

Treating Eating Disorders in Sexual Minority Populations

by

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Dedication or Acknowledgement

This paper is dedicated to the many individuals suffering with an eating disorder. The suffering is usually in silence and this paper is to acknowledge that you are not alone. Further, those from the many and diverse minority populations were highly considered when writing this paper. You are seen and appreciated. Given the intensity and uncertainty of societal tolerance and backlash these days, this paper is dedicated to those promoting hope and inclusiveness. To those working with eating disorders, I hope there is knowledge to be gained here to help in your necessary and important work. To the family and loved one of those suffering with eating disorders, this is for you. You are critical in the fight against these complex and frustrating disorders. I would also like to acknowledge my colleagues, classmates, teachers, and loved ones. Thank you for always showing up, your encouragement, your challenges, and your guidance.

Abstract

This capstone investigates the complex and nuanced world of eating disorders and disordered eating in sexual minority populations. It delves into the lack of research into eating disorders generally, and especially in the minority community. It explores the complexities that contribute to a greater occurrence of disordered eating behaviours in sexual minorities due to intricate integrations between enacted stigma, discrimination, minority stress, societal pressure, and isolation. Gendered ideology affects many aspects of being in Western society. It is particularly harmful to those who do not fit into the firm, gender binary. This can also be impactful when there is no proper social and professional support. Gender minorities have a dual model of disordered eating reinforcement when trying to fit certain gender prescriptions, whilst also coping with isolation through food control. Medical and mental professionals need further education about the unique position sexual minorities face about proper physical, mental, and emotional care. This capstone addresses the issues and provides suggestions for professionals working with sexual minorities with preventative interventions for sexual minorities in treatment for eating disorders.

Key Terms: disordered eating, eating disorder, enacted stigma, minority stress, sexual minority

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Treating Eating Disorders in Sexual Minority Populations

Chapter 1: Introduction

There are few mental health conditions with recent academic publications and news articles citing phrases like ‘alarming increase’, ‘more severe than ever’, and ‘on the rise.’ This happens to be the case for eating disorders, particularly for children and adolescents. According to Pastore et al. (2023), “alarming data from several European countries show a remarkable increase in eating disorders of <40% in the 6- to 18-year-old populations...[and] a significant increase in eating disorders in children and adolescents has been observed recently in the US” (para. 7). Eating disorders are characterized by a significant prevalence and are linked to various psychiatric and medical comorbidities. “These conditions lead to considerable functional and psychosocial impairments, including an elevated risk of suicidality (Citrome & Grilo, 2021, p. 1, para 1). This silent but deadly disease afflicts millions of people and is the deadliest mental health illness (Canadian Eating Disorders Strategy, 2019). Those identifying in the LGBTQ2S+ (sexual minority) community are at greater risk of developing disordered eating patterns and yet, less likely to receive proper medical care and psychological support than peers in the majority population (Parker & Harriger, 2020). This group faces more stigmatization and minority stress leading to further isolation due to their disorder. Disordered eating habits are utilized to both control one’s body and to cope with stressors. In this way, the disorder can reinforce itself.

The aim of this capstone is to highlight the significance of eating disorders as a pervasive mental health issue, with a particular focus on their disproportionate impact on LGBTQ populations and the substantial financial and systemic burden they impose on our healthcare system. By understanding the scope of the issue, we as clinicians can better advocate for our clientele and be educated resources supporting a minority population that is underwhelmingly

assisted. In the first chapter, eating disorders will be discussed fully as well as the problematically, high rate of cases in sexual minority groups. Chapter one will also define common terms used throughout the paper and the significance this research has to those in the counselling profession. In the following chapter, a literature review will be summarized and flushed out in terms of the topic. Finally, chapter 3 will provide conclusions and suggestions for utilizing this information in counselling practice and examples of pragmatic ways to advocate for our minority clients.

Background to the Issue/Problem

Eating Disorder Prevalence and Statistics

Eating disorders (EDs) afflict an estimated 2.7 million Canadians and approximately 1.4 million of those are youth (National Initiative for Eating Disorders (NIED, 2016)). Eating disorders do not discriminate and torment individuals across gender, age, race, sexual orientation, or socio-economic background. These afflictions have the highest mortality rate of any mental illness, with estimates between 10-15% with suicide being the second leading cause of death for those with an ED (Canadian Eating Disorders Strategy (CEDS, 2019)). These statistics do not reflect suicide attempts, which can range from 20% - 25% of those diagnosed with an ED (CEDS, 2019). EDs are tricky and costly to treat. At an individual level, eating disorders are debilitating and cause significant suffering to the individual and their families. The complex nature of disordered eating results in too few seeking help or ever being diagnosed. According to NIED (2016), “the social and economic costs of untreated eating disorders are similar to those of depression and anxiety, with debilitating physical and mental health effects

comparable to psychosis and schizophrenia” (para. 6). Determining the actual costs of eating disorders in the population is quite difficult, to say the least, with broad ranges of undetermined numbers. For example, in 2003, the province of British Columbia estimated long-term costs to be anywhere from \$2.5 million to \$101.7 million (Stone et al., 2021). In 2018, The Canadian Institute of Health Information estimated Canada spent an average of \$24,017 per individual with an eating disorder in hospital care (2021).

The instances of EDs skyrocketed during the COVID-19 pandemic putting a strain on our healthcare system shedding a much-needed light on the poorly understood and poorly researched area of eating disorders (NIED, 2016). Stone et al. (2021) indicate that millions are being spent on treating eating disorders every year in Canada, while research invested in this area ranges from approximately \$0.08 to \$0.61 per individual. Comparatively, In Canada, other psychiatric disorders such as schizophrenia receive funding at a rate of \$47.01 per individual and bipolar sees funding at \$7.78 per individual (Stone et al., 2021). Considering the elevated risk of death associated with eating disorders and the strain on our health system, one should wonder why we are not putting more funding into understanding a preventable and treatable mental health illness.

The preventable and treatable nature of the illness should be more of a consideration in research around prevention and early detection. As it stands currently, approximately 20-30% of individuals do not respond to evidence-based treatments, leading to a persistent treatment resistant illness (Bryson et al., 2024). Anorexia nervosa has a remission rate of 25% to 33%, bulimia nervosa has a full remission rate of up to 30%, and binge eating disorder remission rate varies between 13% and 86% (Friedlich, 2023). It is well-known in the eating disorder treatment community that in some cases, clients will have a life-long disorder.

Eating Disorders Sexual Minority Populations.

Eating disorders affect all demographics but are disproportionately higher in sexual minority groups (Calzo et al., 2017). Sexual minority is an umbrella term for those who do not identify as heterosexual. This is inclusive of many sexualities such as bisexual, asexual, queer, and homosexual. Given this minority status and the discrimination they have experienced, there has been less research over the years into this population. Research has not focused on this group historically. Additionally, minority stress and discrimination have largely discouraged those identifying in sexual minority populations from volunteering for such studies. That said, it is determined that this group of individuals experiences eating disorders and disordered eating at a much higher rate than the heterosexual population (Feldman and Meyer, 2007). They have higher risk factors such as minority stress, enacted stigma, and comorbidities that lead to an increased risk of eating disorders (Cusack et al., 2022). These factors may contribute to body image concerns along with unhealthy coping mechanisms like controlling eating. Feldman & Meyer (2007) found that certain subgroups within the LGB (Lesbian, Gay, Bisexual) community are particularly vulnerable; gay and bisexual men experience heightened pressures around body image compared to heterosexual men and lesbian and bisexual women face distinct pressures different than those faced by heterosexual women. The chronic stress from discrimination and social stigma leads to an increase in mental health concerns among sexual minorities.

Barriers to Care for Sexual Minorities.

In general, there are many misconceptions about eating disorders and the illness continues to be underrecognized by health care providers (Citrome & Grilo, 2021). It is theorized that treatment providers lack education and/ or effective screening tools. Contributing to this

issue is the low rates of help-seeking by those experiencing EDs, particularly among men and minorities (Citrome & Grilo, 2021).

Gender-diverse clients face a unique struggle to find both affirming and inclusive treatment from healthcare clinicians (Ferrucci et al., 2023). Enacted stigma in the form of microaggressions or discriminatory comments leaves sexual minority patients feeling a mix of fear and anxiety when attending healthcare appointments. Further, research has shown that medical schools lack proper education in areas about queer and trans health. According to Wyton (2021), Canadian bodies about physicians "have no explicit assessment objectives mandating that graduating residents and medical trainees must show knowledge or management skills specifically related to health care for 2SLGBTQIA+ patients" (para. 10). This lack of knowledge extends to mental health. As found by Fish et al. (2024), effective LGBTQ+ affirmative mental health care is essential, yet there is a shortage of affirmative mental health care providers due to the lack of focused training.

Medical and health care in Canada is lacking inclusivity and understanding. As explained in a news story by Wyton (2021), a patient seeking treatment for depression was not given the proper medication as the side effects included a low libido and the doctor did not understand the patient identifying as asexual. In this case, low libido was not a concern for this client, their depression was. These misunderstandings or lack of interest in affirmative care for patients cause harm. The more discrimination felt, the less likely people will seek help, potentially worsening both physical and mental health issues. "Being judged, misgendered or poorly treated by health-care providers is a barrier that makes issues worse" (Wyton, 2021, p. 3).

For an alternative perspective from the medical community, Morris et al., (2022) investigated the experiences of sexual minority service users accessing mental health services for

common mental health problems (anxiety, depression) in the UK. This was a small study with twenty-six participants self-identifying as sexual minority individuals. They conducted a semi-structured audio recorded telephone interview. The researchers found there were both service user-centred barriers and practitioner centred barriers. Users noted fear of discrimination, unconscious bias, or stereotyping as reasons they did not want to disclose their sexual identity. Practitioner centred barriers were inclusive of neglecting sexual orientation all together and a lack of understanding even when the topic was discussed. Most participants, but not all, felt that an important part of their identities was neglected by not discussing sexuality.

The lack of knowledge concerns raised were regarding language, unique stressors this community faces, stereotyping, heteronormative assumptions, and pathologizing their queerness (Morris et al., 2022). The participants felt that sexual minority training and tailored support would be beneficial in addressing their needs in an accepting way.

Dearing and Hequembourg (2014), studied health care for sexual minority women and found barriers to care related to their minority stress and health care providers being poorly equipped to understand and address their unique needs. Indeed, stigma, microaggressions, and fear seem to be common barriers to receiving proper medical care. The authors similarly noted training improvements as a way to effectively support sexual minority clients. This same concerns around barriers to care such as heteronormative attitudes, homophobia, and discrimination was also raised by Rojas et al., (2024) when studying medical school curricula in Chile.

Lack of Queer Curriculums.

In Canada, there is a push from some health care professionals to formalize queer and transgender care by including mandatory training in medical schools and residencies across the

country (Wyton, 2021). Some medical professionals argue that there is a very human aspect to medical care that is not taken as seriously as the medical science knowledge being taught in medical school curriculums (2021). By not considering these human, soft skills, patients are being harmed. This concern with medical training lacking sufficient attention around the needs of the LGBTQ+ community is not limited to Canada. Rojas, Canepa, and Ortiz-Lopez (2024) did a cross-sectional mixed method study of 24 medical schools in Chile between 2020 and 2021 to characterize the teaching of curricular content related to LGBTQ+ health issues in medical schools in Chile. The authors noted health concerns this community faces such as increased risk of chronic diseases, mental health conditions, and substance abuse concerns. This seems to be more universal than just a North American phenomenon. They noted that Chilean medical schools spent around one to five hours on LGBTQ+ training. Their research also indicated similar findings in the US and Canada where roughly five hours was spent in that area and eleven hours in UK medical schools. Like Wyton's article, the researchers argue for a more holistic approach to LGBTQ+ health that is not just biomedical focused.

The research into queer care often sites a need being training programs for health care professionals tailored to the sexual minority population. There was one study that implemented a LGBTQ+ medical health services training program in order to determine feasibility and acceptability. Fish et al. (2023) implemented a virtual, organizational and therapist-focused training program to improve mental health worker's cultural competence in working with the LGBTQ+ community. The adoption of such training was mostly positive with participants indicating an intent to further training and a concern with the lack of opportunities for this kind of education.

Purpose of the Paper/Study

The purpose of this capstone is to explore the high prevalence of disordered eating in sexual minority groups and the intersecting reasons why. The goal of the research is to investigate preventative solutions to this unique population and provide mental health professionals with suggested education to assist these unique client needs in the therapy office.

Research Question

The research questions this paper will address are: What unique risk factors contribute to the development of eating disorders among sexual minority individuals? What are the perceived barriers to treatment for eating disorders among sexual minority individuals? How do therapists address identity-specific issues when treating clients with eating disorders? What therapeutic approaches and therapeutic training is best to manage eating disorders in the sexual minority population? In what ways should therapists consider systemic oppression and intersectionality when dealing with eating disorders in sexual minority populations?

Significance and Context

The lack of resources focusing on the prevention and treatment of eating disorders is shocking given the severity of the illness. Disordered eating habits that give way to more critical

eating disorder behaviours have thrived in silence and shame for a long time. Ignorance is leading to increased costs for our healthcare system and citizens who are suffering. Eating disorders have been heavily studied in the context of anorexia nervosa in white, middle-class women. There is less research around those in minority populations, inclusive of sexual minorities. Further, there is even less research available on sexual minorities who are also in racial minority groups. There seems to be a call for more action for these groups but very little has been studied. This is important to study and understand as it increases minority stress and enacted stigma. Families do the best they can to support their loved ones with an illness, causing a further network strain on mental health and our health care system. Economically, our society suffers when our citizens are sick.

Sexual minorities face more stigmatization and have less access to health care than the majority of the population (Ferrucci et. al., 2023). Without proper knowledge of eating disorders, our healthcare professionals have the potential to do more harm than good; this is particularly true of sexual minority populations. With eating disorders being more rampant among this group that already faces more barriers to care, lack of understanding and connection adds further discrimination. This lack of understanding pushes our minority folk further into isolation where coping mechanisms like controlling eating thrive. The more knowledgeable those managing mental illness are about proper care for sexual minority populations, the more proactive they can be in identifying problematic eating behaviours early before they explode into a larger issue.

Theoretical Orientation

The theories being discussed in this paper are queer theory and attachment theory. Queer Theory was first introduced by Teresa de Lauretis in the early 1990's. Queer theory "is a set of critical practices that challenge assumptions about gender, sex, sexuality, anatomy, and identity, and the relationship among these" (Tilsen, 2021, p. 16). It focuses on questioning and deconstructing assumptions around identity, power, social norms, and specifically gender and sexuality (2021).

Attachment theory was introduced by Bowlby (1969) referring to the tendency of young children to seek contact with one or more consistent caregivers for comfort when in a state of stress or vulnerability (cited in Fearon & Roisman, 2017). Children with secure attachments develop a sense of basic security and are confident in their caregivers and inevitably, their interactions in the world. Those with insecure attachments due to caregiver unavailability or unresponsiveness, are thought to develop a sense of shame around those needs and come to believe that they cannot depend on others.

Positionality Statement

Researching and disseminating the knowledge, ideas, and conclusions of a capstone project requires personal consideration of the researcher as to why they are researching such a topic and what lens they are viewing the research through. Considering researcher bias is important for both the research and the greater audience. I am a 38-year-old, cisgender, heterosexual, able-bodied, woman of European descent. I was born and raised in Canada to a middle-class family. I acknowledge the privilege I have been bestowed by being born in a Western Civilization and being positioned in most majority groups.

I have chosen this area of study as I have volunteered for 6 years with an eating disorder non-profit. I am acutely aware of the struggles those facing eating disorders face. I have also struggled with an eating disorder so I understand how difficult the battle can be. I have always felt a strong social justice lens and providing a platform for those less empowered than I am. Gaining the knowledge that those in a minority group experience eating disorders at a higher rate than those in the majority population pushes me to explore why and the areas in which I can help. I feel strongly about using this profession to elevate those voices who are not considered the dominant population.

The fact that I have had an eating disorder does bias my research as well. I will have to maintain an awareness that my experiences are personal and not to generalize my experiences to others, particularly those whose identities intersect differently than my own. In that same vein, I must understand that there can be room for overlap, and differences in identity can equate to similar experiences. This is where I let client voices lead me.

I do not identify in the sexual minority population. As such, I want to ensure I am researching to gain an understanding of a different perspective. I will be working with those with eating disorders and will likely counsel those who do not identify with the sexual majority. I want to have a foundational understanding of those with different experiences as me as I don't want to rely on my clients to use our sessions to educate me. That said, I again find it valuable to still let my clients guide me but with a basis of knowledge and contemporary research.

Acknowledging my biases and areas for blind spots is a step toward the role of a researcher.

Definition of Terms

The following terms are defined conceptually and operationally.

Affirmative Care / Gender Affirming Care – “is a therapeutic stance that focuses on affirming a patient’s identity and does not try to “repair” it. Core themes of gender-affirming care include trauma, shame, depression, self-harm, violence, sexuality, medical treatment, and societal stigma. Core interventions include affirmation, space for processing, linking to social supports, creating a safe space, allowing for diversity, reflection, and empathy” (Yarbrough et. al, 2017).

Attachment Theory – “The theory that humans are born with a need to form close emotional bonds with a caregiver and that bond will formulate during the first 6 months of a child’s life and have implications for future development and bonds” (Fearon & Roisman, 2017).

Comorbidity – “any distinct clinical entity that coexists with or occurs during the clinical course of another illness or condition. In other words, it refers to the co-occurrence of two or more distinct illnesses, disorders or conditions in a single individual” (Brown, 2020).

Disordered Eating – “Encompasses eating disturbances (or unhealthy eating patterns) but not all of the symptoms meet diagnostic criteria for an ED” (Cusak et. al., 2022).

Eating Disorder (ED)- “Mental disorders according to the DSM-5. These disorders are diagnostically inclusive of pica, rumination disorder, avoidant/ restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge-eating disorder, other specified feeding or eating disorders, and unspecified feeding or eating disorders” (American Psychiatric Association, 2013).

Enacted Stigma – “external stigma, discrimination) refers to the experience of unfair treatment by others. Felt stigma can be as damaging as enacted stigma since it leads to withdrawal and restriction of social support” (Gray, 2004).

LGB/ LGBTQ +/ LGBTQ2S+/ 2SLGBTQIA+ - “Lesbian, gay, bisexual, transgender, queer, spirit, intersexed, asexual, and other sexual and gender minorities” (Fish et. al., 2023).

Minority Stress – “posits that SM groups experience increased levels of stigma-related stress associated with their minority status, which can lead to higher rates of psychopathology, including disordered eating. The theory delineates distal stressors (e.g., discrimination, prejudice, stereotypes) and proximal stressors (e.g., internalized homophobia, expectations of rejection, concealment), as both distinct stressors and interdependent processes” (Convertino et. al., 2021).

Queer Theory – “A set of critical practices that challenge assumptions about gender, sex, sexuality, anatomy, and identity, and the relationship among these. It is inclusive of the ideas of many scholars who work in many critical disciplines and fields of study” (Tilsen, 2021, p. 16).

Sexual Minority – an umbrella term used for those who do not identify as heterosexual (Convertino et al., 2021).

Outline of Chapters

In this chapter, I provided an introduction of the topic, the research questions, a review of key terms that will be discussed throughout the capstone, and other relevant areas of research about the topic.

In the next chapter I will review the literature on eating disorders. The literature will center on Western culture's emphasis on beauty ideals and the idealization of thin bodies, explore how diet culture in Western society contributes to women's body dissatisfaction, and investigate the interconnection between fatphobia, the thin ideal, and the emergence of disordered eating. The chapter will conclude with an exploration of efforts taking place to change the narrative of fatphobia.

In chapter 3 I will discuss the results and their application to the mental health field as well as an exploration of future directions for research.

Chapter 2: Literature Review

In this chapter, the following research questions will be addressed: What is the difference between an eating disorder and disordered eating? Why are eating disorders more prevalent in sexual minority populations? What current theoretical frameworks are used to analyze the current body of research and why? What current interventions are used to treat eating disorders? The exploration of these research questions was broken down into four subcategories: eating disorders vs. disordered eating and the lack of research, sexual minorities experience with eating disorders, theoretical frameworks, current interventions.

Disordered Eating and Eating Disorders (EDs)

Disordered eating and eating disorders are not the same. A simplistic model to understanding is a spectrum from normal eating to the far extreme of eating disorders, with disordered eating falling between the two. Normal eating is considered a healthy and balanced diet that contains enough nutrients and calories to meet the body's daily needs (Raquel & Alvarenga, 2007). Eating disorders are classified as psychiatric disorders marked by disordered eating (Pereira & Alvarenga, 2007). These disorders are diagnostically inclusive of pica, rumination disorder, avoidant/ restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge-eating disorder, other specified feeding or eating disorders, and unspecified feeding or eating disorders (American Psychiatric Association (APA, 2013)). From the list above, anorexia nervosa and binge eating disorder are the most heavily researched.

Disordered eating is a broad spectrum of eating-related issues from skipping meals, bingeing, weight-control behaviours, extreme dieting, etc. These eating patterns can be intrusive to one's life and cause significant emotional disturbance yet still do not meet the criteria for a diagnostic eating disorder (Schaefer & Thompson, 2018). Disordered eating patterns are exceedingly common in the population at large. Both eating disorders and disordered eating lead to greater health risks such as psychosocial impairment, high rates of comorbid psychopathology, and elevated mortality rates. Paradoxically, some individuals who do not meet the criteria for a diagnosable ED will sometimes engage in further disordered eating behaviours to be validated by receiving a diagnosis. Disordered eating is broad and despite extensive research, there are still gaps in areas such as cultural differences, minority populations, social influences, and the grey area between disordered eating vs. full disorders (Schaefer & Thompson, 2018). Identification of factors that contribute to and maintain these patterns is vital for prevention and intervention and may lead to further prevention of eating disorders.

Causes of Eating Disorders

Given the complexities associated with eating disorders, it is no surprise that those same complexities exist around causes and risk factors for development of disordered eating patterns. By understanding the risk factors, health care professionals are better equipped to provide support to clients before these patterns devolve into a dangerous psychiatric condition. A recent rapid review of risk factors for eating disorders by Barakat et al. (2023) sought to identify and summarize 284 research studies from the past 12 years to identify risk factors associated with eating disorders. Their results found nine main categories of risk factors and numerous sub-categories (Barakat et al., 2023). This to itself speaks to the complexities and confusion around

identifying eating disorders risks early. The list was divided into the following categories: genetics, gastrointestinal microbiota and autoimmune reactions, childhood and early adolescent exposures, personality traits and comorbid mental health conditions, gender, socio-economic status, ethnic minority, body image, social influence, and elite sports (Barakat et al., 2023). The extensive list of both biological and environmental factors explains why eating disorders are present in many different populations. Culbert et al. (2015) also noted a complex etiology manifesting from multiple biopsychosocial influences influencing eating disorders and/ or disordered eating. Their study using integrative methodologies inclusive of twin studies, neuroimaging, and gene-expression found that “psychological and environmental factors interact with and influence the expression of genetic risk to cause eating pathology” (Culbert et al., 2015, para. 1). Byrne et al., (2024) systemic longitudinal review sought to explore research on male adolescents’ development of eating disorders. This area has been overlooked in favour of research into female adolescents with eating disorders. Like the Barakat (2023) review, Byrne et al., (2024) also found psychological, sociocultural, family and peer factors, and body image to be factors in the onset of eating disorders.

Perhaps surprising, there is a strong genetic and biological component to eating disorders. Recent research supports genetic factors contributing to both anorexia nervosa and bulimia nervosa (Barakat et al., 2023). In a meta-analysis, a genome-wide association study found there to be a correlation between genetics and metabolic drivers of anorexia nervosa (Watson et al., 2019). The authors concluded by encouraging reconceptualization of anorexia nervosa as a metabo-psychiatric disorder and calling for future research to consider both psychiatric and metabolic factors (2019).

Both Fetissov & Hokfelt (2019) and Carbone et al. (2020) point to the role of gut microbiota and immune system reactions in the development and maintenance of eating disorders. Though this is an emerging area of study, there has been more attention in recent years with much focus around diagnosable eating disorders, particularly anorexia nervosa and bulimia nervosa. Recent research regarding genetics and biology in terms of eating disorders is limited and focused on anorexia and bulimia. Perhaps if there was more research into the biomarkers of eating disorders, the greater understating there would be by medical professionals and more incentive to treat the disorder beyond one of just a psychiatric issue.

Compounding biological factors are psychosocial factors contributing to the onset and subsistence of eating disorders. Culture plays a part in how we perceive disordered eating and, in some cases, normalizes eating disturbances (Raquel & Alvarenga, 2007). In a westernized society, “media exposure, perceived pressure to be thin, thin-ideal internalization, and thinness expectations have all been shown to prospectively predict increased levels of disordered eating cognitions and behaviours” (Culbert, Racine, & Klump, 2009, p. 1145). Perez et al. (2023) sampled 195 female patients from an eating disorder clinic in Mexico City using sociocultural analysis and found that family pressure had significant impact on eating disorder prevalence. This was more than the ‘thin ideal’ internalization or media. The authors noted that in Latin America, family plays a large role in the relationship with food and body image, so this was an anticipated finding. Sociocultural factors and influences will be discussed more below when examining major theories regarding eating disorders amongst sexual minority population.

Sexual Minorities and Eating Disorders

It may seem surprising to associate sexual identity with greater risk of an eating disorder at first thought. What does sexuality have to do with mental health? Ideally, nothing. This is not the case, however. Sexual minorities demonstrate significantly higher levels of disordered eating than their heterosexual counterparts, particularly among males (Calzo et al., 2017). Those of the minority group are subject to the same risk factors of their peers inclusive of self-objectification, weight misperception, drive for thinness, drive for masculinity, and social media influences (2017). There are additional factors unique to sexual minorities that also contribute to the onset and maintenance of disordered eating patterns. Cao et al. (2022) describe these to be both external factors (stigma, discrimination, and prejudice) and internal factors (cognitive dissonance, fear of “coming out”). They further synthesized that all these factors pre-dispose these groups to more unhealthy coping mechanisms and are secondary to feelings of body dissatisfaction or weight concerns (2022). This disparity of greater risk to disordered eating patterns is not limited to this mental health condition. There is a greater risk of psychiatric comorbidities in general and inclusive of depression, substance abuse, and self-harm/ suicide (Calzo et al., 2017).

Differences within Sexual Minority Groups

Though there are greater risk factors for developing an eating disorder amongst sexual minority populations, there are differences within said population. Calzo et al. (2017) and Feldman & Meyer (2007), reported that gay and bisexual men had higher prevalence of eating disorders compared to heterosexual men. This difference did not exist between heterosexual women and lesbian and bisexual women (Feldman, 2007). Convertino et al. (2021) noted that

eating disorder risk among sexual minority women is less conclusive but recent systematic reviews have found higher rates of eating disorders, binge eating, and purging behaviour, but lower body dissatisfaction compared to heterosexual women. Though there have been a few studies dedicated to the differences within the sexual minority population, those studies are limited as this is an area of growing interest. The only difference clarified have been between gay/ bisexual men and gay/ bisexual women. Given the complexities of analyzing sexuality and differentiating sexual preferences based on a spectrum, the generalities in these studies of lumping all LGBTQ+ folk together are sensical. That said, broad generalizations can be counter productive as they have been in the past of lumping all eating disorders into one category or treating those afflicted in the same way. A glaring hole in all this research has been a lack of intersectional considerations for individuals; those with an eating disorder alone and those in a minority population. This will be discussed in more detail later in the chapter.

Theoretical Models

Prevailing theoretical models examining the relation between sexual minorities and eating disorders risk are predominantly a sociocultural approach and the minority stress approach. There is recent work on a tripartite/ quadpartite model and objectification theory. Though, these are not as established as the sociocultural and minority stress models. Sociocultural models emphasize how societal norms and cultural messages about sexual objectification influence individuals' self-worth and self-perception. Sociocultural models work to understand the impact society has on mental health. In terms of eating disorders, there are two predominant sociocultural theories utilized in research, objectification theory and the tripartite model. As an extension and contributor to sociocultural models, minority stress models argue

that marginalized groups experience chronic stress due to difficult social situations which can lead to negative health outcomes. This model is mainly used in studies around the LGBTQ+ community but can be used on any minority group. In a way, these two theories can overlap. There is not much in the way of research utilizing both theories in explanations of eating disorders within minority populations. The research that exists, shows promise in explaining the complexities that are at work in the maintenance of eating disorders within this minority population.

Sociocultural Models

Culture is defined as “the values, beliefs, language, rituals, traditions, and other behaviours that are passed from one generation to another within any social group” (American Psychological Association (APA), (2023), para. 1). Culture is a broad term used to encompass many social aspects that make up one’s identity. Though not a new theory, sociocultural movements have been gaining support and momentum as scholars are emphasizing the fundamental role social and cultural environments have on human experiences (Chirkov, 2020). According to Calzo et al. (2017), “the sociocultural theory posits that sexual orientation disparities in disordered eating are rooted in gender and sexual minority-specific (e.g. community) norms concerning ideal appearance or the importance of appearance and physical attributes” (p.3, para 2). These models do not simply highlight the influence social and cultural factors have, but empathize these factors are indivisible from human experience and development (Chirkov, 2020). Indeed, there is an environmental influence that can change depending on the social environment one is in. There are also considerations around people’s brain development being embedded social systems. These frameworks emphasize the influence

of social, cultural and historical contexts shape cognitive functions and identity formation. There are many different frameworks within the sociocultural model umbrella. Considering the nuances and broad-brush definition of culture, there are as many ways as possible of analyzing the ways in which society influences us. These can be studied at the levels of power dynamics, collectivism, gender, etc. The ones prominent in research involving sexual minority disordered eating habits were the theory of sociocultural models (TSCM), the tripartite/quadripartite model, and objectification theory.

Minority Stress Models

The minority stress model has been used to explain the disparity sexual minority people experience in physical and mental health compared to the heterosexual population. “The theory postulates that sexual minority groups experience increased levels of stigma-related stress associated with their minority status, which can lead to higher rates of psychopathology, including eating disorders” (Convertino, et al., 2021, p. 2, para 2). This model is also inclusive of resilience factors like social support and community connection and their impacts on health (Meyer et al., 2021). In short, there is a belief that the health of sexual minorities is determined by their social environment. As their social environment improves, so does their health. A national probability sample inclusive of three defined cohorts of sexual minority cohorts (1956-1963, 1974-1981, and 1990-1997) were studied by Meyer et al., (2021) to test the tie between social environment and health outcomes. They theorized that as society improves and becomes more accepting, the health and well-being of the later cohorts would be better than the earlier. They found no signs that an improved social environment attenuated their exposure to minority stress (Meyer et al., 2021). In fact, they found quite the opposite, that younger generations fair

worse psychologically than the older cohorts. Despite the appearance of acceptance and those of a sexual minority status sharing their sexual preferences earlier, their exposure to violence and rejection was still high. This speaks to the strength of how ingrained certain cultural ideologies are. On another hand, we cannot discount the value of social supports provide in the minority stress model. Perhaps, in a way, the older generations found comfort in privately held LGBT communities. The fact that these groups are more public does not seem to discount the fact that sexual minority groups still face discrimination. That said, Meyer et al. did find a high correlation between sexual minority sense of centrality and connection to the LGBT community.

Tripartite/ Quadripartite Model

One such sociocultural model that has been discussed in research is the tripartite influence model. This model emerged in the late 1990's and proposes that "pressures from family, friends, and the media to conform to dominant sociocultural appearance ideals leads to body dissatisfaction and restrained eating via internalization of the thin ideal and social appearance comparisons" (Convertino et al., 2021). A more recent modification includes a fourth variable, "significant others" which is not limited to romantic partners, but those applying pressure to achieve certain body ideals making it a "quadripartite" model (Convertino et al., 2021). These social factors have been long postulated to be risk factors for negative body image, which is a big contributor to eating disorder development (Perez-Bustinzar et al., 2023). When messages are delivered about looks, weight, appearance (sociocultural factors) they can be internalized (mediation factors) which predicts body dissatisfaction levels (2023).

Objectification Theory

One possible explanation for the lower body dissatisfaction among lesbian women, and the higher rate of eating disorders in gay and bisexual men is objectification theory.

Objectification theory is “an influential framework that captures points of convergence across other sociocultural theories and delineates how sexual objectification experiences can contribute directly and indirectly to psychological symptomology with disproportionately high rates among women, specifically including eating disorder and depressive symptoms” (Moradi & Tebbe, 2022, para 2). In layman’s terms, self-objectification is the internalization of the dominant culture’s standard of beauty and this internalization, can lead to adverse mental health outcomes depending on how close you feel your body adheres to cultural standards (Simpson, 2024).

Living in a patriarchal society, women’s bodies have traditionally been looked at, evaluated, and objectified more than men’s bodies. Gender oppression has existed in many forms and is amplified through our media. The objectification theory has been analyzed through the lens of heterosexual women and eating disorders almost exclusively. However, Simpson (2024) used objectification theory to study body image and body satisfaction in gay and bisexual men. The results showed that bisexual men between the ages of 16-25 have a higher body dissatisfaction than cisgender women (Simpson, 2024).

Considering a risk factor of disordered eating is highly correlated to body image, the risk for gay and bisexual men to engage in such behaviours is higher. In a similar application of objectification theory with sexual minority women, Moradi and Tebbe (2022) studied the implications on both eating disorders and depressive symptoms within this population. Results showed there were no indirect or direct relations to objectification and eating disorders or depressive symptoms in gay and bisexual women (Moradi & Tebbe, 2022). There were,

however, direct and indirect relations for eating disorders and body shame and body surveillance due to cultural standards (2022). Though not new, objectification theory is only recently being applied to populations other than heterosexual, Caucasian females.

Applying a Queer Theory and Attachment Lens

Attachment Theory

Attachment theory at its core is a developmental concept used to frame psychology and behaviour in terms of early bonds in life. “Attachment theory is probably the prime contemporary scholarly construct in terms of which human bonding is conceptualized and investigated, with a vast body of literature focusing on the different attachment styles described by and their consequences and application in human life across the lifespan” (Robledo et al., 2022, p. 1, para 2). The roots of attachment theory began with a simple observation by John Bowlby, a respected physician and researcher. At a basic level, Bowlby’s (1969) theory argues for the tendency of young children to seek contact with one or more consistent caregivers for comfort when in a state of stress or vulnerability (cited in Fearon & Roisman, 2017). Children with secure attachments develop a sense of basic security and are confident in their caregivers and inevitably, their interactions in the world. “Throughout the developmental history of an individual, secure attachment relationships provide emotional support, comfort and availability especially during stressful moments...and eventually, form our internal working models of attachment” (Gander et al., 2015, para 1). In securely attached individuals, attachment events have led them to anticipate availability and responsiveness from caregivers. As a result of this, their internal working model is one of a competent and valuable individual. Attachment theory states that secure relationships are crucial in solving developmental tasks in life such as physical

changes, identity, and goal development (Gander et al., 2015). In this regard, secure attachments create an important buffer to psychological harm.

Opposite to secure attachments are insecure attachments. Mary Ainsworth (1971) expanded Bowlby's original theory and described three main attachment styles; securely attached, avoidantly attached, and anxiously attached (cited in Leben et al., 2023). Anxious and avoidant attachment are both considered insecure attachment styles. Avoidant attachment styles are "characterized by negative representation of others, discomfort with closeness in relationships, and denial and suppression of attachment needs" (Gruneau et al., 2022, para 6). Individuals with these type of attachment styles tend to turn away from support, socially distance, and disengage from emotional connections. Anxious attachment is characterized by a "hyperactive attachment needs marked by excessive worrying about someone's lovability, fear of abandonment, sensitivity to rejection, and highly emotional responses to separation" (Gruneau et al., 2022, para 7). Attachment anxiety is correlated with greater distress and more negative emotions (Gruneau et al., 2022). When exploring insecure attachment and mental health, there copious research on insecure attachment and its impact on jealousy (Deng et al., 2023), defiance of authority (Gruneau et al., 2022), and suicidality (Leben et al., 2023) to name a few.

Over the decades, attachment theory has expanded into a vast and advancing field with extensive research focusing on examining the structure, function, development, and clinical applications of attachment concepts (Allen, 2023). Indeed, this research is now inclusive of development across the lifespan and in research encompassing romantic partners, parents, siblings, children and friends, adult relationships and parental styles (Robledo et al., 2022). Bowlby's work was pivotal in the field of development as it centred on the importance of child-

caregiver relationships in early ages and how those relationships impact development and relationships well into adulthood (Allen, 2023).

It is worth noting that Bowlby's (1969) attachment theory relied heavily on evidence from his studies which usually involved mothers over fathers. For this reason, there has been accusations of Bowlby's theories being sexist in nature (cited in Allen, 2023). Though attachment researchers have made great strides in refuting this and finding no difference in diverse primary caregivers from sex to sexuality, there still lies a gap in attachment research and non-maternal caregivers (Allen, 2023). Further criticism is provided by Keller (2021) who suggests that the reason why there is universal acceptance of attachment theory is because it is a western, individualized viewpoint. Keller (2021) highly encourages cultural considerations when applying attachment theory and introduces concepts of "attachment networks" instead of the concept of singular attachments being critical in development. In criticism to Keller's criticism, Ainsworth's studies were conducted in Uganda. Further, her findings inspired major longitudinal attachment studies in the United States, West Germany, and Israel (Bretherton, 2025).

Attachment Theory and Eating Disorders

As indicated by Tasca et al., (2011) attachment functioning and eating disorder research is a small but growing field. Since the printing of that research in 2011, there has been more research into the field, but it remains small. A recent longitudinal study aimed to explore the role of attachment insecurity by assessing patients over the course of a year (Rossi et al., 2022). They concluded that insecure attachment predicted a worse trend of eating disorder psychopathology and because of such, stated the need for personalization of treatment programs taking into consideration developmental perspectives. Tasca (2019) also concluded that models of eating

disorder tend to focus less on developmental issues like affect regulation and self-conceptualization and more on cognitive and behavioral factors. These developmental factors reside within attachment theory. For example, “research into attachment and eating disorders has found a moderate and significant association between attachment insecurity with general eating disorder pathology” (Taska, 2019, para. 4). From the articles and research, the association between insecure attachment styles and eating disorders is well established and shared. Jewell et al. (2023) conducted a meta-analysis comparing attachment styles in the eating disorder population compared to community controls. The implications of their study provide insight for practitioners working with eating disorder clients. They concluded that those with eating disorders were significantly less secure, which could potentially have ramifications on the therapeutic relationship (Jewell et al., 2023). It is helpful insight to understand from a developmental lens, that individuals experiencing eating disturbances are likely to form insecure attachments. The therapist can focus on rapport and potentially prepare for and watch for ruptures in the relationship. The study by Jewell et al. concluded with suggesting more studies to understand if attachment is a worthwhile treatment target and the need to control for other psychopathologies.

An interesting theory mentioned in a couple studies and formally discussed by Mantilla et al. (2018) is the idea of eating disorders as a form of attachment relationships. They also postulate that insecure attachment is associated with higher eating disorder risk and also suggest the patient-eating disorder relationship is one based on anxiety and ambivalence to change as seen through an attachment lens (Mantilla et al., 2018). This research also provides us another possible avenue for exploration with clients inclusive of exploring alternative safe relationships and working on secure bases in the form of other relationships or activities.

Moving from the individual level to external relationships, there is also an argument made for improving social connections. Laporta-Herrero et al. (2021) focused on the influence of family and friends through an attachment lens in the onset of eating disorders. They discovered a significant correlation between parents' attachment and body dissatisfaction. Furthermore, peer alienation was also highly corroborated to body dissatisfaction, a leading contributor to eating disorders. Working with clients to maintain good relationships with both family and peers can work as a protective factor against body dissatisfaction. The research indicates that when working in the eating disorder field, exploration of attachments and working to improve them can be one area to explore in counselling relationships.

Queer Theory and Eating Disorder Research

Many common psychological theories used in treating eating disorders are rooted in heteronormative views. Though those words may not be entirely baked in, they were developed in a dominantly heteronormative environment and many, established by men in western society. There are influences at work that shape theory and perspectives even subconsciously. Queer Theory challenges heteronormative assumptions and creates a space where clients can explore their gender and sexual identities freely (Tilsen, 2021). This theory works to deconstruct normative and empower clients to live authentically without the confines of societal expectations. Queer Theory challenges binaries which open up possibilities for proliferation of identities (2021). Utilizing queer theory with folks identifying in the LGBTQ+ community feels natural in that the theory is more fluid and similarly, aligns with the concept of gender and sexuality being on a spectrum. Queer Theory is informed by societal constructs and post-structural theory (2021). It intersects with other theories like race theory and also explores the

meaning behind power dynamics. This is something notably missing in eating disorder literature. Two other important parts of this theory are its emphasis on representation and activism. When working with minority populations it is important to consider who is not in the room/ whose voice is not being heard and how to elevate those voices so society is more inclusive for all.

Attachment Theory Relationship with a Queer Theory Lens

Attachment Theory focuses on human bonds both past relationships with primary caregivers and impacts on adult relationships (Gander et al., 2015). Queer Theory expands upon this with highlighting social constructions and questioning rooted beliefs (Tilsen, 2021). A criticism of attachment theory can be its lack of consideration regarding cultural effects on attachment. Query Theory is very inclusive of culture on both the large scale and also in terms of microcultures. Both provide a unique and balanced perspective to the current research. Given the emphasis on social concepts at work regarding eating disorders, these frameworks serve to examine the research from a more holistic standpoint.

Current Treatment of Eating Disorders

Despite eating disorder recognition dating back to ancient times, it has only been in the last 50 years that EDs have been recognized as serious, multifaceted illnesses (Marks, 2019). Reviewing eating disorder treatment over the decades highlights the complex interplay of biopsychosocial factors involved in the evolution and maintenance of EDs. This is acknowledged

in treatment research frequently. Further, it also explains the shifts and adaptations of certain interventions, along with the extensive trial of many treatment modalities. There have been studies from a behavioural, developmental, attachment, cognitive, environmental, genetic, social, etc. perspective. For example, there is a recognition of the important need for medical intervention, which is inclusive of hospital stays and sometimes, refeeding. As is often the case with hospitalized clients receiving medical interventions, psychological interventions are also utilized.

Cognitive behavioural therapy (CBT) and its variants, interpersonal therapy (IPT), and family-based therapies are the most frequently cited treatments in the literature. Evidence of efficacy for other treatments and other conditions is limited by several methodological factors including the small number of studies, failure to use appropriate control conditions or randomization procedures, and small sample sizes.

Cognitive Behavioural Therapy (CBT).

Cognitive behavioural therapy (CBT) focuses on the connection between thoughts, feelings, and behaviours. It is based on the premise that negative thoughts and behaviours contribute to emotional distress and psychological issues (American Psychological Association (APA), 2017). CBT is an evidence-based psychotherapy used for a variety of conditions such as eating disorders, anxiety, depression, severe mental illness, and many more (APA, 2017). CBT can be delivered in many formats, often involving structured sessions focusing on efforts to change thinking patterns and/ or behavioural patterns. The focus is on moving forward with more effective coping techniques (APA, 2027). In the context of eating disorders (EDs), sometimes, specific forms of CBT such as CBT for Eating Disorders (CBT-ED) and its enhanced version

(CBT-E) are employed to address the unique needs and challenges associated with this population (Atwood & Friedman, 2020). CBT-E is more of an individualized form of CBT based on your personal situations and preferences. “CBT is considered the most extensively studied psychological treatment for eating disorders” (Linardon et al., 2017, p. 1, para 1). It has long been considered the recommended treatment choice for eating disorders, particularly anorexia nervosa, bulimia nervosa, and binge eating disorder (Linardon et al., 2017).

There is a significant amount of research on CBT and its use for eating disorders (EDs). It is worth noting that research has been focused primarily on anorexia nervosa (AN), binge-eating disorder (BED), and bulimia nervosa (BN). The research is comprehensive in terms of specific disorders, different forms of CBT, various delivery models, differing lengths of treatment, clinical efficacy, and comparison to other treatment modalities.

In a systematic review and meta-analysis of 79 trials comparing therapist-led CBT against both inactive (wait-list) and active (alternative therapies) treatment conditions, Linardon et al. (2017) found a significantly greater efficacy for therapist-led CBT for both BN and BED. They concluded that CBT worked well to reduce binge-eating and purging behaviours, as well as negative thoughts about food and body image. Comparatively, it outperformed no treatment and other therapy methodologies. Interestingly, the results were unclear for anorexia nervosa treatment with CBT. The results didn't show a significant advantage over other treatments (Linardon et al., 2017). This study did conclude that better studies were needed and more research on anorexia nervosa specifically. Similarly, a systemic review by Kaidesoja et al. (2022) also studied the effects of CBT for eating disorders in comparison to other active interventions. Their conclusions seem to reflect Linardon et al. (2017) results in some ways. They concluded that CBT is beneficial for BED and BN but also, there is a lack of evidence proving its efficacy

for AN (Kaidesoja et al., 2022). The authors noted that critical gaps remain in the treatment of AN and that research should focus on enhancing treatment options for low-weight individuals.

A worthwhile consideration in any treatment are the drop-out rates and effects on efficacy. In a study by Lindardon et al. (2018), a meta-analysis was conducted to estimate the rates of drop out of CBT for eating disorders, compare dropout rates between CBT and other forms of therapy, and to identify factors influencing dropout rates. The study found that people were more likely to dropout of internet-based CBT compared to face-to face therapy (Lindardon et al., 2018). This indicates that connecting with a therapist is more likely to ensure clients remain in CBT treatment for EDs. A secondary factor is length of treatment. Lindardon et al. (2018) found that longer treatment plans were associated with lower dropout rates. Finally, dropout rates were shown to be consistent across therapy modalities with not distinct difference (Lindardon et al., 2018). Perhaps dropout rates are not discussed enough in the field. More consistent definitions of dropout and discussion of causes can lead to improving treatment retention and efficacy (Lindardon et. al, 2018).

There is sufficient research in CBT for anorexia nervosa (AN). Many studies state a difference between CBT for ‘underweight’ eating disorders or for ‘non-underweight’ eating disorders which inexplicitly means AN vs. other EDs. Anorexia Nervosa (A) is notoriously difficult to treat, largely due to patient reluctance and poor treatment outcomes (Dalle Grave et al., 2015). Treatment reluctance is a particular issue in out-patient programs. Multiple studies cited high patient drop-out rates reaching over fifty percent. Despite this, CBT-E does show promise. In an outpatient setting at a public hospital, Frostad et al. (2018) recruited adult patients with AN to receive at least 40 sessions of CBT-E over a period of twelve months. From those that completed the treatment, there were significant increases in their BMI. In a similarly, more

recent study by Frostad et al. (2021), CBT-E was used for severe cases of AN in an outpatient ED unit at a public hospital in Norway. Again, results showed a significant increase in BMI for those that completed the program. Both studies had high drop-out rates yet seemed to support positive effects of CBT-E as a viable option for adult out-patients. More research should be conducted. It is a question of the patients dropping out due to patient general reluctance, a disconnect with CBT, the length of study, or some other reason. From the research, there are consistent results in the efficacy of CBT-E for AN, both in-patient and out-patient. Most studies seem to consistently have adolescent and adult patients and delivery of CBT-E seems to be regulated by trained and qualified psychologists. Further, studies show that early intervention and monitoring throughout treatment can lead to significant improvements in weight and ED symptomology (Duggan et al., 2025).

Family Focused Treatments.

Family-based treatment (FBT) is a specific form of family therapy that has been developed to treat adolescents with eating disorders, particularly anorexia nervosa (AN) and bulimia nervosa (BN). FBT utilizes family resources and dynamics to help the adolescent recover from their ED (Lock & Le Grange, 2019). FBT is a transdiagnostic, evidence-based approach to eating disorders that has become the leading treatment for adolescents with EDs (Rienecke & Le Grange, 2022). By volume, there is much less research into FBT than there is CBT. That said, the research is also indicating that FBT has been used as a first-line ED defense for a couple of decades. FBT takes an agnostic, externalizing, pragmatic, and empowering approach to dealing with eating disorders (Rienecke & Le Grange, 2022). The focus on treatment is not the cause of the disorder or assigning blame. Therapists focus on engaging and

empowering parents to be the primary agent of change and prioritizing behavioural changes that lead to weight restoration (Rienecke & Le Grange, 2022). The research is indicating that FBT is successful at increases in weight both in a short period of time and in a sustained way after treatment. Austin et al. (2025) found a significant efficacy in achieving weight restoration compared to individual therapy. Gorrell et. al (2019) also confirmed that FBT was superior to individual therapy for adolescents and longitudinal outcomes showed higher rates of full remission compared to individual therapies. In an interesting comparison between FBT and CBT-E, Le Grange et al. (2020) concluded that FBT was far more effective in immediate weight gain, while both treatments showed similar symptom relief. The authors concluded that CBT-E remains a good alternative for those preferring individual therapy. There was not much recent evidence of the use of FBT outside of AN or BN at the time this research was conducted. However, Baker et al. (2024) did explore the treatment of binge-eating disorder (BED) with FBT in adolescents. This study as limited to one individual patient. The author's results were supportive of the efficacy of FBT for BED in adolescents (Baker et al., 2024).

The research suggests that FBT is an especially effective treatment option for patients struggling with AN where weight restoration is critical. The limitations of FBT seem vast as studies were limited to AN and BN, mostly white adolescent female cohorts, and predicated on having a supportive family environment. Many studies did indicate a lack of diversity in populations and patient preference sometimes being individual therapeutic options.

Interpersonal Therapy (IPT).

Interpersonal therapy (IPT) is a time-limited, affect, life-event, and present-focused psychotherapy initially developed for treating depression, though its principles have been

adapted to treat a wide variety of disorders like AN, BN, and BED (Miniati et al., 2018). IPT focuses on improving interpersonal relationships and social functioning to help alleviate symptoms of mental disorders. The therapy involves discussing interpersonal issues, processing feelings related to these issues, and improving interpersonal skills (Bäck et al., 2020). IPT overlaps FBT in the relationship aspect of therapy but is distinctive in that it is individual based. IPT is considered a good alternative to CBT(-E) with its focus on interpersonal relationships. In a systematic review and meta-analysis of over 468 studies, Zhang et al. (2024) compared the effectiveness of IPT to CBT and found that both therapies had similar effects on ED scores, but IPT was notably more effective in improving interpersonal issues and more helpful for younger cohorts with a lower body mass index (BMI). Similarly, Miniati et al. (2018) concluded that IPT is a reasonable and cost-effective alternative to CBT for EDs, particularly in the long-term. Many authors suggested that the mechanisms of change associated with IPT would be future directed research. Further, exploration into the efficacy with CBT and/ or other therapies would be useful future exploration. In a comorbid study of bulimia nervosa (BN) with depression, IPT was utilized with 31 patients to measure its effectiveness in the reduction of both depressive and BN behaviours (Bäck et al., 2020). Results showed a significant reduction in both behaviours and reduction of depressive symptoms in one session significantly predicted reductions in ED symptoms at the next session. This study highlights the value in considerations around comorbidities and the interplay at hand. The research into IPT is promising in many aspects but also limited in comparison to CBT research.

Other Established Theories

As knowledge increases around eating disorders and new, innovative studies emerge, expanded treatment strategies have also developed. Newer treatment strategies include various forms of CBT, dialectical behavioural therapy (DBT), acceptance and commitment therapy (ACT), IPT, and FBT (Marks, 2019).

Novel treatments including neurosurgical and neuromodulatory approaches have risen and show promising outcomes for treatment for AN. These approaches include stereotactic ablation and deep brain stimulation (Friedlich, 2023). Virtual Reality (VR) Therapy combines traditional therapeutic strategies with immersive environments to address body image issues and eating behaviours (Bryson, 2024). Literature is suggesting some effectiveness in using VR, but studies are limited and require more extensive research and standardization (Bryson, 2024).

Pharmacological Treatments

Pharmacological treatments are mentioned as interventions for eating disorders. However, they are usually utilized when patients have high levels of comorbid depression, anxiety, and/ or obsessive-compulsive symptomology (Bryson, 2024). It is also important to note that the research into pharmaceuticals for eating disorders be used as adjuncts to psychological therapies (Bryson, 2024). Results into studying the use of antidepressants, antipsychotics, and stimulants for ED's has shown that some SSRIs, lisdexamfetamine, and olanzapine have been effective and safe in reducing some ED psychopathology and/ or comorbid symptoms in the short-term (Bryson, 2024).

Psychedelic-Assisted Therapy (PAT)

Psychedelic-assisted therapy (PAT) has emerged as a promising intervention for EDs, particularly for, anorexia nervosa (Gukasyan et al., 2022), Psychedelics are psychoactive

substances found to induce alterations in perception and mood (Bryson, 2024). Historically, indigenous cultures have utilized psychedelics for healing ceremonies and more currently, there is a large body of literature demonstrating the antidepressant effects of psychedelics (Bryson, 2024). The use with eating disorders has been trialed with the psychedelic substance's psilocybin, LSD, MDMA, and ayahuasca. There has been a growth in academic papers researching and suggesting trials with psychedelic drugs. The historical research is scant, but more recent qualitative studies do suggest ayahuasca may reduce disordered eating behaviours (Gukasyan et al., 2022). Indeed, Ledwos et al. (2023) conducted a meta-analysis of five studies exploring psychedelic uses for EDs. They found that the preliminary evidence reviewed suggest that psychedelics may offer a promising avenue for treating body dysmorphic behaviours and obsessive-compulsive behaviours. Body dysmorphic disorder does have overlap with those experiencing eating disorders, particularly anorexia nervosa (Ledwos et al., 2023). The drugs seem to show some ability to influence cognitive flexibility, enabling individuals to break from maladaptive, rigid thoughts about their bodies (Ledwos et al., 2023). The research into this area is promising as all authors note. That said, they all recognize a need for more research, regulation, collaboration, and risk that comes with using psychoactive substances. Overall, there is a compelling case for integration of psychedelic medicine into treatment frameworks for eating disorders, emphasizing the importance of holistic, client-centred support. It is essential to maintain a cautious yet open-minded perspective on the potential of psychedelics in fostering recovery and healing for individuals with EDs (Lafrance et al., 2024).

Chapter Summary

This chapter highlighted the nuances between eating disorders (EDs) and disordered eating. The two are not synonymous with each other though there is significant overlap. It is more accurate to consider the behaviours on a spectrum from healthy eating behaviours to diagnosable psychiatric disorders. Disordered eating is a broad spectrum with many gaps in research including the grey area where they cross into psychiatric disorders. The identification of factors and patterns that lead to and maintain these disorders is critical for prevention and early intervention.

Identifying the factors that contribute to onset and maintenance of eating disorders is difficult. These are very complex disorders with many contributing factors and intersectionalities of identity. There is research identifying genetic, societal, gastrointestinal, childhood exposures/experiences, personality traits, comorbid mental health concerns, gender, socioeconomic status, minority status, body image, and participation in elite sports as critical factors (Barakat et al., 2023). This does contribute to difficulties in studying eating disorders from a holistic perspective. There is no perfect formula for the weight of each of the contributing factors or knowledge of where one will fall on the normal to psychiatric disorder spectrum,

With regards to sexual minority (SM) individuals, the risk of eating disorders is much higher than their heterosexual counterparts, particularly in males (Calzo, et al., 2017). This is different from heterosexual individuals where women show the higher prevalence of disordered eating behaviours. The unique factors impacting a greater prevalence in SM individuals is inclusive of external factors (stigma, discrimination, prejudice) and internal factors (cognitive dissonance, fear of “coming out”) (Cao et al., 2022).

Prevailing theoretical models used to examine the relations between sexual minorities and eating disorder risk are predominantly a sociocultural approach and minority stress approach. The tripartite/quadpartite model and objectification theory are used frequently but maintain value. The sociocultural model is used most frequently and highlights the influence of social and cultural factors and emphasize their indivisible connection from human experience and development (Chirkov, 2020). The minority stress model is frequently used with the sexual minority population and postulates that these groups experience increased levels of stigma leading to more psychiatric disorders (Convertino et al., 2021). Looking at eating disorders in sexual minorities from an attachment and queer theory lens provides a framework from a developmental and cultural perspective. Challenging heterosexual norms and deconstructing these views lays a foundation for minorities to express themselves more freely.

Current treatments of eating disorders are predominantly CBT-based, IPT, and FBT. CBT leads the charge both in terms of research and application. FBT is becoming more predominant in practice and research. It is considered the best intervention for youth with eating disorders. Given the complexity of eating disorders, it is no surprise there is research in many interventions. There is emerging research in novel treatments, pharmacological treatments, and psychedelic-assisted treatments.

The research into eating disorders is comprehensive. The research into sexual minority mental health is gaining momentum. The intersection between these identities and minority status is lacking. There are unique needs of sexual minority individuals that is not represented properly in the research on eating disorders. There is a general lack of diversity that should be considered for future studies.

Chapter 3: Results and Future Directions

Summary of Findings

Eating disorders are a highly prevalent and deadly disorder that show no discrimination. Sexual minority individuals face a greater prevalence of eating disorders and face more barriers to care. This population has unique factors affecting the onset and maintenance of EDs, as well as a need for better access to and affirmative care. The purpose of this paper was to explore why the prevalence of eating disorders is higher in this population, why are there more barriers to care, how can counsellors successfully interact and help this problem within this minority population, and how therapists can be considerate to a larger system when handling intersecting identities.

The review of the literature highlights how complex eating disorders are. There are many factors that contribute to onset and maintenance of EDs. This basis of complexity is built upon when considering EDs in the sexual minority population. There is a good amount of ED research. However, what is lacking is considerations of intersecting identities, minority identities, and exploration of EDs outside of AN, BN, and BED. Research into sexual minority individuals and mental health, inclusive of eating disorders is in its infancy, though there is more interest in recent years. Extraneous factors with SM individuals are inclusive of minority stress, the influence of social and cultural factors, objectification, stigma, and community factors. Barriers to treatment vary but are inclusive of training gaps for professions, lack of understanding of unique factors affecting this population, lack of consideration for their unique identities, and non-affirmative care.

Chapter 3 will discuss the research questions with the knowledge gained in chapter 2, highlight learnings, discuss limitations and gaps in the current research, provide recommendations for practice, provide recommendations for future research, and finally, conclude the paper.

Recommendations for Practice

Medical Professionals

Elperin (2024), a medical doctor, reviewed eating disorders in the evolving medical landscape to determine the impact of supportive interventions in managing eating disorder with a focus on adopting new approaches. The impetus for the research was a stark increase of eating disorders after the COVID-19 pandemic. The COVID-19 pandemic exacerbated these issues, increasing the prevalence of EDs and reducing access to treatment (Friedlich et al., 2023). Elperin's holistic review evaluated supportive interventions from medical care to therapy, medications, support groups, and nutrition education. Given the rising cases of eating disorders and the multifaceted nature of eating disorders, Elperin's (2024) conclusions were a need for a mix of treatment modalities, reduce barriers to treatment, peer support is critical in prevention and recovery, and a need for long-term support. This article recognized the need for a multifaceted approach to EDs and that involvement with psychological therapy, nutrition education, medical monitoring, etc. is critical for effective management of these disorders. There was a strong recognition to barriers to treatment, particularly professional lack of awareness regarding other treatment options. This was identified as an issue because of the need for sustained support for these individuals and the need for professionals to proactively refer patients to support resources and create an integrated treatment plan. For medical professions, there

should be an awareness of treatments for EDs and how to be considerate of intersecting identities. Though there is much research into the efficacy of certain medical and psychological interventions, Citrone & Grilo (2021) found that the types of help sought and received were not evidence based. Despite the availability of effective treatments, many misconceptions about these disorders persist, leading to under recognition among healthcare providers. This under recognition may stem from a lack of awareness of signs and symptoms, insufficient screening tools, and factors such as patient shame and the ego-syntonic nature of disorders like anorexia nervosa (Citrone & Grilo, 2021).

There needs to be enhanced awareness and understand of eating disorders among healthcare provides. There should be an emphasis on the importance of evidence-based treatments, acknowledgement of gaps in knowledge, considerations of holistic and long-term care, and sensitivity to minority populations.

Community Involvement

Much of the research highlighted values in community involvement and suggested more research into that area. It is generally believed that having a sense of community (belonging) has positive influences on mental health. Community involvement can play a dual role in relations to eating disorders among sexual minority individuals. Community connectedness (cognitive identification with community) and community participation (concreate behaviours) yield different results regarding impacts on disordered behaviours (Convertino et al., 2021). Feldman et al (2007) found similar results indicating that participation in gay recreational organizations or groups was associated with a higher prevalence of current subclinical EDs among gay and bisexual men. However, a sense of connectedness to the gay community was linked to fewer

EDs. In some instances, greater community involvement, this can be societal generally and that of the sexual minority community, led to a greater risk of eating disorders because of heightened heterosexist discrimination and internalized homophobia as well as the association between appearance pressures and muscularity internalization (Convertino et al., 2021). Santoniccolo and Rollè (2024) also found the role of community involvement having both risk and protective elements. The findings about risk were like Convertino et al.'s findings. When individuals felt positive about their sexual minority status, had supports, and were open about their identity, they were less likely to engage in disordered eating behaviours (Santoniccolo & Rollè, 2024).

Therapists

Eating disorders and disordered eating behaviours can be a difficult topic to broach for therapists. Much of this has to do with a lack of training in this area. Given the prevalence of disordered eating, it is of sound ethical practice to do some research in this area and be familiar with support systems. Like the medical community, it is vital to consider an integrated approach to handling these illnesses and the complex nature to their onset and maintenance. It is vital to consider long-term care as well.

From general research on eating disorders, community is an interesting factor. In many ways, a community is helpful in eating disorder recovery. Within SM populations, they are both a risk and strength. Understanding the nuances of these risks and strengths can provide a healthy group with which individuals can express themselves freely, which is shown to reduce ED behaviours. This research highlights the need for clinicians to consider the unique experiences of non-binary individuals in relation to eating and body image issues, promoting a deeper understanding of how gender identity impacts these concerns. Further exploration into gender-specific factors that influence the risk and recovery from eating disorders within non-

heterosexual populations is critical (Cusack et al., 2022). Further to this, minority stress plays a significant role in the higher incidence of disordered eating among SM individuals. Addressing these issues through targeted interventions and policies can improve health outcomes for this marginalized group (Santoniccolo & Rollè). Advocacy for minority groups would go a long way in supporting funding for research into both proper intervention techniques and work towards preventative measures.

A final note about the role of a therapist in battling EDs within the sexual minority population, when it seems complicated, fallback to the basics of rapport. Specifically, the emphasis on the therapeutic relationship is crucial in promoting better treatment outcomes for adolescents with EDs (Growth et al., 2019). Giving an open environment that actively assists in deconstructing normative narratives creates a safe environment for SM individuals. By focusing on the therapeutic relationship, therapists can empower patients through active engagement in their treatment process (Growth et al., 2019).

Application: Distribution of Knowledge in Accessible Ways

The application of the research conducted and discussed in chapter 2 of this capstone will be in the distribution of knowledge in various accessible forms; this is inclusive of one-pager information documents and presentations. The focus of this information will be towards counsellors. The presentation and handout will aim to provide psychoeducation around the alarming statistics around eating disorders, the severity of the problem, and how it impacts the sexual minority population at greater rates than the heterosexual population. By distributing this knowledge, the hope is it will give counsellors space to reflect, ask questions, and seek further training around treating both eating disorders and queer populations. Many therapists have

apprehensions on both discussing and treating eating disorders. By providing some psychoeducation and support, the desire is to remove barriers to providing affirmative and essential treatment.

The presentation will start with information around eating disorders specifically. This comprehensive overview of eating disorder statistics both in the world and Canada will provide a picture into the severity and complexity of the disorder. Further, by discussing the lack of research, the presentation will lean into both normalizing the lack of information counsellors have about eating disorders but also encourage seeking further training. The idea is to remove the mystery of eating disorders and provide some tangible insights. It is important that this view into EDs be thorough enough to equip counsellors with knowledge and evidence-based practices in their treatment. They will learn the distinction between eating disorders and disordered eating which can assist them in assessing client's relationship with food. The hopes would be to eventually spot disordered eating patterns and work on preventative measures before they develop to full blown, diagnosable eating disorders. The research will also highlight the complex mix of risk factors and what the research indicates to watch for.

With the knowledge of eating disorders and their pervasiveness, the presentation will then move towards discussing eating disorders in the sexual minority population and why the experience increased rates of the disease. The presentation will highlight the increased risk factors faced by those in the non-dominant sexuality group. Counsellors will also get a sense of some differences within the minority group that should be considerations when treating and assessing disordered eating. It is important to know generalities, but it can be harmful to paint an entire minority group with the same brush. Counsellors will learn that the research into minority

groups is limited, particularly when coupled with eating disorders. Both areas lack the necessary funding despite the prevalence and cost to the medical system.

Finally, the presentation will give a lens of which to view this therapeutic work through. By approaching this presentation with an attachment theory and queer theory focus, counsellors will gain a perspective of why it is important to approach this minority population through a lens best suited for them.

Justification

The presentation's relevance is underscored by the substantial body of research illustrating the detrimental impact of eating disorders on individual mental health and strain on the medical system. Further, this problem is exacerbated in the sexual minority population and causes serious mental and physical ramifications. The references used in the rationale are grounded in empirical studies and scholarly work, lending to the credibility of the presentation. CEDS (2019) described EDs as having the highest mortality rate of any mental illness. Despite this high mortality rate, Stone et al. (2021) found that millions are spent on treating EDs in Canada each year, while research invested is negligible compared to less deadly mental health issues. Pastore et al. (2023) shared alarming data showing a rapid increase in eating disorders. Citrome and Grilo (2021) highlighted the considerable functional impairments, psychosocial impairments, and elevated risk of suicidality of those experiencing an eating disorder. Parker and Harriger (2020) underscored that members of the queer community are at greater risk of developing disordered eating patterns yet less likely to receive proper medical care and psychological support than their heterosexual peers. Cusack et al.'s (2022) research indicated the sexual minority population faces higher risk factors such as minority stress, enacted stigma, and

other comorbidities that increase their risk of EDs. Fish et al. (2024) found that effective, affirmative mental health care for the queer community is essential, yet there is a shortage of affirmative mental health care providers due to the lack of focused training. Finally, Cooper and Bailey-Straehler (2015) identified the research-practice disparity as a major concern and is particularly pronounced in ED treatment.

In light of these research findings, this presentation emerges as a vital form of information for counsellors to use to enhance their knowledge, consider their practice and approach to those in minority populations, and provide both ethical and compassionate support to clients navigating the complex and nuanced terrain of disordered eating, eating disorders, and intersecting identities. By fostering a safe and inclusive therapeutic space, counsellors can play a vital role in mitigating the detrimental effects of stigma and discrimination on our client's lives.

Ethical Considerations

As true in any context, power dynamics, privilege, oppression, intersectionality, and context play a significant role. This presentation has been developed with this in mind in a way that minimizes potential issues and ethical concerns. The mention of positionality in this context is important as those who do not identify with the SM group hold more power over clients who do not. This presentation is an opportunity for counsellors to consider their positionality and inherit bias. Reflection is encouraged as we discuss powerful sociocultural narratives at play and how they may spill over to the counselling room.

There is an understanding that some parts of this presentation may be difficult for some. This is a serious mental health concern that has taken lives. For those that may have experienced an ED or are experiencing one, this may be difficult to sit through. It could potentially bring up

feelings of anxiety, hopelessness, or distress. At the beginning of the presentation, it will be made aware what topics are being explored and an invitation to leave at any time if it feels necessary. There is a period to ask questions or talk to the facilitator if feeling distressed by what was presented.

Limitations and Gaps in Research

Disordered eating has been well researched over the decades in certain aspects. There is much to be found in terms of anorexia nervosa, bulimia nervosa, and binge-eating disorder. These are the much-studied areas by far. The most common population studies are those of young, American, white girls and women (Williams et al., 2025). Further, Williams et al. (2025) searched five databases across ethnic populations in Australia, Canada, Aotearoa New Zealand, and the UK and found that despite eating disorders being comparable across ethnic groups and higher in some minority ethnic individuals, there is quite a large exclusion of minority ethnic individuals from much of the research. This disparity means little is known about the unique experiences that may contribute to the onset and maintenance of eating disorders in these minority populations. Like the lack of minority group representation, Byrne, Basten, and McAlloon (2024) noted that the existing female-centric psychometric assessments are normed for female participants and may not be appropriate for use with adolescent males. Given the rise of eating disorders in the youth male population, preliminary research is showing that a “phenotypic difference exists between disordered eating attitudes and behaviours in adolescent male and female populations” (Byrne, Basten, & McAllon, 2024, para. 2). Once again, there are variances between populations and the nuances that contribute to eating disorder inception.

Treatment approaches that are highly utilized, studied, and used to frame research are cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), and family-based

therapy (FBT). It is no surprise that CBT has been considered the most effective approach over the years as it is evidence-based in terms of treating eating disorders. Family-based therapy is emerging in the world of eating disorders and used more frequently for in-patient eating disorder treatment. There is little on other psychological treatment modalities with regards to effectiveness in the use of eating disorders. Given the complexity of the disorder and the varying influences that lead to its development, an integration of psychological theories could be of benefit, particularly if clients do not respond to the standard treatments.

Given the increased likelihood of individuals with EDs have comorbid concerns, considerations around siloing the issue or treating the individual as a whole need to be made. There has been much linkage studied between eating disorders and other comorbidities inclusive of anxiety, depression, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD). According to Danielsen et al. (2016), there is a high prevalence of depression and anxiety disorders among individuals with AN, significantly increasing the risk of suicide. This highlights the need to effectively evaluate client needs and apply treatment frameworks that consider the whole of the client and their most critical needs.

The areas where the research is lacking are glaring in some cases and subtle in others. Most of the research reviewed stated in its own limitations there was a lack of cultural differences and called more studies on minority populations. A large proportion of the studies were systemic reviews of other studies, showcasing many research articles and participants, yet still lacking diversity both in terms of studying males and in marginalized communities. Throughout the research, there was a fine line between disordered eating and eating disorders and many seemed to use the terms interchangeably in many cases. This signified a lack of understanding between n the grey area of disordered eating vs. diagnosable eating disorders. It is

not necessarily a matter of what determines the disorder, as it is when this occurs for the individual. The lack of acknowledgement by the medical community of disordered eating patterns puts those experiencing the issue at greater risk for developing an eating disorder. Researching disordered eating can help clinicians identify early warning signs that a client may be heading down a dangerous path. Preventative measures should be a consideration to save on medical expenses and for the betterment of the individual and our economy.

Another potential limitation is most studies relied on self-reported identification of sexuality. Sexuality is considered as a continuum between heterosexual and homosexual, which is different than gender identity (Zhangqi, et al., 2022). Gender identity is a more complicated subject that deserves more study as does the intersectionality of gender identity and sexual orientation. Regarding sexual orientation, limitations may exist in self-reporting given the fluidity of the spectrum and the point in time subjects were included in the study. As noted by Zhanqi, et al. (2022), the fluidity of sexual orientation cannot be ignored, and it is recognized by individuals between 14 and 21 years of age.

More research is needed to explore the intersections of sexual orientation, gender, and ethnicity, as well as to develop effective treatment interventions strategies for EDs. However, the lack of effective treatment and prevention strategies underscores the critical need for further exploration. Further, health practitioners should consider the sociocultural factors affecting these populations when developing interventions (Calzo et al., 2017).

Research into eating disorders is important to understanding occurrence and best treatment practices for those suffering. That said, there also needs to be action to this research to make change. There needs to be a “concerted effort to translate research into practice for improving the mental health landscape for individuals suffering from eating disorders” (Kazdin

et al., 2017, p. 170, para 1). Cooper and Bailey-Straehler (2015) identified the research-practice disparity as a major concern and is particularly pronounced in eating disorder treatment. As the plethora of research points to the effectiveness of treatments like CBT-E and IPT, the gap is in application of these methodologies. Kazdin et al. (2017), identified two main voids in the treatment of eating disorders: a disparity between researched treatments and implementation, as well as a difference in the prevalence of eating disorders and the number of individuals receiving adequate treatment. Cooper and Bailey-Straehler (2015) identified the barriers in application of these evidence-based treatments being clinician attitudes and beliefs and the lack of access to trained therapists needed to learn these therapies. Peterson et al. (2016) concur with the need for research and clinical expertise and offer a third critical component to selecting an eating disorder treatment; patient values. The effectiveness of any therapy does have a reliance on the patient themselves. Considering patient preferences and ideologies is key to a working alliance and ethical practice. However, as Peterson et al. (2016) also note, it is wise to be weary to patient treatment preferences as they may prefer ineffective treatments. A helpful shift in research should be in focusing on scalable-training and treatment models, as well as effective use of technology to assist with this disparity (Kazdin et al., 2017).

Conclusion

This research presented in this capstone highlights the urgent need to broaden the scope of eating disorder (ED) research and treatment beyond the historically narrow focus on heterosexual, white females with diagnosable conditions such as anorexia nervosa, bulimia nervosa, and binge eating disorder. Sexual minority populations experience significantly elevated rates of disordered eating and ED behaviours, largely influenced by minority stress, societal

stigma, internalized biases, heteronormativity, and body objectification. These complex and intersecting factors often place individuals within the grey areas of the ED spectrum—areas that are under-recognized and under-treated in current clinical practice.

Despite the extensive research on EDs, there remains a substantial gap in understanding and addressing the unique experiences of sexual minority individuals. By integrating queer theory and attachment theory, this review underscores the importance of viewing EDs through a lens that accounts for identity, relationships, and systemic oppression. Current treatment models, such as Cognitive Behavioural Therapy (CBT) and Family-Based Therapy (FBT), show effectiveness but must evolve to reflect the diverse needs and lived realities of this population.

To ethically move forward, the field must prioritize inclusivity, cultural competency, and long-term care approaches. Health care professionals require comprehensive training to reduce harm and improve outcomes for sexual minority clients. Furthermore, future research should intentionally center these communities, using methodologies that honor their voices and resist further marginalization. Addressing these gaps is not only a clinical necessity—it is an ethical imperative in the pursuit of equitable and affirming care.

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Appendix A

Presentation: Eating Disorders in Sexual Minority Populations



DEDICATION



This paper is dedicated to the many individuals suffering with an eating disorder. The suffering is usually in silence and this paper is to acknowledge that you are not alone. Further, those from the many and diverse minority populations were highly considered when writing this paper. You are seen and appreciated. Given the intensity and uncertainty of societal tolerance and backlash these days, this paper is dedicated to those promoting hope and inclusivity.



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KEY TERMS

- **Affirmative Care / Gender Affirming Care** – “is a therapeutic stance that focuses on affirming a patient’s gender/ sexual identity and does not try to “repair” it. Core themes of affirming care include trauma, shame, depression, self-harm, violence, sexuality, medical treatment, and societal stigma. Core interventions include gender affirmation, space for processing, linking to social supports, creating a safe space, allowing for diversity, reflection, and empathy” (Yarbrough et. al, 2017).
- **Disordered Eating** – “Encompasses eating disturbances (or unhealthy eating patterns) but not all of the symptoms meet diagnostic criteria for an ED” (Cusak et. al., 2022).
- **Eating Disorder (ED)** - “Mental disorders according to the DSM-5. These disorders are diagnostically inclusive of pica, rumination disorder, avoidant/ restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge-eating disorder, other specified feeding or eating disorders, and unspecified feeding or eating disorders” (American Psychiatric Association, 2013).
- **Sexual Minority** – an umbrella term used for those who do not identify as heterosexual.



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THE BEGINNING



ED Statistics

- Alarming increase in eating disorders of <40% in the 6 - 18 year old populations in the UK and US (Pastore et. al, 2023).
- Highest mortality rate of any mental illness, with estimates between 10-15% with suicide being the second leading cause of death for those with an ED (CEDs, 2019).
- Afflict 2.7 million Canadians and 1.4 million of those are youth (NIED, 2016))
- NIED (2016), "the social and economic costs of untreated eating disorders are similar to those of depression and anxiety, with debilitating physical and mental health effects comparable to psychosis and schizophrenia"
- Millions are being spent on treating EDs every year in Canada, while research invested in this area ranges from approximately \$0.08 to \$0.61 per individual. Comparatively, In Canada, other psychiatric disorders such as schizophrenia receive funding at a rate of \$47.01 per individual and bipolar sees funding at \$7.78 per individual (Stone et al., 2021)



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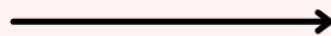
EDS IN SEXUAL MINORITY POPULATIONS

Statistics



Perhaps unsurprising, though data indicates much higher rates of EDs in this populations, there is not as much research regarding EDs within the SM community.

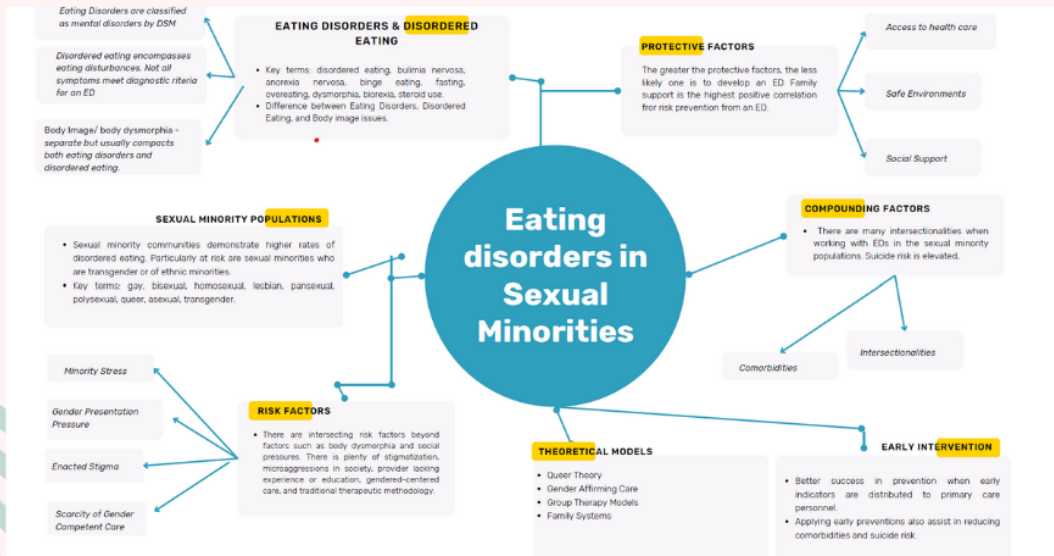
- Eating disorders are disproportionately higher in sexual minority groups (Calzo et al., 2017).
- Higher risk factors such as minority stress, enacted stigma, and comorbidities that lead to an increased risk of eating disorders (Cusack et al., 2022).
- Differences within sub-groups of LGB community exist with regarding both occurrence and vulnerabilities to EDs.
- More barriers to care inclusive of affirming care, knowledge, and discrimination.



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MIND MAP



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Purpose



RESEARCH QUESTIONS

- 1) What unique risk factors contribute to the development of EDs among SM individuals?
- 2) What are the perceived barriers to treatment for EDs among SM individuals?
- 3) How do therapists address identity-specific issues when treating clients with EDs?
- 4) What therapeutic approaches and training is best to manage EDs in SM populations?
- 5) In what ways should therapists consider systemic oppression and intersecting identities when treating EDs in SM populations?



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LITERATURE REVIEW



EDs vs. Disordered Eating

Eating Disorders

- Extreme end of eating spectrum opposite healthy eating behaviours.
- Psychiatric disorders inclusive of anorexia nervosa, binge eating disorder, bulimia nervosa.
- Recent updates to DSM to include more eating disorders.
- Usually involve great disturbances to one's life.
- Complex reasons as to why they occur.

Disordered Eating

- In the middle between healthy eating & disordered eating spectrum. Broad spectrum.
- Skipping meals, weight-control behaviours, extreme dieting, etc.
- Not all disordered eating is considered an ED.
- Can be intrusive to one's life & cause distress.
- Exceedingly common in the population



WHAT CAUSES AN ED?



- Causes are as complex as the disorder is.
- Genetic factors
- Gastrointestinal, microbiota, and autoimmune reactions
- Childhood and early adolescent exposures
- Personality traits and comorbid mental health conditions
- Gender
- Socio-economic status
- Ethnicity
- Body image
- Social influence
- Elite sports



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ADDITIONAL RISK FACTORS FOR SM INDIVIDUALS



Review

External Factors

- Stigma
- Discrimination
- Prejudice

Internal Factors

- Cognitive Dissonance
- Fear of "coming out"
- Internalized shame/ stigma

Comorbidity Risk

- Risk to comorbidities higher and inclusive of depression, substance use, self-harm, and suicide.

Coping & Dissatisfaction

- Are predisposed to more unhealthy coping mechanisms.
- Secondary - body dissatisfaction, and weight concerns.



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Within Group

DIFFERENCES

1. Men

Gay and bisexual men had higher prevalence of eating disorders compared to heterosexual men. This difference did not exist between heterosexual women and lesbian and bisexual women (Feldman, 2007).

2. Women

Eating disorder risk among sexual minority women is less conclusive but recent systematic reviews have found higher rates of eating disorders, binge eating, and purging behaviour, but lower body dissatisfaction compared to heterosexual women (Convertino et al., 2021).



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PREVAILING THEORETICAL MODELS FOR SM (WITH ED)



Sociocultural

- Emphasize how societal norms and cultural messages about sexual objectification influence individuals' self-worth and self-perception.

Objectification

- Internalization of dominant culture's standards

Minority Stress

- Increased level of stigma related stress.
- Resilience factors: support & community.

Tripartate

- Pressures from family, friends, and media to conform.
- 4th variable: Significant others.



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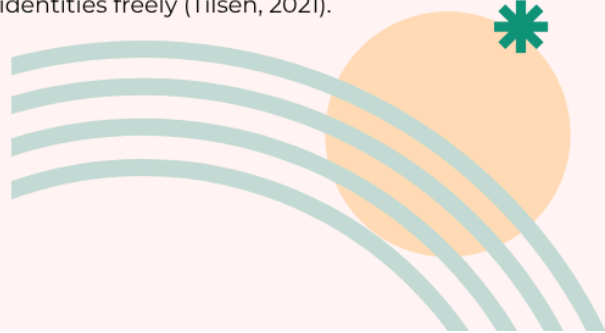


Frameworks

APPLYING QUEER THEORY & ATTACHMENT THEORY



- Research lacks in queer theory & attachment theory in relation to EDs & particularly, among minority groups.
- **Attachment theory** states that secure relationships are crucial in solving developmental tasks in life such as physical changes, identity, and goal development (Gander et al., 2015). In this regard, secure attachments create an important buffer to psychological harm.
- **Queer theory** challenges heteronormative assumptions and creates a space where clients can explore their gender and sexual identities freely (Tilsen, 2021).



LITERATURE REVIEW

Attachment Theory & Queer Theory

Attachment Theory

- "Throughout the developmental history of an individual, secure attachment relationships provide emotional support, comfort and availability especially during stressful moments...and eventually, form our internal working models of attachment" (Gander et al., 2015).
- Attachment anxiety is correlated with greater distress and more negative emotions (Gruneau et al., 2022).
- "Research into attachment and eating disorders has found a moderate and significant association between attachment insecurity with general eating disorder pathology" (Tasca, 2019, para. 4).
- Insecure attachment predicted a worse trend of eating disorder psychopathology and because of such, stated the need for personalization of treatment programs taking into consideration developmental perspectives (Rossi et al., 2022).

Queer Theory

- Utilizing queer theory with folks identifying in the LGBTQ+ community feels natural in that the theory is more fluid and similarly, aligns with the concept of gender and sexuality being on a spectrum.
- Queer theory is itself is informed by societal constructs and post-structural theory
- Queer theory intersects with other theories like race theory and works to understand power dynamics. This is something notably missing in eating disorder literature.



Current



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PSYCHOLOGICAL TREATMENT OF EDS

- **Cognitive Behavioural Therapy (CBT)**
 - CBT-E & CBT-ED.
 - CBT is considered the most extensively studied psychological treatment for eating disorders (Linardon et al., 2017)
 - Research has been focused primarily on anorexia nervosa (AN), binge-eating disorder (BED), and bulimia nervosa (BN).
- **Family-Based Treatment (FBT)**
 - Best fit for adolescents & those with AN where weight restoration critical.
 - Utilizes family dynamics to help in recovery.
 - First line defense with EDs- agnostic, externalizing pragmatic, empowering (Rienecke & Le Grange, 2022).
- **Interpersonal Therapy (IPT)**
 - More effective than CBT when used with younger cohorts with a lower body mass.
 - Effective as reduction for BN behaviours & reduction in depressive symptoms.



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Shout out to



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Page 13

OTHER PSYCHOLOGICAL TREATMENTS

- Dialectical Behavioral Therapy (DBT)
- Acceptance and Commitment Therapy (ACT)
- Various forms of CBT.

- Novel treatments:
 - Virtual Reality (VR)
 - Pharmacological Treatments - anti-depressants, antipsychotics, stimulants
 - Psychedelic-Assisted Therapy (PAT)- psilocybin, LSD, MDMA, ayahuasca.



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• • * **Finally** * • •

KEY FINDINGS

- Eating disorders and disordered eating are not the same thing. Disordered eating is pervasive in society. EDs are clinically diagnosed. Eds are also pervasive and deadly.
- Eds are complex and many factors contribute to onset & are unique to individuals.
- SM population greater risk for ED. Minority stress factors, objectification, sociocultural issues, barriers to care, comorbidities, stigma, and community factors are all factors that increase the chances of SM individuals having an ED.
- Research is highly focused on AN, BN, and BED and on adolescent females
- Barriers to care: lack of training, lack of understanding unique factors, lack of consideration for unique identities, and non-affirming care.



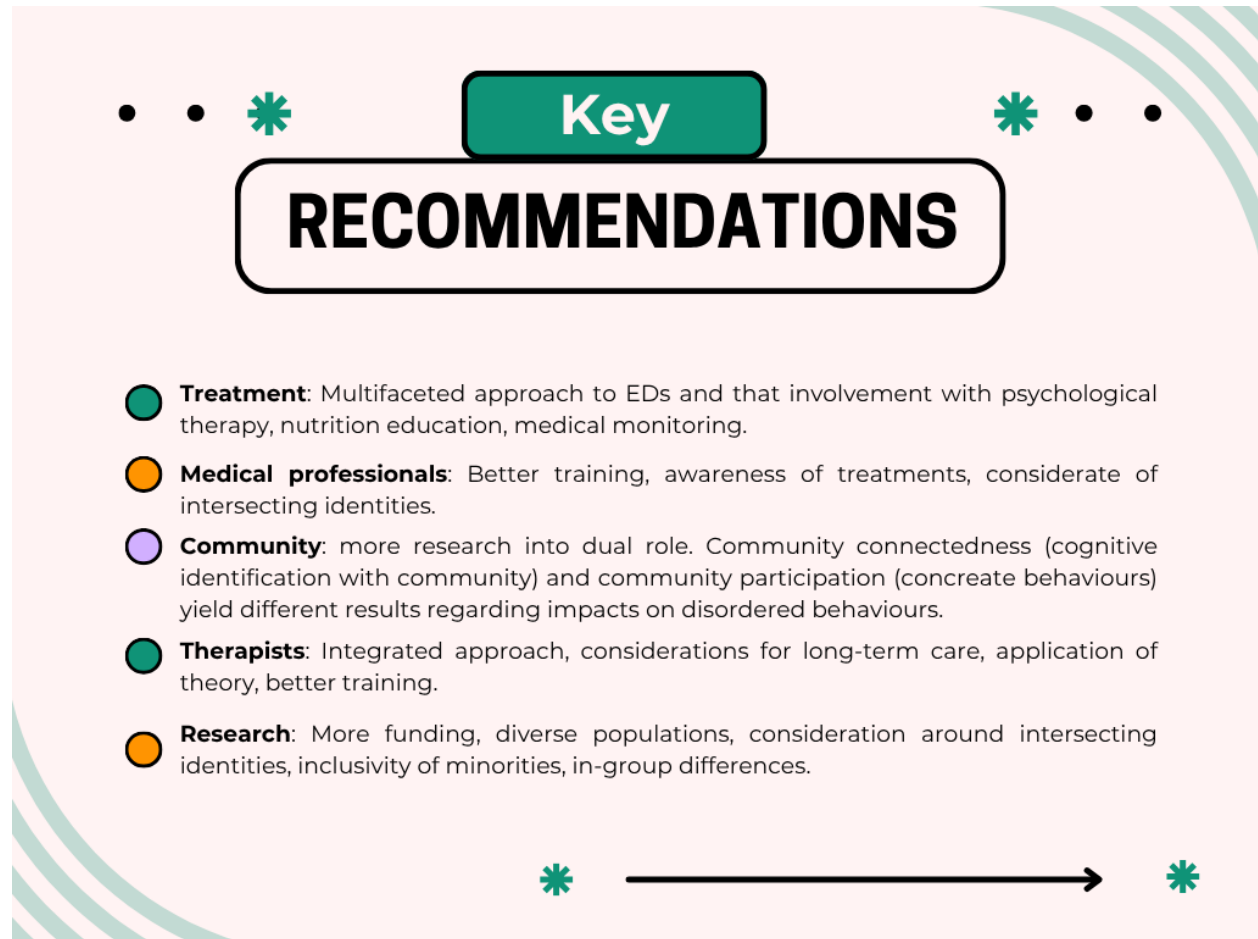
GAPS IN RESEARCH



- **Demographics:** Research focused on North American adolescent females.
- **EDs:** Research focused on Anorexia nervosa, Bulimia Nervosa, and Binge-eating disorder. That said, research further concentrated on AN.
- Lack of research on disordered eating.
- Research into diverse populations is limited (minorities).
- Lack of research **within groups** (e.g. gay/ bisexual men vs. gay/ bisexual women).
- Differences in **theory vs. application.** Research lacks directives on applying learnings from studies.
- Lack of **holistic perspective** - both in terms of EDs and in terms of treatment.
- Minimal research on intersecting identities & implications.

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Key

RECOMMENDATIONS

- **Treatment:** Multifaceted approach to EDs and that involvement with psychological therapy, nutrition education, medical monitoring.
- **Medical professionals:** Better training, awareness of treatments, considerate of intersecting identities.
- **Community:** more research into dual role. Community connectedness (cognitive identification with community) and community participation (concreate behaviours) yield different results regarding impacts on disordered behaviours.
- **Therapists:** Integrated approach, considerations for long-term care, application of theory, better training.
- **Research:** More funding, diverse populations, consideration around intersecting identities, inclusivity of minorities, in-group differences.

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THANK YOU

FOR YOUR ATTENTION



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