Investigating the Biopsychosocial Factors Impacting Eating Disorder/Disordered Eating Etiology, Treatment, and Advocacy Within the LGBTQIA+ Community

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Trigger warning: the topics to be discussed in this thesis may be disturbing or triggering for select audiences. Examples of topics include eating disorders, eating disorder symptoms, homophobia, transphobia, and self-harm. Please proceed with caution and avoid reading if necessary.

For my recovery and LGBTQIA+ families: thank you for not giving up. Thank you for being here and being you. May you understand justice, love, and peace. May you be vibrant and joyful. May you never be erased.

“We will recover

The worst is over now

All those fires we've been walking through

and still we survive, somehow.”

-*Recover,* Natasha Bedingfield

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Introduction

A topic with increasing urgency in modern contexts is eating disorders. Greater visibility of not only survivorhood of these diseases but discourse surrounding such has contributed to heavier presence of either in the media, higher acknowledgement of and efforts towards remediating these diseases in healthcare and the research informing such care, and as a result of either, greater social awareness. While the increase in representation is constructive, it does not come without limitations. Prior to engaging to a deeper extent with this topic, it is important to clarify the difference between two noteworthy terms to be explored in this thesis: eating disorders (EDs) and disordered eating (DE). While both are critical issues requiring greater focus in research, health, and social contexts, what sets the two apart is severity. EDs are diagnosable illnesses categorized as both acute and chronic, characterized by intense fear of food; compensatory actions; and various ramifications within one's life such as significant disruptions in performance at school or work, within relationships, and in one's own relationship with themselves, their body, and/or food. DE, on the other hand, is a chronic state of eating disorder-adjacent signs and symptoms occurring below the threshold for diagnosis. In spite of their differences, both are distressing and deserve proper visibility, representation, and care.

Compared to DE, EDs in particular are prevalent illnesses and impact a number of individuals across various demographics. Statistics vary. Jason Nagata et al. note that lifetime prevalence of anorexia nervosa within non-marginalized populations is 1.7%, whereas that of bulimia nervosa is 1.5% and binge-eating disorder is 2.2% [1]. However, no two people, let alone demographic groups, experience these illnesses in the same way. Furthermore, these statistics only pertain to threshold EDs and exclude subthreshold cases of disease. In fact, incidences of EDs/DE, threshold or not, tend to be higher among marginalized populations such as those

related to racial, sexual, gender, and socioeconomic identities. A specific example of this can be found among the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, aromantic/asexual, +) community, with individuals within it having been noted to experience greater levels of disordered eating behaviors and eating disorder patienthood. A variety of studies have investigated these statistics, one of which notes that transgender men and women experience notably higher rates of eating disorder occurrence at approximately 10.5% and 8.1%, respectively[1]. Increased rates of eating disorder and disordered eating behavior occurrence have also been noted among other individuals within the LGBTQIA+ community such as non-binary individuals, bisexual adolescents, and gay men[1,2]. For instance, in a study by psychologist Dr. Mar Chung, non-binary individuals were found to display a self-reporting rate of ED patienthood 3.16 times higher than trans women and men considered in it[2]. Alongside this, a 2018 study by Jerel P. Calzo, S. Bryn Austin, and Nadia Micali elucidated that gay and bisexual adolescent boys reported higher rates of DE behaviors than their cisgender, heterosexual counterparts at 2.5% reporting any purging behavior (including self-induced vomiting, laxative abuse, or exercise), 7.5% reporting binge eating, and 22.5% reporting any type of restricting behavior, alongside a marked pressure to increase physical muscularity: a notable biopsychological phenomenon among gay and bisexual boys and men[1–3]. Considering the wide array of populations impacted by this illness, it is clear that eating disorders do not discriminate. This said, there are a variety of potential reasons for these increased rates of illness, both similar and not to those in cisgender and heterosexual individuals, which are to be explored in this thesis. It is critical that one not oversimplify and give in to what might be perceived as “obvious reasoning” as this can further ostracize underrepresented and underprivileged populations, thus presenting another boundary to equitable, effective care. Furthermore, one must note that the rates that the accepted rates of

ED/DE frequency are just that—accepted. These rates only pertain to the noted, diagnosed cases of eating disorders among a given population[2]. There may be even more individuals within these demographics that have not sought care (and thus not received a diagnosis), as well as those who may fall under the diagnostic threshold for an eating disorder yet experience symptoms of one, hence prior mention of subthreshold EDs. As a result, reported rates may be inaccurate. They are also subjective, pertaining only to the sample from which they were derived and difficult to extrapolate to a greater population. On a population level, the data tends to be more ambiguous. Drive for thinness, for instance, has been noted in similar demographics across age groups, and similar rates of self-reported actions may be noted across different population subsets. Or, although many instances of treatment seeking occur in white cisgender women, similar rates are noted in Latina and multiracial populations[4]. Thus, the pathology of EDs may be difficult to specify to one group without proper context.

In a broader context, there are also several issues pertaining to EDs'/DE's space in healthcare, research, and sociocultural representation. Perhaps the most outstanding is that research on EDs/DE is new, only having emerged over the past few decades. Prior, there was little presence of EDs and related illnesses in academic environments, thus putting EDs at a disadvantage in both academia and surrounding topics by including research of lesser quantity, research conducted in lesser depth, and greater amounts of bias in the study process. A potential factor related to this is that EDs are not suitable for research due to their more acute symptomology and requirement of a more immediate intervention. If a patient is struggling with this illness, why endanger them further by thrusting them into a setting unrelated to providing care? Why benefit from the manipulation of such a vulnerable, diseased state? Patients and their wellbeings must be centered, therefore, research on EDs must be executed when further removed

from an acutely ill condition. While this ensures greater ethics, this also introduces bias by providing perspectives more removed from such an urgent, diseased space. As one proceeds away from their illness and further into recovery, recounting times spent in sickness may be triggering, difficult to recall, or otherwise inaccessible. This is not to say that there is any issue with waiting until a patient is stable—as just mentioned, it is imperative that it is so. Rather, this is to indicate that existing data and impressions based on them may only hold part of the complete narrative within professional settings.

Second, a portion of the existing research surrounding EDs and related illnesses is biased because it focuses on a specific few demographics, namely white women. There is a reason for this: much of the reported cases of EDs are sourced from cisgender, heterosexual white women. This is backed by a multitude of studies suggesting women and individuals assigned female at birth (AFAB) may be impacted to a greater degree by biologic and social factors contributing to ED development. However, ED survivors are by no means monolithic. It is not only unjust, but it is inaccurate to focus on only one population at the dismissal of others. Again, EDs are non-discriminatory and can affect anyone. In terms of medical care, it is important to understand the principle of evidence-based practice: ethical, recent, and relevant research informs care principles and protocols. However, given reported cases, medical research and care may undermine this fact and continue to contribute to this societal myth. The individuals being researched may not fit diagnostic criteria and thus give way to inaccurate rates. Research participation criteria may be exclusionary of different identities, study design may not cater to sociocultural differences, and/or data documentation may be executed in a poor, more biased manner. An instance of this can be noted in a 2022 study undergone by a team of researchers at the University of Delaware[5]. Its goal was to investigate intuitive eating as an intervention for DE

among college-aged women. One note included in this research is that it needed to focus on women due to the increased rate of eating disorders among them. While this reasoning is valid, it also poses a risk of neglect to other populations experiencing the same illness, perhaps at higher rates than women, and further reinforces the myth of the "perfect patient." Symptoms may be incorrectly generalized, either by over- or under-generalization, thus excluding a majority of patients that may seek help for their disorder. The various environments attributing to these symptoms may also be incorrectly attributed, or abandoned entirely, focusing instead on merely one category as a catch-all. The truth is, the etiology of ED/DE is rooted in a trans-disciplinary model, referred to as the biopsychosocial model: biologic, psychologic, and societal influences. Without proper visibility in research, there may be a lack of representation within care contexts, the consequences of which may be detrimental in a span of settings. Furthermore, statistics are borne from diagnoses. Current numbers pertain only to cases that have been documented. How many more cases might there be that have *not* been able to be monitored by a professional, regardless of whether one's ED case meets diagnostic threshold? An array of privilege plays into this documentation: access to care, access to food and other mechanisms for recovery, and health literacy being a few. These can be expensive, geographically inaccessible, or difficult to obtain due to sociocultural presumptions or stigma impeding the patient's abilities. On the other hand, providers may buy into their own bias and under-diagnose patients that do not fit their script of what an ED/DE patient looks like, merely because the patient's social presentation and roles do not subscribe to the ones commonly perceived as "average" in the context of an eating disorder. Though it is morbid to consider, it is a tangible possibility that numbers are underrepresented to a severe degree, further attributing to bias in all aforementioned environments.

The third issue with EDs and their representation, especially in research, is that existing research tends to focus on prevention of eating disorders. This removes focus from the complete lens on EDs—which spans from etiology to advancement of care—thus emphasizing only one facet at the ignorance of others and exhibiting perhaps the most common theme amongst disparities related to EDs/DE. EDs are complex illnesses, requiring attention from all disciplines: dietetic, medical, psychological, sociological, familial, and so forth. Further, this lack of focus can leech into impressions of such fields, which are already biased. Consider the overwhelming femininity rife within impressions of ED and the care provided for them. If attention is diverted from the full reach of symptoms, would this not neglect remediation of their (falsely) inherent gendering, too? Sasha Gorrell et al. note this shortcoming, stating, "To date, the study of eating pathology across gender identity has been considerably hindered by our sexually dimorphic approach…which has consequently limited our ability to consider potential critical nuances in ED presentation that may inform future screening and treatment approaches[4]." With this, let us acknowledge that medical care, including and especially in the realm of EDs, is based on research per evidence-based practice. Flaws in doctrine give way to flaws in practice, thus providing improper care as well as impressions around such. As mentioned in previous sections, the research surrounding individuals belonging to marginalized populations is not only deficient, but of severely compromised quality. Not only does this attribute to poorer care praxis, but this pervades into other relevant environments. Compromised care results in further "othering" of marginalized populations, thus inhibiting their advancement in healthcare and associated rights. In short, compromised care comes at the expense of these people. What must happen is that these setbacks in care must be extracted at the root, rebuilding systems of care and advocacy from the ground up.

It is easy to maintain scripts that have been prescribed through a variety of external environments. However, the difficult truth is that not all of these are constructive nor accurate, which can contribute to increased prejudice and consequent discrimination against the LGBTQIA+ community as they navigate treatment for a severe experience. Thus, to overcome these obstacles, the complete span of ED/DEs must be considered in seeking answers to the following questions: What are the current statistics relating to queer and trans/GNC individuals with DE/ED? What might be impacting these stats to be higher or lower? How may one facilitate recovery for queer and trans/GNC individuals in the most holistic, inclusive ways possible? To commence this exploration, a selection of factors influencing etiology of these diseases is to be explored, spanning from personal biology to collective culture. Advocacy for EDs/DE is then to be discussed, focusing largely on sociocultural influences. Last, an inventory on provision of ED/DE care will be inspected, again rooted in the biopsychosocial model of ED/DEs in order to pose limitations to current efforts and note vital future directions.

Etiology

Bio

The development of EDs/DE may be attributed to a variety of factors—to commence, the biologic impacts are to be investigated. Biologic factors can be summarized as internal bodily processes and their relationship with the environment surrounding such. There is an array of potential biologic influences on the development of EDs/DE: gut microbiome composition and diversity and endocrine function to name a few[6]. A more prominent effect on ED development within many individuals is genetic influence: whether a parent developed their own ED and whether that experience imparted upon offspring to predispose them to the same. Sarah Barakat

et al. expand upon this, noting that individuals with a parent who experienced ED/DE were over twice as likely to develop their own as compared to individuals without[6]. Furthermore, these patterns appeared to affect AFAB people, thus contributing to greater disparity among ED/DE survivors in terms of gender.

In the realm of the LGBTQIA+ community specifically, it is sensical that these influences may cross over. However, it is critical that biologic factors affecting ED/DE development and other traumas be considered. For instance, trauma (from childhood in particular) may stimulate the formation of genetic polymorphisms that further relate to disease formation through mechanisms such as poor neurotransmitter production and reuptake regulation[6]. Given the social discrimination and negative effects of such among the LGBTQ+ community, it is sensical that this factor may be emphasized in the biologic etiology of EDs/DE among this demographic. Other impacts, such as family dynamics, may contribute to the exacerbation of biologic impacts on ED/DE etiology. Many LGBTQ+ individuals may not have a supportive family, the effects of which may be severe and may further attribute to trauma and trauma-related dynamics. The primary drawback to these influences is that they are not readily able to be inventoried. Genetic influences manifest generations away from when trauma may first appear, so they might not be timely enough to be relevant in this case. Though much of the data on (presumably) cisgender, heterosexual individuals in relation to this variable is ambiguous and requires further exploration, it is reasonable to say that these dynamics are magnified among the LGBTQ+ community and their families, especially given psychosocial influence.

Psycho

Closely related to biologic factors are psychologic, characterized by internal mental processes and care institutions related to such. Many of these factors are noted to be aggravated within queer and trans contexts and tend to be more complex than biologic factors in that they are more individualized—though patterns may be observed, they may not be quite as generalizable as some biological symptoms such as genetic influence. In other words, these patterns are more population-specific rather than extrapolatable to communities as a whole. For instance, there are many similarities among increased occurrence of EDs/DE and related disorders within the transgender community, meaning that compared to non-trans populations, trans people can experience more shared causes or upholders among their own cases of ED/DE and illnesses related to it such as anxiety or depression. Chung substantiates this statement, noting, "…there may be similarities across ex manifestations, comorbid disorders, and higher prevalence of DE behaviors in trans populations compared to cis populations…Further, the intersections between body dissatisfaction and gender dysphoria may put trans individuals at increased risk[2]." There are a variety of reasons why this may be so for trans individuals in particular. Most notably is dysphoria and trans congruence versus incongruence: the similarity a trans or gender non-conforming individual may possess between their external presentation pre-transition and their true internal gender. This is characterized by an inverse relationship wherein the greater one's trans congruence, the greater their satisfaction with their body and, potentially, lower their risk of EDs/DE.

However, it is important to consider the interplay of trauma and privilege in the construction of psychological entities, especially those that one might consider to be a practical, even revolutionary mechanism of recovery. A primary example of this in a recovery context is intuitive eating (IE): a concept adopted in 1995 by Evelyn Tribole and Elyse Resch that is

formed around the idea of honoring one's body and its food-related cues over external influences such as social expectations[7]. While this approach might be conceived as accessible, it may not cater to everyone the way it may seem. It largely assumes everyone has the ability to feel safe in their bodies—for many LGBTQ+ folk, this is not the case due to varying lenses of discrimination. As explicated by Maxie Castle and Lucy Aphramor, "the "trust body signals" stance of IE assumes a safe world, a safely inhabitable body, sanity, and privilege…but our "intuitive" body signals are not innate or pure or neutral; they are learnt, shaped, and contoured over time, including by our experiences of harm, violence, and oppression[8]." As noted, a central factor that may shape queer and trans experiences, in healthcare in particular, is trauma. Trauma informs trust (albeit negatively), therefore, if one's experiences are so shaped by trauma, it is sensical that bodily mistrust is also rampant among this demographic. Why would a prescription based off trust be reasonable? Furthermore, IE like so many other therapeutic interventions tends to base itself off binary thinking, antithetical to queer and trans existence and experience. Castle and Aphramor also note that LGBTQ+ individuals are often "…dissuaded from noticing and honouring body signals so much of the time that it can feel confusing, if not hypocritical, for IE to insist [trust] is the pathway out of our misery[8]." The primary issue sprouting from these two approaches is that many psychological institutions—ironically enough, those catering to recovery as well—tend to assume a healthy standard characterized by ample access to care as well as motivation to pursue such. The leading theory explaining the effects of this discrimination, then, is minority stress theory[9]. Originally coined by Ilan H. Meyer in 2003, minority stress theory explains that disparities that marginalized individuals are subjected to have been constructed by hegemonic social and psychological factors and the excessive stress imparted upon these individuals in their interaction with them[10]. Compared to general stress,

which may be experienced by anyone, minority stress theory is rooted in stigma and resulting oppression[10]. It leads to two forms of acute stress: proximal stress, which is characterized by personal impressions and processing of stressors and distal stress, which occurs due to events occurring external to oneself[11]. Because it is psycho-social in nature, this theory tends to pervade deeper into systems and more deeply shape individuals' experiences. In terms of the LGBTQIA+ community accessing ED/DE recovery-promoting care, this may occur because of prejudice among medical professionals, refusal of care providers to use the right name or pronouns for patients, trans and queer patients' personal bias against healthcare institutions and the quality of care which they provide, or patients' fear of being outed to others hindering the pursuit or sustenance of care. Healing and recovery are not able to be generalized, yet the institutions constructed around the two often fall victim to it and therefore provide flawed impressions of not just recovery, but the illnesses for which recovery is needed. Herein lies the factor impeding psychological advancements in the etiology of EDs/DE among the LGBTQ+ community: privileged care models that uphold biased perceptions of ED/DE, therefore inhibiting proper representation and equitable care.

Social

The social etiology of EDs/DE among the LGBTQ+ community is comprised of individuals, their surrounding environments, and their interactions with others within them and thereby may be understood best as a marriage between biologic and psychologic factors. Social factors also tend to be the most diverse and influential upon ED/DE etiology, in particular among marginalized populations such as the LGBTQ+ community. A primary example of this sort of factor is the rigidity of food and nutritional contexts within society alongside the heteronormative healthcare institutions upholding this form of education. Institutions such as

these are constructed off binary themes: male or female, healthy or sick, patient or doctor. There is little room left to explore ideas of transition, in particular with regard to gender and sexuality—again, this is antithetical to queer and trans existence. Thus, there is even less room to introduce these ideas to interactions, be they within the scope of healthcare or outside of it. With this lack of representation, there is a stark neglect of queer and trans bodies alongside their health and pursuits of such. This is dire in the context of EDs/DE. Experiences of rejection are negative for anyone, however, in queer and trans contexts—confounded by prejudice—they can be exacerbated towards detriment. There is an inverse relationship between rejection and body appreciation and satisfaction, thereby establishing this subjugation and the web of influence attached to it as core facets in ED/DE etiology[2]. With them, the schism between the current and ideal is widened, further enforcing binaries and other manifestations of cis-heteronormative thought, thus establishing a more hostile social environment for not only LGBTQ+ individuals and systems, but also their improvement and motion towards health. Yet, this may also serve as a means of survival.

The etiology and symptomology of EDs/DE are exacerbated by assimilation, an instance of which is quoted by Castle and Aphramor. As noted from a student's perspective, "…this view of health became embodied in a mandatory "health" performance--an externalization of health that replicated the appearance of "health" but did not serve us or our wellbeing as people[8]." As a result of this, one staunch impression of health is presented, and as mentioned, one-size-fits-all approaches do not work and can even make different people and groups sicker—perhaps obliviously so. If a certain display of health is framed as the pinnacle, practitioners and patients alike assign completely to it that all others may simply fall under its scope. Thus, assimilation: the negation of one's personal health behaviors, structures, and beliefs to the edification of

privileged systems with limited access and efficacy. Another instance of assimilation pertains to the management of oneself and policing of queer and trans bodies. Chung notes that the use of DE might be enacted in order to limit one's external appearance, especially in regard to secondary sex characteristics and outward manifestations of one's sex, congruent with gender or not[2]. This may be for several reasons: dysphoria, sociocultural expectations, or other attempts at control. Regardless, it is evident that assimilation is rampant in both doctrine and practice of healthcare, as well as in both professionals and recipients of care. Despite this, it is possible that assimilation is a protective mechanism against the very systems it upholds. Experiences of ED/DE are transdisciplinary, holding relationship with a multitude of life events and institutions: family, self-worth, and social standing being a few. LGBTQ+ experiences are the same. Yet another common denominator between the two is cis-heteronormativity, further upholding oppressive structures and the privilege upon which they have been founded. It is sensical, then, that characteristics of either may be set apart by hiding either oneself or behaviors they may exhibit. This reduction enables individuals, especially LGBTQ+ individuals with ED/DE, to evade stigma and maintain senses of privilege and connection in two fields characterized by suffering or other lack thereof these qualities.

Thus, systems characterized by oppression, their effects, and subjugation of queer and trans individuals to such tend to increase the prevalence of EDs/DE through unrealistic expectations, lack of access to food and/or quality nutrition education, or coping. Again, a central psycho-social factor connecting these influences is minority stress theory: a set of negative health outcomes as a result of identity-based discrimination that may manifest through three main ways: external events, anticipation of events, and internalization of external beliefs and attitudes[2]. Recall that negative experiences are faced by and hinder anyone, however,

marginalized identities may be influenced by them on a deeper, more detrimental level. For example, body dissatisfaction may be present in anyone, especially those under ED/DE patienthood, yet LGBTQ+-specific elements such as dysphoria may exacerbate harm done to individuals within this context[1]. Other documented examples include weight stigma and gender roles, either of which may deepen harmful experiences for those who have faced it in society and healthcare[1]. Disproportionate levels of bigotry may then introduce disproportionate rates of illness.

There are a variety of social risk factors attributing to a LGBTQ+ person's ED/DE experience, ranging from family history and habits to general beliefs, culture, values. In short, similar to the psychological etiology, the social etiology of ED/DE among the LGBTQ+ community is context-dependent and not generalizable. This being said, a collection of individual narratives and their relation to collective recovery can help to construct the most holistic, effective treatment set of protocols possible for the greatest amount of survivors possible.

Cultural

Last, culture plays a massive role in the development of EDs/DE and appears unique within queer contexts. For instance, cultural categories and associated stereotypes may lead to the manipulation of one's body to fit in and maintain status, especially if these categories are characterized by certain eating practices. One example of this mentioned in literature is bears: a gay subculture marked by broad figures and supple tummies alongside abundant eating practices. Ramiro Fernandez Unsain et al. recall attending a barbecue hosted for bears and note the dietary habits of the bears at that event. Though practices of over-eating are correlated with negative

long-term health outcomes such as cardiovascular disease or type 2 diabetes mellitus, the sample involved in this inventory noted them as a collective sort of belonging and unique facet of their culture[12]. Participants interviewed at this event discuss that, while they could change their patterns and improve their health practices, they also feared exclusion from their niche and loss of characteristics associated with it. The main characteristic participants were anxious about losing was domineering, hegemonic masculinity; this particularly behooved these individuals within the context of a patriarchal, homo- and transphobic society. Cultural practices may be, in short, a means of advantage. Absence of such, as elaborated by Adam W. J. Davies, can propagate bodily shame within these populations[13]. It is a rock and a hard place, a purgatory between two forms of marginalization: personal gender and sexuality and the societal arena for such, including the ideas that shape it.

Regardless of one's identity, it is evident that gender, sexuality, and practices of either in a cultural context inform many experiences with ED/DE and one's body. Fergal O Baoill notes, "gender is an arena for relations of domination and subordination, struggles for hegemony, and practices of resistance…hegemonic masculinities continue to be valued in subjects whose sexuality is not necessarily hegemonic[14]." Davies expands on this by explaining, "Such emphases on hypermasculinity have remained within GBQ (gay, bisexual, and queer) men's communities in current times, impacting body image ideals and self-conceptions of GBQ men who experience immense pressures to continually tone their bodies and build muscles to attract other men. These norms produce psychosocial pressures from within GBQ men's communities to employ muscularity to attract the attention of other men and gendered power relations that constitute hierarchies of desire that subordinate GBQ men who are feminized[13]." Pressures such as these tend to be emphasized among transgender individuals—in particular with transgender

men and muscularity—and are usually driven by two main factors: gender dysphoria and cultural gender ideals[15]. However, these pressures only appear to apply to binary transgender individuals and not to non-binary people, thus creating greater disparity within this space[15].

Advocacy

Given the intricate array of factors affecting the etiology of EDs/DE within the LGBTQ+ community, it is imperative that advocacy and other liberation-based efforts be as comprehensive as possible. Creating space for as wide a span of identities and experiences as possible is critical. However, many institutions constructed for recovery—social and psychological institutions in particular—tend to be binary and ultimately exclusive, which is ironic given the purpose for which they were established. Thus, caretakers within either field ought to begin a reformation towards justice from the inside out and emphasize momentum forward, rather than remaining sedentary—in other words, complicit.

Psycho

Psychological institutions have long faced fallacies involving marginalized populations. To this day, this has yet to change. Many constructions within this institution fall victim to binary, exclusionary ways of thinking that not only provide an inaccurate, superficial impression of conditions and experiences with such, but also a flawed mechanism of treatment. A main instance of this revolves around diagnosis. Consider the DSM-5, the inventory used as the primary means of diagnosis for psychiatric disorders. It lists sundry criteria for diagnosis of mental health conditions, which would insinuate an objective approach to diagnosis that is applicable to all. Yet there may also be different degrees of subjectivity on behalf of practitioners that confound diagnosis. For instance, internalized bias against the LGBTQ+ community may

predispose a clinician to inaccurately perceive patients and their symptoms and to provide unfair, ineffective "care." Therefore, disproportionate rates of illness are further upheld, continuing to widen the chasm between illness and recovery. It is also notable that the DSM is not perfect on its own as a diagnostic means since over time, the standards within it have fluctuated. A recent occurrence of this is from 2013, when amenorrhea—absence of a menstrual period—was eliminated as a requirement for diagnosis of anorexia nervosa. Prior, the fact that individuals with anorexia may exhibit amenorrhea unrelated to their condition was denied. So, people such as those assigned male at birth (AMAB) or assigned female at birth (AFAB) that had undergone procedures or live with conditions affecting their menstrual periods were not able to be properly diagnosed. With this all in consideration, a means of advancing advocacy within a psychologic context is continuing to reform DSM standards to be more inclusive and mindful of diverse experiences. These sets of standards and their subjectivity allow for increased flexibility in this area, especially in consideration of other voices. Increased dynamicity gives way to greater inclusivity, facilitating progress towards care standards more closely aligned with better practice.

Next, research must continue to be developed and expanded to include greater consideration of access and equity. As mentioned before, research on EDs/DE is new, especially in the context of under-privileged demographics. As such, it requires further development, but more urgently, the impressions of this research need to move away from the binary and hegemonic standards and embrace greater nuance and existence of different experiences and what may impact them. This is urgent in particular because research often informs evidence-based practice and shapes care protocols. Many modern approaches to therapy have not been constructed in consideration of population-specific stressors—those of the queer and trans communities being no exception. Thus, this lack of consideration tends to lead to incongruent

care content and administration and remain ineffective towards its audience, whereas culture-specific approaches have a history of enhanced efficacy in terms of treatment[11]. Expanding research to be led by LGBTQIA+ professionals, to encompass a greater span of LGBTQIA+ identities, to recruit more diverse participants through more targeted outreach, and to explore LGBTQIA+ specific treatment methods would introduce greater equity and advocacy for this group. Queer- and trans-affirmative care would enable individuals benefitting from it to uncover how stigma relates to their disease, to challenge internalized biases that may inhibit their access to care, and develop more specific and sustainable coping skills so as to promote recovery and decrease rates of ED/DE morbidity[16].

Social

Social perspectives on ED/DE advocacy mirror those of psychological perspectives by relying on research and provision of care to advance ideas of recovery. However, rather than focusing on doctrine-based principles, social care is more based on praxis: "iteratively building theory from action and taking action informed by such theory[17]." This means that social advocacy manifests in an inherently flexible setting rather than relying on dogma accumulated by past rigid practices—if psychological institutions are administration-oriented, social institutions are application-oriented.

It is important to note that, despite the differences between psychological and social fields, the two are highly interrelated. As such, they share similar problems and potential solutions to them. A primary issue plaguing social spaces is reinforcement of a binary and false categorization of individuals based on their societal standing and identity like misgendering. Continued reinforcement of these ideas further ingrains them into social contexts and gives way

to greater degrees of oppression. Nicholas Hickens et al. note an instance of this phenomenon in a 2022 study, stating that individuals are influenced by social systems and principles that they teach, albeit in an implicit manner, thus imparting assumptions about certain groups on those involved in such systems in the same implicit way[18]. As a result, these assumptions inhibit readiness for interaction and recovery intervention, therefore posing detriment to the effectiveness of care. In order to reverse this happening and increase inclusion, advocacy, and justice, practitioners ought to assume an intersectional approach to their efforts both in and out of office so as to acknowledge the maximum array of identities and unique experiences related to them. This may be relevant in increasing understanding of transgender and gender non-conforming identities or pursuing knowledge about various cultural groups within the LGBTQ+ community and their food/nutrition-specific aspects. Most notably, professionals ought to include overlapping identities in their advocacy. Seldom do individuals assign to one given facet of their identity—even more rare are they unrelated. This overlapping feedback constructs a majority of queer experiences with self, so how much more may it relate to care that must consider them?

It would also be helpful for professionals and allies to educate themselves on resources for queer and trans individuals with EDs/DE, especially resources geared towards their unique identity and resulting circumstances. This would help to construct a more holistic model of care that may reach out of care office confines and in turn increase efficacy of recovery and decrease rates of illness through not only including a greater volume of individuals and their respective identities, but also through equipping professionals with knowledge and skills to provide equitable care pertaining to them. The most important outcome of this measure would be decreasing stigma around EDs/DE, queerness, and transness, along with decreasing stigma related to the interrelations of these topics. Especially given that this stigma may worsen ED-

related habits for LGBTQIA+ individuals, it must be demolished and replaced with an environment characterized by acknowledging, knowing, understanding, and acting.

Care

Among ED/DE survivors, it is common to be sick in community. This is seen in a variety of spaces such as treatment center cohorts, pro-ana spaces on social media, and recovery support groups. Thus, it can be inferred that healing in community would be more effective and powerful. This reflects the principle of collective liberation: if we are in greater proximity to each other and our experiences, we are more likely to understand, learn and grow from them so as to create a more holistic path of healing for all involved. Furthermore, this emphasis on community may catalyze advancements in other aspects pertaining to ED/DE by proximity. The interdisciplinary natures of sociology, psychology, and medicine may combine to promote a potent model of care that transforms existing systems to be as expansive as possible and as aligned with best practice as possible.

Bio

Biological factors have a considerable presence in the realm of ED/DE care; however, they may not always be considered to their fullest extent. According to Davies, much of the research involving this factor is still in development, which can limit the amount of evidence used to inform practice and introduce obstacles to providing equitable, inclusive, and effective care[13]. Current dietetic systems may not be sufficient to support the care that different people of different groups may need, in particular given these systems' orientation towards binaries and other queer- and trans-exclusive patterns of thinking. Instead, a critical, more intersectional take on dietetics must be introduced, centering around oppression individuals may face in their daily

lives and how that interacts with their diet patterns. In other words, it must, "[situate] how the dietetics field is implicated within structures and systems that pathologize and subjugate marginalized communities[13]." This must apply to care protocols and to programs designed to educate dietitians themselves in order to ensure greater professional preparedness and patient outcomes. In a LGBTQ+ context, this may appear through queer- and trans-specific competencies that students and professionals may train in, increased visibility of LGBTQ+ caregivers, and/or increased representation of LGBTQ+ individuals with EDs/DE.

Of course, it is worth considering administration of appropriate medical nutrition therapy to ensure physical means of recovery. However, the physical means cannot operate alone. Recovery from an ED/DE requires a complex, multidisciplinary approach that covers many domains of wellness. This ensures the most potential recovery for an individual and the ability for it to be retained and sustained.

Psycho

In psychologic contexts, LGBTQ+ inclusion in recovery may be best approached through reformation of care. There are many potential targets for psychological interventions in ED/DE care, even more so within the LGBTQ+ community. This acts as a complicating factor, exposing population-specific struggles and confounding care for the less informed. Dr. Chung elaborates on this, noting shame as a common denominator among queer and trans participants in their research. As members of the LGBTQ+ community, non-binary in particular, many of these individuals noted feelings of shame surrounding their identity as well as their condition[2]. Shame already exists in many individuals with an ED/DE, regardless of their demographic. Within this context, however, this shame often festered rather than being articulated, in turn hindering

recovery. Furthermore, ED/DE care professionals were cited as having a singular approach to care, not minding nuance related to gender, sexuality, nor presentation of identity. Even "reformed" mechanisms of care, like cognitive behavioral therapy-enhanced (CBT-E), do not seem to consider specific obstacles encountered by marginalized populations nor focus on skills to navigate situations related to them, especially in regard to eating disorders[9]. There may be many reasons for this: hegemony, lack of proper education, or lack of representation. Chung notes that the prevalence of these phenomena is not hopeless, though—rather, the effects of this prevalence serve as an excellent starting point for many recovery journeys by introducing principles of community (regarded as a catalyst for ensuring effective care among the LGBTQ+ community). In their words, "…healing comes when people are able to experience and walk through the shame with themselves and others and experience acceptance[2]." In consideration of this, care must be reformed.

There are a variety of mechanisms through which care may be reformed. First, prioritizing therapeutic practices based on self-acceptance and compassion have been noted as constructive in motivating recovery. Means such as these are interdisciplinary and direct, allowing clients to articulate their experiences and emotions and efforts surrounding them with consideration and affirmation of their identity, which is the most critical aspect of care reformation. This communication, especially when paired with open and non-judgmental communication, enables empowerment of the client and can help to diminish dynamics of shame. In terms of compassion, receipt of such from allies in particular creates a safer, more welcoming space for individuals of marginalized groups to pursue care[19]. When accompanied by proactive involvement in pro-queer/trans discourse and learning, this becomes all the more effective. So, along with introduction of compassion and acceptance, training in such disciplines

needs to be introduced alongside. Learning may occur through mandatory training for professionals, care policy alterations, and/or minority-centered, trauma-informed treatment. It is important, however, that this care remains proactive. Patients do not deserve the increased burden of educating their providers since it can maintain a hostile environment for LGBTQ+ individuals seeking care for their ED/DE. Next, alteration of pre-existing therapeutic systems can provide more accessible, better-known means of care for professionals and clients alike. Shifting protocols such as dialectical behavioral therapy or cognitive behavioral therapy may allow professionals to practice therapy they are more knowledgeable of, as well as provide patients with forms of care that may be more specific to them. It has also been noted that mental health interventions constructed for the affirmation of one's identity and development of adaptive, protective skills against instances of oppression may decrease the occurrence of comorbidities such as depression, anxiety, use of substances, or risky sexual behavior[9]. However, such interventions have not been utilized in the treatment of ED/DE, so outcomes pertaining to this illness may vary. A final effective mechanism for care reformation is the construction of new therapeutic protocols for LGBTQIA+ patients. An example mechanism constructed is Promoting Resilience to Improve Disordered Eating (PRIDE), a 14-session treatment based on cognitive behavioral therapy and affirmative therapeutic practices in the treatment of ED/DE[9]. Examples of session components are establishment of a regular eating pattern, setting a personal care agenda and incorporating home practice, and discussion of minority stress' impacts on ED/DE prevalence and symptomology, as well as inclusion of these considerations in constructing skills for recovery[9]. A variety of factors determine the efficacy of this protocol, but baseline administration demonstrates a lower dropout rate than other empirically supported ED/DE

treatment protocols[9]. Greater convenience, such as an accessible location and availability of treatment, further ensures program adherence and recovery effort[9].

In an environment as rigid as healthcare, compassion and revolution can often be neglected in favor of other more objective mechanisms of care. As a result, there can be evidence of strict roles, regulations of them, and ultimate subjugation based on these. Disrupting this pattern can disrupt systems inhibiting care to its fullest extent: transdisciplinary, queered, and revolutionary.

Social

Last, care systems exhibit heavy ties to social dynamics. Both institutions manifest similar structures and operate because of these systems' repercussions and inherent nuance. For instance, power dynamics are noted in both society and medicine, as well as inhibition of inclusion and care across levels of status—ranging from patient to provider—as a result. As noted, many prominent systems in society and medicine tend to pedestalize a given set of identity traits at the expense of others; maintaining such via incongruent care practices only widens these gaps and exacerbates the negative experiences individuals of that identity may undergo.

Another social field pertaining to advancement of care is examination of foodways: the practical processes and cultural meanings involved in food production, preparation, and provisioning[20]. In other words, foodways refer to the societal mechanisms affecting food procurement, production, and distribution, including values and beliefs relating to them. A unique factor connected to foodways is their dimensions of control: that within personal matters, cultural spaces, and social structures. Per Hoffelmeyer, a variety of bodies require a variety of

needs for each of them[20]. Foodways cater to this by demonstrating, "struggles and adaptations, oppressions and innovations, customs and cultures which characterize the way people eat. Foodways combine the pragmatic means of growing, cooking, and consuming food to examine how such practices are shaped across generations[20]." Given the relevance of food to human rights and daily life, these principles are inextricably linked to liberatory practice. Note that just because a system is present, it may not be effective. It is possible that foodways may be inherently flawed by generational patterns as shaped by sociocultural doctrine, abnormalizing various groups into assimilation and reduction. Thus, a solution in this realm is to undergo a queering of the systems under it, morphing existing ideas into practices oriented towards anti-oppression and ultimate freedom. A holistic approach may be assumed, applying to food access and freedom for such, combatting emerging foodways that may predispose LGBTQ+ individuals to increased risk of ED/DE and balancing the personal with the collective. There are as many queer and trans experiences as there are queer and trans people, so it is imperative that as broad a scope of experiences as possible is understood. This understanding therefore helps to create the most holistic, intersectional, effective set of solutions for such an urgent issue.

The most important aspect of social care, however, is community. Sickness in community begets healing in community, and shared experiences can catalyze many recoveries. Chung affirms this, stating that social influence may positively enhance one's recovery to increase visibility of identity and experience and to validate the same[2]. This influence has been suggested as uniquely prevalent among non-binary individuals, who are under- and misrepresented in care dogma. Increasing discussion among people within the same demographic may increase mention of group-specific experiences, thus establishing greater rapport, community, and collective healing. Now, community must not only include identities already present within discourse and

care settings. It is vital that other, lesser-acknowledged identities, such as Two-Spirited or aromantic/asexual, be introduced and held with the same capacity as others. Rather than being uni- or even bilateral, care communities must encompass a multilateral span of personhoods and their relation to recovery. Rigid, binary systems in clinical nutrition reenforce unilateral directions of care, in turn impacting the institutions attached to it such as research and representation. Deconstruction of these and emphasis on community are required for progress towards a greater span of anti-oppressive care. This occurrence may not proceed on its own, however. It first occurs on multiple levels: within oneself, interpersonal, and systematic. Given the potential relationship between feelings of ostracization due to one's identity and due to one's condition, a comprehensive span of visibility is imperative for reversing effects resulting from such. It must secondly be coupled with a systematic shift towards liberation via priority of patient visibility, connection, and empowerment. These three principles aim to support patients in a synergistic manner, intertwining in principle and practice, with Chung explaining that, "choice and being seen [are] often intertwined, for example making choices surrounding [patients'] gender expression, and experiencing their identities being affirmed and accepted by others[2]." This maintains itself as the primary factor in interdisciplinary care: a broad, yet integrated approach ensures greater chances of inclusion, thus mitigating a variety of efforts expressed in the LGBTQ+ community that may disrupt their own care.

Limitations

In spite of the increasing visibility surrounding the matters of ED/DE recovery and LGBTQIA+ advocacy, a slew of limitations remain. The primary issue is that existing research does not fully encompass the span of identities impacted by this matter, nor the potential span of disease. Therefore, the information contained in this thesis discusses only a fraction of the matter at hand,

such as limiting the amount of different identities represented. For instance, in reviewing the literature involved in this thesis, there was a notable absence of aromantic, asexual, and Two-Spirit identities. Research yielded one article penned by a Two-Spirit author[21], as well as one study noting asexual identities—as less than one percent of participants[15]. Further, in attempting to research other gay subcultures such as twinks or otters, there was a complete lack of available literature. This underrepresentation thus presents an obstacle for proper advocacy and care of the individuals within these groups: lack of research gives way to a lack of discourse within health-related environments especially, thus imparting ultimate harm on such groups. Another limitation pertains to the lack of biologic interventions for queer and trans ED/DE care. While yes, this field is more influenced by psychological, social, and cultural factors, the lack of representation of queerness and transness in discussing biological factors was curious. Visibility and proper representation of both identity and risk factors are critical, and future directions ought to close these gaps and facilitate recovery for the maximum amount of people possible. In establishing this, providers may consider intersectionality theory: different people encompass different identities, many of which may overlap. This also presents another limitation to this research: because many studies have not yet considered this notion in-depth, limited information on how this topic may affect intersections of identities and thereby confound cases of ED/DE within them was presented. Honoring the wonderful and immense diversity within communities such as expanding research to overlap alongside different identities (e.g. assessing both race and sexuality) or targeting outreach to be more population-specific may encourage greater representation, inclusion, and as a result, care.

Conclusion

Given the prevalence and nondiscriminatory nature of EDs/DE, greater representation in research

and healthcare is imperative. However, current research yields a multitude of discrepancies. Primarily, ED research is relatively new (and hence under-explored), hindering representation and findings as a whole. Furthermore, much of this research tends to center an inaccurate and unjust population in care, excluding many populations that tend to be affected by this issue at a disproportionate rate. EDs also tend to be unsuitable for direct research due to their acute nature and ethical concerns related to that. As a result, the impressions of EDs noted in research may not be as accurate given their removal from such a diseased state. Last, much of the literature surrounding EDs/DE focuses on ED prevention rather than symptomology and related factors. This removes the focus from the complete span of EDs/DE and compromises care practice, emphasizing certain aspects and affected populations at the expense of others. EDs must be considered in a more holistic manner, honoring each set of factors influencing their development: biological, psychological, and social from etiology to advocacy and treatment.

In terms of ED development among the LGBTQIA+ community, biological factors do not appear to have a notable role because their effects are tardy and often impacted by other exogenous factors. Psychological factors are more complex and individualized than biological, thereby posing more relevance to the matter. The complexity of these factors needs to be honored as it provides specific context to various populations. Some psychological institutions, however, encounter the shortcoming of being constructed by privilege, which renders them inaccessible to many. A leading theory discussing the intersection of oppression with mental health etiology (EDs included) is minority stress theory: disparities encountered by marginalized populations are due to hegemonic social standards and institutions and the stress they impart on these individuals. This reflects in the social etiology of EDs/DE since many social determinants of ED patienthood are based off heteronormative and binary standards imparted in environments such

as education and healthcare. These standards therefore leave little room for queerness and transness and representation of such.

An irony noted in the assessment of sociological influences on ED/DE is that, while standards such as these may be oppressive, they may also provide a sense of safety towards those impacted by them via assimilation. Policing of queer and trans bodies is wrong. Yet it also explains how EDs may be developed among LGBTQIA+ individuals: if one may hide themselves through behaviors, they bay be rendered safe from this policing as a queer/trans person. Last, a factor more specifically impacting LGBTQIA+ people is culture and factors within that. Queer and trans culture is heavily marked by subcultures, like bears and twinks, that can be further set apart by certain eating practices and ideas related to them, even if they may be characterized by unhealthy patterns. This presents a "rock and a hard place" between health promotion or subjugation within these cultural spaces.

Advocacy for LGBTQIA+ individuals within recovery spaces is critical, too. Psychological institutions have historically been impacted by fallacies regarding marginalized groups such as binary constructions and flawed impressions of symptomology due to such. To overcome this and introduce greater inclusivity and progress, reformation of diagnostic standards and increased dynamicity within recovery spaces is required. Research must continue to be expanded and aligned with principles of equity and access, away from binary standards perpetuating hegemony and, therefore, exclusion. Rather, the inherent nuances of recovery and queerness and transness need to be welcomed and embraced, as this can welcome the complete span of ED/DE experiences, especially in LGBTQIA+ contexts, and advance care for such as a result. This may occur by including efforts to be spearheaded by LGBTQIA+ individuals as possible, to target

outreach and recruitment for research, and establish methods of treatment specific to LGBTQIA+ populations.

Strongly related to advocacy in psychological spaces is that within sociological spaces. Because of this interrelation, these two institutions face similar issues such as reinforcement of binary ways of thought leading to false categorization of individuals and the issues they encounter in healthcare or repetition of flawed ideals hence ingraining them more deeply into practice, either of which exacerbate discrimination. The most direct means of remediating this is to adopt an approach based off intersectionality and acknowledge the wide array of individuals affected by these issues. This may be established through educating professionals on LGBTQIA+ history, issues, and resources, as well as actively working to dismantle the discrimination upheld by the issues within these spaces and decrease stigma associated with queerness, transness, and surviving an ED or DE. There is no room for rigidity in spaces meant to be queered—one cannot be afraid of embracing change, especially if this change is for the better.

A most effective means of reforming ED/DE care for LGTQIA+ individuals is to assume a critical lens and be open to critique of various fields, in particular if they are upheld by privileged ways of thinking and resulting actions. For instance, critical dietetics centers itself around oppression encountered by various individuals and how that may interact with their patterns of eating and nutrition. This idea may reflect into other fields of recovery such as clinical counselling: denying singular approaches to care, considering queer- and trans-specific barriers to recovery, and introducing alternative therapeutic protocols, especially for LGBTQIA+ experiences. More important, this idea of criticality must also reach their practitioners so that they may be properly equipped and ensure the best patient outcomes. Criticality may also reach

foodways, especially in their relation to control: an idea prevalent in the development and maintenance of EDs as well as sociocultural constructions related to EDs and personal identity.

Both within and outside of clinical settings, one principle remains the most important to consider in expanding advocacy and care: community. Often, individuals with EDs are sick in community, sharing "tips" in pro-ED communities on social media or working through the throes of recovery in inpatient cohorts. As such, sickness in community begets healing in community. Shared experiences in illness can provide patients with feelings of visibility and assuage feelings of loneliness or depression which may exacerbate ED symptoms. Would this sharing of experiences not do the same on the path to recovery?

In expanding ED/DE care and representation for LGBTQIA+ individuals, it is imperative that queer and trans trauma is not the primary focus. To capitalize on this single aspect of LGBTQIA+ life is an injustice. It does not provide a holistic, accurate depiction of queer and trans experience—the full span of which must be honored. While oppression and trauma must be discussed, yes, queer and trans culture, joy, and freedom must be at the forefront. If we are aiming for complete liberation, complete expression must be in the picture. This may be encouraged through inviting equity into queered recovery spaces, providing LGBTQIA+ clients with what they need such as personalized approaches to recovery (consider PRIDE), enhanced patient-professional relationship that continues to put the patient's full personhood first, and creating a designated "safe space" within one's care environment. This may also be introduced by remaining flexible and understanding that even the most prevalent theories may be flawed. Theories will remain imperfect and a transdisciplinary approach must remain a priority. An instance of this pertains to minority stress theory, again often understood as the leading factor in disproportionate rates of ED/DE among LGBTQIA+ individuals. David M Frost substantiates

this claim, noting that while the original model for this theory included talk of coping skills and positive health outcomes at a variety of levels, it has evolved to resemble a more negative, "downer" view of queer and trans health practices, outcomes, and resilience given these[10]. As just noted, this provides an inaccurate view of LGBTQIA+ folk, their culture, and best practice, thereby impeding their care. Furthermore, Lisa M Diamond and Jenna Alley suggest that minority stress may not be the best reasoning behind this theory, but lack of social safety due to inequalities relating to gender, sexuality, and health[22]. Social safety determines much of one's wellbeing, for if one does not feel safe, they will not have room for growth, development, nor actualization. Further, this idea of safety is often compromised by stigma—only a portion of the original rationale for minority stress theory.

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