maladaptive coping mechanism for their emotional distress. Furthermore, internalized stigmas such as transphobia and homophobia exacerbate body dissatisfaction, increasing the drive to engage in ED behaviors to conform to social norms, and thus a greater prevalence of ED.[9,11] For gender minorities, the Project AFFIRM study found that individuals with internalized transphobia have 41% greater odds of being associated with ED, and individuals with anxiety have 3% greater odds of ED association.[9] It also found that the gender nonbinary individuals had greater levels of minority stress and psychological distress compared to the binary transgender individuals, suggesting that minority stress potentially leads to heightened ED symptoms for gender nonbinary individuals.

For sexual minorities, the study from Tennessee showed that depression was significantly associated with ED proneness in gay and lesbian individuals.[10] The logistic regression analyses from the study further indicated that depression and self-compassion were the predicting factors of ED proneness in gay individuals, and depression was the predicting factor of ED proneness in lesbian individuals. Similarly, the 2021 literature review found that depression was a significant predictor of a positive ED screen among lesbian individuals among a sample of 267 SGM adults in the United States.[3] It also found that depression and perceived stigma are predictors of ED behaviors among gay individuals among a sample of 317 gender minority adults.

Gender/Sexual Dysphoria and Body Dissatisfaction:

Gender dysphoria is the psychological distress felt by gender minorities, resulting from the incongruence between sex (assigned at birth) and gender identity.[12] For gender minorities, this distress can manifest as body dissatisfaction, as one's sex characteristics don't align with one's gender identity, yet one has already internalized the beauty ideals that contradict one's body. Therefore, this population may employ disordered eating to change the shape of their body or specific body parts in an attempt to suppress or accentuate gender.[11] Beauty standards of conventional masculinity and femininity are significantly amplified for transgender individuals, especially transgender youth, who are highly influenced by social media's reinforcement of these narrow beauty standards.[11] For example, the Project AFFIRM study found that 50% of transgender and gender nonbinary participants over-reported their weight, and more than 50% attempted to restrict food intake to change their body shape or weight.[9] The shape and weight concerns reported among the transgender participants were also greater than is typical in cisgender individuals, leading to further gender dysphoria within this community. One possible explanation for this finding is that in some cultures, masculinity may be linked to muscularity while femininity may be linked to thinness. According to this theory, transgender men could display ED symptoms like fasting, vomiting, or excessive exercise in an attempt to achieve a masculine physique, and transgender women could adopt restrictive diets to appear thinner, to match the conventional beauty standards for women, as shown in the 2021 literature review.[3]

For sexual minorities, all participants from a study published in 2022 said in the interview that gender dysphoria was a critical factor in the development of their eating disorder, but it was often overlooked.[13] The study showed how sexual minorities endorse higher body dissatisfaction because their idealized body image is different from heterosexual peers, with sexual minorities enduring heightened appearance pressure.

The study reported high levels of body dissatisfaction for gender-diverse individuals, suggesting that their bodies may often be a primary source of overall distress. ED behaviors are reinforced when these individuals feel decreased gender dysphoria and body dissatisfaction as their bodies change. For example, the 2021 literature review showed that gay and bisexual boys have higher chances of fasting, skipping meals, or using diet pills than straight boys.[3] Several studies on gay and bisexual men have found that men in sexual minorities report a greater prevalence of eating disorder behaviors related to weight loss or muscle-building, and one study found that gay and bisexual adolescents have greater rates of purging and restricting behavior. Similarly, lesbian and bisexual girls and women also have higher rates of disordered eating behavior, such as fasting, skipping meals, or using diet pills.

Desire for Passing:

Passing is when someone is perceived as their affirmed gender identity and not suspected as transgender. The desire to pass has a strong association with disordered eating behaviors, which can be used to change body shape to accentuate and suppress gender-related traits. This desire is strong for many people because those who pass are at a lower risk of discrimination, harassment, and violence.[14] Since gender nonconformity is not desired in a primarily cisnormative society, many individuals turn to ED behaviors in an attempt to gain social validation. A paper published in the Columbia Social Work Review showed that transgender individuals have the pressure to "pass" as cisgender to avoid being visibly identifiable as transgender, which would put them at a greater risk of transphobic discrimination, including harassment, social othering, microaggressions, and violence.[4] Therefore, transgender individuals are often hyper-aware of their appearance as a survival instinct in society, further increasing body dysmorphia and the possibility of engaging in ED behaviors.

However, passing is difficult because beauty standards for masculinity and femininity are amplified for transgender individuals, as shown in the Columbia Social Work Review.[4] The paper documented a study showing that participants with higher transgender congruence (more congruence between gender and appearance, i.e., a greater chance to pass) have lower rates of reporting ED symptoms. Gender nonbinary individuals report lower gender congruence than binary transgender individuals, which suggests heightened difficulties in aligning their identified gender with physical appearance, potentially leading to body dissatisfaction or decreased self-confidence, both of which are factors of ED behaviors. Moreover, when gender minority individuals fail to pass despite taking actions (including extreme measures such as disordered eating), their mental health might be further harmed, and in turn, they might resort to ED as a coping mechanism. In a book published in 2018, it's shown that the resulting sense of all control being lost can lead to intensified ED symptoms to reclaim a sense of control amid overwhelming distress due to the inability to resolve the conflict between sex and gender.[15]

Barriers to Affirming and Inclusive Care:

The ability to receive affirming and inclusive care is crucial for the well-being and health of SGM individuals. However, current treatment models present these communities with several obstacles that prevent them from getting the support they need. Firstly, few ED care providers are knowledgeable about the unique experiences and challenges faced by SGM individuals and thus aren't able to provide affirming and inclusive care.[16] The 2021 literature review found that a significant clinical challenge transgender youth face is the standard use of growth curves based on sex, preventing providers from establishing appropriate goal weights.[3] This can cause distress when these curves don't reflect the individual's identified gender, further exacerbating body dissatisfaction. Furthermore, the 2022 study showed that 70% of gender-diverse participants report treatment experiences impacted by gender dysphoria.[13] For them, ED is more about gender issues and trauma, which doesn't fit the conventional treatment model. For example, one participant said, "There is one thing they had me do, which was to stare into a mirror for half an hour… It seems okay if you're just dealing with body dysmorphia… but with gender dysphoria as well, that's also very triggering." Therefore, transgender youth might also be discouraged from seeking medical care in the future, resulting in a cycle of untreated ED.

Secondly, many of these individuals face discrimination in general healthcare settings, which can include misgendering, misnaming, or a direct refusal to provide healthcare services.[17] For example, the Columbia Social Work Review paper showed that transgender individuals often face discrimination, such as misgendering, misnaming, or direct refusal of service when seeking mental and medical healthcare.[4] These negative experiences discourage SGM individuals from seeking medical support in the future, contributing to the persistent cycle of ED behaviors. Thirdly, many of these individuals face geographic or financial barriers. For example, the Columbia Social Review Paper found that these individuals have a high possibility of living in a region where this specific type of healthcare is not provided or might not be able to afford such care.[4] The paper also showed that these individuals might also face social barriers such as a lack of support from family members, further increasing the difficulty in accessing affirming care. When the needs of these individuals are unmet, they might turn to disordered eating again in an attempt to gain control over their bodies since they can't exert control through acquiring treatment.

Conclusion

This review has cited several studies that support the disproportionately high prevalence of ED in SGM individuals compared to CH individuals. This prevalence can be explained by unique factors they face, including minority stress, gender or sexual dysphoria, body dissatisfaction, desire for passing, and barriers to affirming and inclusive care.

The current ED care system should be improved to provide more effective support to these individuals. Current treatment models are mostly tailored for CH individuals, especially white women, failing to consider the unique stressors faced by the

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SGM community. Healthcare providers should be trained to be aware of these factors and ensure that treatment environments are inclusive, such as adjusting sex-based growth charts for transgender patients. To take it one step further, there could be interventions targeted to address SGM patients, such as using patient-centered language and assessment methods to avoid assumptions based on gender or sexual orientation. From an institutional level, policy adjustments can assist in implementing inclusive practices across healthcare systems. For example, policies regarding growth charts can expand to include sex-based growth charts to suit more kinds of patients. It's important to note that diversity exists within the SGM community, so these interventions should be designed to meet the needs of different SGM groups.

Further research is also crucial for advancing our knowledge of the intersection between ED and SGM. First, future studies should expand the scope of SGM groups. As seen in this review, a lot of current research is focused on transgender individuals, while other SGM individuals are underrepresented. This means that important factors, like barriers to affirming care faced by sexual minorities, may not be well-documented due to insufficient research in this area. Second, future studies can explore the intersectionality of SGM, race, ethnicity, and socioeconomic status, and how the interrelation may heighten one's chance of developing ED. Addressing these knowledge gaps helps raise awareness of the challenges these individuals face and enhances healthcare systems, helping them become more inclusive, affirming, and effective.

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