Body Image, Eating Disorders, and LGBTQIA+ Identities: Supporting Youth, Older Adults, and Non-binary People

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NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER

INTRODUCTION

Eating disorders have steadily increased in the U.S. population, especially since the onset of the COVID-19 pandemic.[1] Although once considered a problem for white wealthy girls and women, eating disorders and related body-image disturbances are now known to reach across all races/ethnicities, socio-economic levels, and gender identities.[2] Research suggests that lesbian, gay, bisexual, and transgender people have a high prevalence of eating disorders and negative body image that may require culturally responsive approaches to screening and counseling.[3,4] This clinical publication provides information and strategies for improving the capacity of health centers to screen, assess, and address issues related to eating disorders and body image among lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexually and gender diverse (LGBTQIA+) people, with special considerations for LGBTQIA+ youth, older adults, and non-binary people.

Terms related to body image and eating disorders	
Eating disorders	Disturbances in eating behaviors, thoughts, and emotions related to food, body weight, and shape. Common eating disorders include: • *Anorexia nervosa:* severely restricting or avoiding food to lose/control weight; intense fear of gaining weight despite low body weight • *Atypical anorexia* describes people with symptoms of anorexia but who do not have low body weight • *Binge eating disorder:* out of control eating; eating past the feeling of fullness; and feelings of guilt and shame related to overeating • *Bulimia nervosa:* episodes of binge eating and of vomiting, laxatives, or other compensatory behaviors to lose or control weight
Disordered eating	Unusual or irregular eating behaviors that may or may not rise to the level of a clinical eating disorder diagnosis.
Body image	Beliefs, perceptions, and feelings about one's own body and appearance, including height, shape, and weight.
Body-image disturbance	Negative perception of, and feelings toward, one's body
Body dysmorphia/ Body dysmorphic disorder	• Intense preoccupation and clinically significant distress associated with a perceived flaw in appearance that is invisible or minor to others • People with body dysmorphic disorder may avoid social interactions and pursue multiple cosmetic procedures

Sexual orientation	How people describe their emotional and physical attraction to others
Gender identity	A person's inner sense of being a girl/woman/female, boy/man/male, another gender, or having no gender
Sex assigned at birth	The sex assigned to an infant
Transgender	People whose gender identity does not align with their sex assigned at birth based on society's expectations.
Cisgender	People whose gender identity aligns with their sex assigned at birth based on society's expectations
Non-binary	People who identify as non-binary, including: • People whose gender identity is neither girl/woman/female nor boy/man/male • People whose gender identity is both girl/woman/female and boy/man/male • People whose gender identity changes over time • People who do not identify with a gender
Gender diverse	An umbrella term for all people whose gender identity is beyond the binary of girl/woman/female and boy/man/male, including non-binary people, people with a mix of gender identities, a fluid gender identity, or no gender identity
Gender dysphoria	Strong feelings of distress or discomfort caused by the misalignment of gender identity and sex assigned at birth. Not all transgender and gender diverse people experience gender dysphoria.

Distinguishing body dysmorphic disorder from gender dysphoria

Patients may experience a mix of symptoms related to gender dysphoria, eating disorders, and/or body dysmorphic disorder. It is therefore important for clinicians to discern which behaviors and feelings are attached to each issue, and to treat them accordingly:

- People with body dysmorphic disorder feel distress about perceived flaw/s in appearance related to the face, skin, hair, body shape, or other parts of the body. They often seek cosmetic surgery to "improve" the perceived flaw.
- People with gender dysphoria feel distress about sex characteristics (genitals, chest) or body shape, but the distress stems from the body's misalignment with their gender identity, not from body dysmorphic disorder. An intense desire to change body parts to affirm one's gender identity is different than a strong desire to fix a "flawed" body part.

- After receiving gender-affirming medical interventions, most people with gender dysphoria experience relief from their dysphoria—and may even describe their feelings as euphoric. People with body dysmorphic disorder, however, are unlikely to experience such feelings after medical interventions.

PREVALENCE OF EATING DISORDERS

While most LGBTQIA+ people never develop an eating disorder, LGBTQIA+ people on average are more likely to have an eating disorder compared to straight/heterosexual and cisgender people.[3-5] As shown in **Table 1**, the lifetime prevalence of common eating disorder diagnoses is highest among transgender people, and next highest among LGB cisgender people.

The percentages shown in **Table 1** very likely underestimate the actual prevalence of eating disorders, since many people who engage in disordered eating never receive a diagnosis. For example, in a large sample of U.S. college students of all sexual orientations and gender identities, nearly 27% of college students endorsed symptoms of a current eating disorder, while only 3.6% reported a lifetime diagnosis.[6]

Table 1. Lifetime prevalence estimates of eating disorder diagnoses by sexual orientation and gender identity[3-5]

	Transgender men	Transgender women	LGB cisgender	Straight cisgender
Anorexia nervosa	4.2%	4.1%	1.7%	0.8%
Bulimia nervosa	3.2%	2.9%	1.3%	0.2%
Binge eating disorder	n/a	n/a	2.2%	0.8%

LGB = Lesbian, gay, or bisexual

Studies point to several factors that may increase LGBTQIA+ people's vulnerability to developing eating disorders and body-image disturbances, as described below.

Societal stigma and cultural norms

- Discrimination and stigma based on gender identity, gender expression, and sexual orientation create stressors and trauma for LGBTQIA+ people. These stressors can produce depression, anxiety, and post-traumatic stress disorder, which are associated with eating disorders.[7-9]
- LGBTQIA+ youth experience a high volume of bullying and harassment;[10] bullying contributes to negative body image and eating disorders.[11]
- LGBTQIA+ people may engage in binge eating as a maladaptive way of coping with social isolation, suppression of sexual identity, and internalized homophobia.[9,12]
- Some gay and bisexual men may have negative body image due to rigid standards

of appearance in their community.[9] A strong cultural norm of muscularity may have started as a way to defy stereotypes of gay men as weak or "feminine," or as ill from HIV/AIDS.[13]

Gender dysphoria

- Transgender and gender diverse (TGD) youth may engage in disordered eating in order to prevent puberty or to attain a body shape more associated with their gender identity. For example, a TGD person assigned female sex at birth may restrict eating to prevent breast growth and menses.[14]
- Some TGD people may overeat or restrict eating to attain a more traditionally masculine, feminine, or androgynous body shape (e.g., *"I'll limit eating until I have no curves"*).

PROMISING PRACTICES

Screening, assessment, and treatment for LGBTQIA+ people require using the best available evidence-informed tools and techniques for patients of all sexual orientations and gender identities, while also attending to the unique stressors and sociocultural factors specific to LGBTQIA+ patients.

Screening

Given the increased risk and prevalence of eating disorders among LGBTQIA+ people, experts recommend that providers pay increased attention to the possibility of eating disorders among this population.[9,15-17] As a first line of screening, providers can assess for unexpected or large changes in body mass index (BMI). BMI screening is a required Uniform Data System (UDS) reporting element for HRSA-funded health centers (see the UDS Reporting Requirements Manual) and a quality-of-care measure. The American Academy of Pediatrics Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity (2023) provides helpful recommendations on BMI screening for youth. Clinicians should assess for both losses *and* gains in BMI, keeping in mind that gains in BMI may be associated with binge eating disorder, while losses in BMI may be associated with anorexia.[6,18] Additionally, providers should know other signs and symptoms of eating disorders, including pubertal delay, bradycardia (slow heart rate), oligomenorrhea (infrequent menstruation), and amenorrhea (absence of menstruation).

Providers can ask about eating patterns and body image using standardized tools or open-ended questions (see **Table 2**). Note that screening assessments have not been validated in TGD populations.[15] A non-judgmental discussion should follow the screening questions. Patients with a possible eating disorder should be referred to a specialist for further evaluation. For detailed screening and assessment recommendations, see **Table 3**.

Table 2. Eating disorders screening tools and questions

Standardized screening tools

- EDS-PC: Eating Disorder Screen for Primary Care
- Screen for Disordered Eating
- SCOFF Questionnaire
- EDQOL Eating Disorder Quality of Life
- BSQ 34: BSQ 34 Body Shape Questionnaire
- BED7: Binge Eating Disorder 7 Question Assessment
- EDE Q: Eating Disorder Examination Questionnaire

Open-ended questions to assess for possible eating disorders

- How often do you eat and what foods do you like to eat?
- How do you feel about your body?
- Do you ever work out or count calories to change your body?
- Have you ever been and are you currently on a diet?
- Do you like your body?
- If you could change something about your body, what would it be?

- Have you done anything in the past 6 months to change your weight?[19]
- What do you think you ought to weigh?
- How much do you exercise?
- How do you feel if you miss a workout?
- What is your self-image (thin or fat)?
- Are there any particular areas of your body that bother you?

Table 3. Eating disorder screening, evaluation, and treatment recommendations from professional organizations

- ***US Preventive Services Task Force*** recommendation statement on screening for eating disorders in adolescents and adults[17]
- ***American Academy of Pediatrics*** recommendations for identifying and managing eating disorders among preteens and adolescents 10 years or older[18]
- ***American College of Obstetricians and Gynecologists' Committee on Adolescent Health Care:*** Gynecologic care for adolescents and young women with eating disorders[20]

Weighing patients with eating disorders

It is important to tread carefully when weighing patients and discussing weight with patients who have, or may be at risk of having, an eating disorder. Hearing one's weight can cause stress and anxiety for patients with eating disorders.[21] Providers may ask patients if they prefer receiving a "blind" weighing, where the patient steps on the scale backwards so they cannot see the number on the scale. For these patients, clinicians can also refrain from discussing specific weight measures or BMI scores with patients.

Stigma-free counseling for nutrition and exercise

When delivering information on BMI, nutrition, and physical activity, it is critical to use neutral, non-stigmatizing language that does not inadvertently lead to the onset or worsening of eating disorders. Weight stigma is a form of stereotyping and discriminating against people who are overweight and obese. In the U.S., socio-cultural norms celebrate thin people and dieting while blaming overweight and obese people for failing to control their weight. Studies suggest that weight bias can become internalized and cause psychosocial harm.[22,23] Perceptions that healthcare providers are biased against overweight people is common and can lower overall engagement in care.[24]

To prevent bias, providers can consider using the following strategies:

- **Check yourself for implicit biases.** For example, do you unconsciously associate obesity with idleness? How can you counter this bias and develop more empathy? Can you think of an obese person whose hard work you admire? Have you ever gained weight because of external stressors that you could not control?
- **Acknowledge and understand intersecting stigmas.** For example, lesbian women and TGD people have a disproportionate prevalence of being overweight and obese; therefore, they must contend with intersecting stigmas related to their weight, sexual orientation, and gender identity. The compounding of stigma-related stressors is hazardous to one's health.
- **Recognize, ask about, and address social determinants that contribute to weight gain.** For example, many people have sedentary jobs and live in areas with minimal access to healthy foods or safe spaces for walking and exercise. Processed and fast food are the least expensive and most filling food available, but are unhealthy and addictive. Health centers can advocate for community improvements, such as walking paths and bike exchanges. Health centers can also develop relationships with farmer's markets and food pantries.
- **Use size-neutral language and frameworks.** A body neutrality framework promotes how our bodies serve us rather than how they look. Body neutral language uses nonjudgmental terms like "big and small" instead of "fat and skinny," and does not refer to food or bodies as "good" or "bad".
- **Use person-first language**, such as "a patient with obesity" or "a patient affected by obesity" rather than "an obese person"; or, "the patient weighs more than what is considered healthy for their height".
- **Emphasize behaviors that are modifiable and apply to people of all sizes**, such as getting enough sleep, choosing whole foods over processed foods, and moving as much as possible. Refrain from talking about diet, calories, and weight loss.

- **Provide information about *joyful movement***, which is finding movement/exercise that is fun and feels good for the body, and is not focused on calorie burning or changing the body.
- **Use a light tone.** Consider ways to engage patients in a conversation about eating and exercise that is less stressful for them. Ask questions such as: *Does movement feel joyful to you? How do you find joy and support in your life?*

Referrals and treatment for TGD people

- When making referrals to eating disorder specialists, look for programs that are as inclusive of TGD people as possible.
- Eating disorder treatment often focuses on helping patients accept their bodies. This approach, however, has negative implications for TGD people with gender dysphoria. Asking patients to accept characteristics that are causing gender dysphoria can harm rather than help them. Instead, eating disorder specialists can collaborate with gender-affirming medical providers to discuss approaches that reduce dysphoria. These approaches may be non-medical, such as binding the chest, or medical, such as puberty blockers or gender-affirming hormone therapy.
- Target weight ranges for eating disorder recovery are based on binary sex (female or male); therefore, clinicians may need to adjust target ranges for TGD patients on gender-affirming hormone therapy.[25]
- No research or official guidance exists on providing gender-affirming hormones to TGD people with eating disorders. Research indicates, however, that by helping patients achieve a body more aligned with their gender identity, gender-affirming hormone therapy may help people recover from an eating disorder.[25]
- TGD patients with eating disorders who take gender-affirming hormone therapy may need additional medical monitoring related to bone density and metabolic syndrome.[25]

CONSIDERATIONS FOR LGBTQIA+ YOUTH

Eating disorders and body-image disturbances often first emerge between the ages of 10 to 24 years. LGBTQIA+ youth may present to their primary care providers with signs and symptoms of an eating disorder, as well as other mental health challenges, including anxiety, depression, and suicidal ideation. Early intervention to treat eating disorders is key to preventing long-term adverse effects on growth, bone density, and reproductive function.[26,27] Family-based treatment methods have the strongest evidence of efficacy for anorexia and bulimia in youth.[28] For LGBTQIA+ youth, tensions within the family about gender identity or sexual orientation may make family-based treatment more challenging. It is therefore important for clinicians to model affirmative communication and care for family members, and to make referrals to LGBTQIA+ welcoming eating disorder specialists and programs. For families of TGD youth specifically, explain that the more affirming we are of their child's gender identity, names, pronouns, and gender expression, the more body satisfaction and overall wellness the youth will experience.

Tips and strategies for LGBTQIA+ youth

- Ask the patient about social media consumption. Social media engagement , especially photo-based (e.g., "selfies") activities, are associated with lower body satisfaction and eating disorders.[29,30] Discuss reducing the patient's time spent on social media, particularly activities that encourage comparison and rating of appearance with peers.
- Ask about engagement in pro-eating disorder online content, and strongly discourage accessing these sites.[30]
- Provide referrals to facilitated social support groups for LGBTQIA+ youth and their parents.
- To help meet the needs of LGBTQIA+ youth, invite them to join a youth community board that actively engages them in developing programs and organizational change; hold focus groups; and create partnerships with local organizations that serve this population.

CONSIDERATIONS FOR LGBTQIA+ OLDER ADULTS

Eating disorders and related body image concerns have not been studied among LGBTQIA+ older adults; nonetheless, older adults (age 65 and older) may present with eating disorders, and especially binge eating disorder.[31] Below are special considerations when engaging in discussions with LGBTQIA+ older adults about nutrition, weight, body-image disturbance, and eating disorders.

- Born before the LGBTQIA+ rights movement, older LGBTQIA+ adults have lived through long periods of stigma and discrimination related to their sexual orientation and gender identity. As a result, LGBTQIA+ older adults experience disproportionate isolation, loneliness, and depression,[32,33] all of which are associated with eating disorders.[34,35]
- LGBTQIA+ older adults may experience bias and discrimination from home care and nursing staff.[36]
- Older lesbian and bisexual women lived through (and may have been involved with) the women's rights movement of the 1960s to 70s, which fought against societal "policing" of women's bodies. Having this background may protect these women from body image disturbances, and may also keep them from following a provider's recommendation to lose weight.
- People with HIV, which includes a disproportionate number of gay and bisexual men over 50 years, may have HIV-related lipodystrophy, a condition that increases abdominal fat and can lead to body dissatisfaction.[37]

Tips and strategies for older adults

- When counseling about nutrition and movement, keep in mind that elderly adults often have limited choices in what they eat due to living arrangements (e.g., long-term care facilities) or meal delivery services.
- Older adults may need support to fully access resources and literature specific to nutrition, exercise, and eating disorders. For example, consider having all reading materials in printed form with larger fonts, rather than only having online-only materials. If using digital activities or forms, use closed captioning, ensure the

information is compliant with the Americans with Disabilities Act and offer hands-on assistance to completing activities.

- Offer educational resources designed specifically for older adults and LGBTQIA+ older adults. Some examples are:
    - Moving Your Way
    - National Institute on Aging's physical activity articles
    - National Resource Center on LGBTQ+ Aging
- Ask patients what name they would like you to use. Although some older patients may prefer to be addressed as Mrs. or Mr. [surname], these terms assume gender identity and marital status. It is best practice to ask all patients, regardless of age, what name and honorifics they would like you to use when addressing them.
- Create spaces that accommodate patients with limited mobility (e.g., designate chairs closer to the exam rooms for older and disabled people) and patients with larger bodies (e.g., offer chairs without arms).
- To ensure you are meeting the needs of your older LGBTQIA+ patients, invite them to join the governing board or community board, hold focus groups, and create partnerships with local organizations that serve these population. Actively engage community members in developing programs and organizational change.
- Learn about the providers and organizations in the community that are LGBTQIA+ affirming in order to make referrals. A good place to look for these resources is on the SAGE Advocacy and Services for LGBTQ+ Elders website.
- Advocate for age and LGBTQIA+ diversity in referrals for exercise programs, nutrition programs, behavioral health, and housing assistance.

CONSIDERATIONS FOR NON-BINARY PEOPLE

Being non-binary is a very personal experience that can differ significantly for each individual. Below we answer some frequently asked questions about non-binary people.

Q: What pronouns do non-binary people have?
A: A non-binary person may or may not use gender-inclusive pronouns, such as the singular "they/them/theirs"; some use "he" or "she" or "any pronouns", and some use new pronouns, such as "ze/zir". It is a best practice to ask everyone what pronouns they would like you to use.

Q: Are non-binary people considered transgender?
A: While non-binary is sometimes recognized as being under the transgender umbrella, not all non-binary people think of themselves as transgender.

Q: Is being non-binary the same as being intersex?
A: Non-binary and intersex are not the same. Intersex traits (often referred to in the medical literature as differences of sex development) refer to a wide range of natural variation in sex characteristics and development that falls outside traditional conceptions of female or male bodies. While some people with intersex traits identify themselves as intersex, and some as non-binary, many others may identify as female, male, transgender, or other gender identities.

Q: Do non-binary people undergo gender-affirming medical interventions?
A: Some non-binary people seek gender-affirming medical interventions (e.g., hormone therapy or surgeries) to align their bodies with their gender identity and to alleviate gender dysphoria. Many non-binary people, however, do not undergo any gender-affirming medical interventions.

Q: Do all non-binary people look androgynous?
A: No, not all non-binary people look androgynous, or want to look androgynous (i.e., appearing neither exclusively female nor male). Non-binary people have a wide variety of gender expressions, including those considered more "feminine" or "masculine".

Barriers to healthy outcomes for non-binary people

Non-binary people face unique and complex issues in relation to body image. Why is this?

- The dominant culture in the United States views gender as binary (either female or male). Non-binary people can therefore feel pressured to look either female or male to avoid rejection, discrimination, and violence.
- Communities that accept non-binary identities may still make assumptions about how a non-binary person should look. The media tends to portray non-binary people as thin, white, and androgynous. These images leave out people of color as well as people with larger bodies and curves.
- Non-binary people may mistrust and avoid medical care for a range of reasons:
    - Experiences of being misgendered or misunderstood by healthcare providers
    - Lack of knowledge among providers regarding gender diverse identities
    - Providers who assume that all people who seek gender-affirming hormones or surgeries desire a binary gender expression

Supporting the body image and mental well-being of non-binary people

Health centers can create clinical environments where non-binary people are welcomed and respected. Below are strategies to achieve a more gender inclusive environment where non-binary people are supported:

- Do not assume a person's gender identity. You cannot tell if someone is non-binary or transgender just by looking at them.
- Include non-binary as an option when collecting information on patient gender identity, and also allow people to write in their gender identity, name they go by, and pronouns.
- Consistently use the name and pronouns a person asks you to use.
- Understand that there is no one way to be non-binary. You do not have to understand what it means for someone to be non-binary to respect them.
- Have gender-inclusive restrooms available and create gender-inclusive bathroom policies.
- During the social history or behavioral health intake:
    - Ask who in the patient's life affirms and supports them.
    - Ask about any experiences of harassment or issues with discrimination in education or employment.
- Ask patients for consent before examining and talking about their body. As an example, you can ask, *"Do I have consent to talk to you about your body? I ask*

because it is important for your health care."

- Ask patients what terminology to use for their body parts. Non-binary, transgender, and gender diverse patients may use terms for their body parts that do not have gender connotations. Examples of gender-inclusive terms are shown in **Table 4.** Clinicians can either ask patients what words they use for different body parts, or can start using a word and then ask the patient if that word is okay. Making a note of desired terms in the patient's chart can help you and others who use the chart continue to use the language to which the patient has consented.

Table 4. Affirming language for body parts

Instead of:	Try:
Breast	Upper body or chest
Vulva	External genital area
Vagina	Internal genital area; opening of the genitals
Period	Monthly bleeding
Penis	Genitals, external genitals
Testes	External gonads
Male pattern balding	Hair loss
Normal development	Typical development
Woman/man with _____ Woman/man who as _____	Person with _____ Person who has _____
Regular, normal, correct, or natural	Common or typical
Looks normal	Looks healthy

ADDITIONAL RESOURCES

- Eating Disorders and Body Image in Gender Diverse Clients
- Body Image, Perception, and Health Beyond the Binary
- Body Image, Perception, and Health Support for Older LGBTQIA+ Adults
- Fighting Eating Disorders in Underrepresented Populations (FEDUP): A Trans+ & Intersex Collective
- National Eating Disorders Association (NEDA)
- Health at Every Size (HAES)
- ThirdwheelED
- Association for size diversity and health (ASDAH)

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