American Journal of
Preventive Medicine

CURRENT ISSUES

Addressing Eating Disorders and Body Dissatisfaction in Sexual and Gender Minority Youth

Hilary B. Goldhammer, SM,[1] Essence D. Maston, PhD,[1] Alex S. Keuroghlian, MD, MPH[1,2,3]

INTRODUCTION

Despite a growing body of literature demonstrating higher prevalence of body dissatisfaction and eating disorders in sexual and gender minorities (SGMs), interventions tailored to address these problems in SGM youth are lacking.[1–3] As with many other behavioral and physical health disparities in SGM populations, disordered eating and shape control may occur in response to common experiences of discrimination and stigma based on sexual orientation and gender identity, and are influenced by sociocultural norms. This article aims to draw attention to the increased risk for, as well as potential contributors to, body dissatisfaction and eating disorders among SGM adolescents and young adults, and to share perspectives on how clinicians and public health programs can use this awareness to screen for, prevent, and treat these disorders.

The term *sexual minorities* (SM) is used to refer to youth who are attracted to people of the same gender or more than one gender, and *gender minorities* (GM) is used to refer to people whose gender identity is different than the sex assigned to them at birth. These terms, which are often considered more inclusive than the terms *lesbian, gay, bisexual*, and *transgender*, are used because an increasing number of young people no longer identify with traditional binary identities like straight and gay, or girl and boy.

Prevalence and Risk Factors

Body dissatisfaction and eating disorders among SGMs often first arise during the adolescent and young adult years, notably at the same time that youth are developing greater awareness of their sexual and gender identities. The higher prevalence of these disorders among SGM youth may best be understood within the framework of minority stress theory, which purports that chronic experiences of stigma, discrimination, and victimization based on SGM status create stressors that negatively influence behavioral and physical health.[4] Among SGM populations, these stress-producing experiences can begin at a very early age. For example, some SGM children receive intense pressure from their families to conform to traditional norms regarding gender expression; those who refuse to conform as adolescents may be forced out of their homes. Other SGM youth conceal their identities from their families and peers to avoid rejection.[5]

Schooling presents challenges for SGM youth as well. Even though bullying is experienced by many school-aged children, bullying and marginalization of SGM youth are disproportionately greater.[5,6] GM youth often experience harassment while using gender-specific restrooms, and many forego eating or drinking to avoid needing to use the restroom while at school or in public places.[7] Continuously managing these and other ongoing stressors can lead to the development of non-adaptive coping behaviors, like substance use disorders and sexual risk-taking, as well as disordered eating and weight or shape control.[3–5]

Eating disorders vary in prevalence and risk factors across different subgroups of SGM youth. Studies of males (most studies have not measured gender identities other than female or male) have consistently found a higher prevalence of eating disorder diagnoses and symptoms among SM males compared with heterosexual males. For example, a large sample of U.S. college students found that 2% of SM males reported having an eating disorder diagnosis or treatment in the past year compared with 0.55% of heterosexual males.[8] In a study of New York City men, 8.8% of SM males were classified as having had an eating disorder in their lifetime.[9] SM males are also significantly more likely to experience body dissatisfaction

From the [1]National LGBT Health Education Center at The Fenway Institute, Fenway Health, Boston, Massachusetts; [2]Massachusetts General Hospital, Boston, Massachusetts; and [3]Harvard Medical School, Boston, Massachusetts

Address correspondence to: Alex S. Keuroghlian, MD, MPH, National LGBT Health Education Center at The Fenway Institute, 1340 Boylston Street, Boston MA 02215. E-mail: akeuroghlian@partners.org.

0749-3797/$36.00
https://doi.org/10.1016/j.amepre.2018.09.011

compared with heterosexual males.[10,11] In a large online survey, 32% of SM males reported a low evaluation of their appearance versus 24% of heterosexual males.[11]

Explanations for the higher prevalence of eating disorders among SM males often point to gay cultural norms that emphasize physical appearance, especially musculature.[9] For some, achieving a highly muscular body is a way of counteracting the stereotype that gay men are weak or feminine.[12] Objectification theory also helps explain body dissatisfaction and associated behaviors among SM males, many of whom may believe they must achieve an ideal body in order to be sexually attractive.[13] Self-objectification can lead to binging, purging, fasting, and use of diet pills and laxatives.[9,12,14] Some SM males even perceive themselves as overweight, despite being of healthy weight or underweight.[14] Furthermore, adolescent SM males disproportionately misuse anabolic-androgenic steroids as a means to enhance musculature.[15] Reported lifetime prevalence of anabolic-androgenic steroid use among SM adolescent males is 14% to 21%[16,17]; usage among black and Hispanic SM males appears to be especially high.[17]

Contrary to sociocultural norms in the gay male community, lesbian community norms may lean towards greater acceptance of overweight bodies and non-traditional models of physical attractiveness.[18] Although SM females are more likely to be overweight or obese than non-SM females, SM females may see themselves as being of a healthy weight even when they are overweight or obese.[18] Still, SM adolescent females have three to four times the odds of engaging in excessive weight-control behaviors, such as purging and using diet pills, compared with heterosexual females.[19] One study found binge eating predicted obesity and being overweight in SM females.[20] Unhealthy food choices, lack of exercise, and binge eating among SM females are recognized as maladaptive coping mechanisms for societal discrimination. The cycle of binge eating and subsequent depression in SM females is often compounded by social isolation, suppression of sexual identity, and internalized homophobia.[3]

GM youth are more likely to be dissatisfied with their bodies compared with their non-GM peers.[2] Body dissatisfaction appears to be related not only to body parts that do not align with gender identity, but also to overall shape and weight. In response to dissatisfaction with their bodies and to societal disapproval of their gender nonconformity, some GM youth engage in disordered eating.[21] Treating pre-pubertal GM children with gonadotropin-releasing hormone agonists to suppress puberty, and then providing them with gender-affirming medical interventions in later adolescence, has been shown to increase body satisfaction and decrease eating disorders and depression. Pubertal suppression, however, may initially create body dissatisfaction for GM youth who are bothered by looking younger than their peers.[22]

SCREENING AND INTERVENTION

Early intervention in treating eating and related disorders in all young people is essential. By addressing these issues during high school or sooner, clinicians can help prevent downstream adverse effects on growth, bone density, and reproductive function. Given the magnified risk in SGM youth, it is important for clinicians to maintain awareness of the vulnerabilities in this population.

Pediatrics experts have published recommendations for screening children and adolescents for eating disorders in primary care settings.[23–26] Screening can also be integrated into HIV and sexually transmitted infection testing and treatment programs, as many SGM youth are already accessing these programs. In addition, clinicians should attend to potential SGM-specific stressors, such as social isolation, bullying, and family rejection. For SM males, clinicians can ask about anabolic-androgenic steroid use as part of substance use screening and can question patients regarding their feelings about conforming to stereotypes of idealized bodies. For transgender patients, discussions should be contextualized within the patient's goals for gender affirmation. Although the standard for reliable screening of adolescent eating disorders is to interview parents/caregivers as well as the patient,[25] strained relationships between SGM children and their parents may make this difficult. Referral to a program that improves family acceptance of SGM children may be a necessary first step.[27]

For SGM youth who screen positive for a possible disorder, it is important to refer them to behavioral health specialists who are known to provide affirming care for SGM youth. In areas with few skilled providers, it may be necessary to find a provider willing to access online or other training in providing affirming care for SGM people, such as from a free educational platform like www.lgbthealtheducation.org.

Treatment for SGM youth with eating disorders can be adapted from available evidence-informed interventions, such as family-based, dialectical, interpersonal, and cognitive behavioral therapies (CBT). To enhance effectiveness of these treatments, clinicians ought to attend to unique minority stressors and sociocultural factors that amplify risk among SGMs, such as those discussed in the previous section. For example, Pachankis[28] has proposed using minority stress treatment principles and techniques with patients to help them understand and modify negative thoughts related to stigma and discriminatory experiences.[28] The approach also aims to motivate patients to improve assertiveness

Table 1. Practice and Program Recommendations for Sexual and Gender Minority Youth

Recommendations
Talk to patients about their sexual orientation and gender identity; assess for minority stress by asking about life at school (peer acceptance, experiences of bullying) and at home (relationships with family members).
Screen SGM youth for body dissatisfaction, eating disorders, and anabolic steroid use as part of the primary care annual exam. Adapt screening questions for SGM youth by probing more about minority stressors, objectification of gay male bodies, and family relationships.
Involve parents/family members only after assessing for family acceptance of the patient's sexual orientation or gender identity. Seek help for family acceptance if needed.
Frame messages on weight loss or gain for GM youth in a way that affirms their gender identity and aligns with their goals for gender affirmation.
Refer patients to behavioral health providers skilled in working with SGM youth, as needed.
Use minority stress principles and approaches when treating SGM youth[28]; avoid using body dissatisfaction as a motivator for change.[25]
Add eating disorders screening to HIV and sexually transmitted infection testing and treatment programs that serve SGM youth.
Adapt evidence-informed interventions for SGM youth by applying minority stress approaches[28-30]; evaluate the effectiveness of the interventions.
Tailor obesity interventions for SM female youth by adding discussions of community norms about appearance and weight.
Create welcoming and inclusive healthcare environments for SGM youth by offering all-gender restrooms, training staff to communicate effectively with SGM populations, and having forms, policies, and materials that reflect the full range of sexual orientations and gender identities and expressions.

GM, gender minority; SGM, sexual and gender minority; SM, sexual minority.

in communication, tap into individual and community strengths, decrease avoidance, and use healthy expressions of sexuality. Although designed originally for SM males, this treatment approach can be applied to all SGM populations. Table 1 provides a summary of practice and program approaches.

Examples of CBT interventions that have been developed or adapted for SGM populations include an intervention by Blashill et al.[29] designed to improve body image and self-care in HIV-infected SM adult males. An RCT of this 12-session, manualized intervention showed preliminary efficacy in improving body image and HIV medication adherence after 3 and 6 months. Another intervention, ESTEEM (Effective Skills to Empower Effective Men), by Pachankis and colleagues,[30] consists of a ten-session CBT intervention that teaches minority stress-related cognitive restructuring and coping skills. In a preliminary study, this intervention significantly reduced depression, alcohol use, and sexual risk behaviors in young adult SM males.

Cognitive dissonance-based programs also show promise for preventing eating disorders in SM males. A 2015 preliminary RCT of the PRIDE Body Project©, a two-session, peer co-led group cognitive dissonance–based intervention adapted for young adult SM males from an existing program for females, demonstrated significant effects on eating disorder risk factors upon completion and at 4-week follow-up.[31] A larger clinical trial of this project began in 2018.[32]

With regard to addressing obesity in SM female youth, interventions can be tailored to recognize and explore lesbian community norms about appearance and weight. In addition, extra caution should be taken to dissuade young SM females from purging as a means of weight loss. In discussing weight loss or gain with GM patients, messages should be framed to affirm a patient's gender identity. Asking youth what words they use to describe their body parts and then using those words with them can help improve rapport and enhance engagement in treatment. It is also important to keep in mind that many GM youth are likely to value gender-affirming hormone therapy over issues related to weight gain, so finding a balance in terms of clinical focus and messaging is essential.

Finally, clinical environments that foster a welcoming, inclusive space for all SGM people will increase the likelihood that SGM youth will feel safe talking to providers about their sexual orientation and gender identity, as well as any issues with eating or weight and shape control. It is important to train all staff, including non-clinical staff, to communicate respectfully and effectively with SGM people by consistently using a patient's correct name and pronouns, and making no assumptions about behavior, identity, or relationships. Other critical aspects of affirming healthcare environments include offering all-gender restrooms, collecting information about sexual orientation and gender identity of all patients, using gender-inclusive language (e.g., "How may I help you?" rather than "How may I help you, young man?"), and having forms, policies, educational brochures, and promotional imagery that reflect a diversity of sexual orientations and gender identities.

CONCLUSIONS

Eating disorders and body dissatisfaction disproportionately affect SGM adolescents and young adults. Primary care clinicians, HIV program developers, and others who care for SGM youth, such as school-based nurses, are well-positioned to screen SGM youth and refer them to behavioral treatment early, before symptoms become disorders. Treatments for SGM youth, such as CBT, can be enhanced by applying minority stress treatment principles and approaches that take into account unique stressors as well as resilience of SGM populations. More data and research are needed to understand the epidemiology of eating disorders, body dissatisfaction, and other weight- and shape-control behaviors in the SGM population, however, this should not deter clinicians and interventionists from tailoring current evidence-informed behavioral health interventions to meet the needs of SGM youth.

ACKNOWLEDGMENTS

This work was supported by grant U30CS22742 from the Health Resources and Services Administration Bureau of Primary Health Care to Dr. A.S. Keuroghlian, the principal investigator, and by the Horace W. Goldsmith Foundation. The funders were not involved in the writing of the article or in the decision to submit the article for publication.

Author contributions: AK developed the original conceptual framework and provided clinical expertise. HG and EM conducted a literature review and wrote the text. HG edited the text. All authors reviewed the manuscript.

No financial disclosures were reported by the authors of this paper.

REFERENCES

1. Murray SB, Nagata JM, Griffiths S, et al. The enigma of male eating disorders: a critical review and synthesis. *Clin Psychol Rev.* 2017;57:1–11. https://doi.org/10.1016/j.cpr.2017.08.001.
2. Witcomb GL, Bouman WP, Brewin N, et al. Body image dissatisfaction and eating-related psychopathology in trans individuals: a matched control study. *Eur Eat Disord Rev.* 2015;23(4):287–293. https://doi.org/10.1002/erv.2362.
3. Calzo JP, Blashill AJ, Brown TA, Argenal RL. Eating disorders and disordered weight and shape control behaviors in sexual minority populations. *Curr Psychiatry Rep.* 2017;19:49. https://doi.org/10.1007/s11920-017-0801-y.
4. Hatzenbuehler ML, Pachankis JE. Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth: research evidence and clinical implications. *Pediatr Clin North Am.* 2016;63(6):985–997. https://doi.org/10.1016/j.pcl.2016.07.003.
5. Higa D, Hoppe MJ, Lindhorst T, et al. Negative and positive factors associated with the well-being of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. *Youth Soc.* 2014;46(5):663–687. https://doi.org/10.1177/0044118X12449630.
6. Birkett M, Espelage DL, Koenig B. LGB and questioning students in schools: the moderating effects of homophobic bullying and school climate on negative outcomes. *J Adolesc.* 2009;38(7):883–866. https://doi.org/10.1007/s10964-008-9389-1.
7. Wernick LJ, Kulick A, Chin M. Gender identity disparities in bathroom safety and wellbeing among high school students. *J Youth Adolesc.* 2017;46(5):917–930. https://doi.org/10.1007/s10964-017-0652-1.
8. Diemer EW, Grant JD, Munn-Chernoff MA, Patterson DA, Duncan AE. Gender identity, sexual orientation, and eating-related pathology in a national sample of college students. *J Adolesc Health.* 2015;57(2):144–149. https://doi.org/10.1016/j.jadohealth.2015.03.003.
9. Feldman MB, Meyer IH. Eating disorders in diverse lesbian, gay, and bisexual populations. *Int J Eat Disord.* 2007;40(3):218–226. https://doi.org/10.1002/eat.20360.
10. Morrison MA, Morrison TG, Sager CL. Does body satisfaction differ between gay men and lesbian women and heterosexual men and women? A meta-analytic review. *Body Image.* 2004;1(2):127–138. https://doi.org/10.1016/j.bodyim.2004.01.002.
11. Peplau LA, Frederick DA, Yee C, et al. Body image satisfaction in heterosexual, gay, and lesbian adults. *Arch Sex Behav.* 2009;38(5):713–725. https://doi.org/10.1007/s10508-008-9378-1.
12. Wilson BD, Harper GW, Hidalgo MA, et al. Negotiating dominant masculinity ideology: strategies used by gay, bisexual and questioning male adolescents. *Am J Community Psychol.* 2010;45(1–2):169–185. https://doi.org/10.1007/s10464-009-9291-3.
13. Wiseman MC, Moradi B. Body image and eating disorder symptoms in sexual minority men: a test and extension of objectification theory. *J Couns Psychol.* 2010;57(2):154–166. https://doi.org/10.1037/a0018937.
14. Hadland SE, Austin SB, Goodenow CS, Calzo JP. Weight misperception and unhealthy weight control behaviors among sexual minorities in the general adolescent population. *J Adolesc Health.* 2014;54(3):296–303. https://doi.org/10.1016/j.jadohealth.2013.08.021.
15. Murray SB, Griffiths S, Mond JM, Kean J, Blashill AJ. Anabolic steroid use and body image psychopathology in men: delineating between appearance- versus performance-driven motivations. *Drug Alcohol Depend.* 2016;165:198–202. https://doi.org/10.1016/j.drugalcdep.2016.06.008.
16. Blashill AJ, Safren SA. Sexual orientation and anabolic-androgenic steroids in U.S. adolescent boys. *Pediatrics.* 2014;133(3):469–475. https://doi.org/10.1542/peds.2013-2768.
17. Blashill AJ, Calzo JP, Griffiths S, Murray SB. Anabolic steroid misuse among U.S. adolescent boys: disparities by sexual orientation and race/ethnicity. *Am J Public Health.* 2017;107(2):319–321. https://doi.org/10.2105/AJPH.2016.303566.
18. Alvy LM. Do lesbian women have a better body image? Comparisons with heterosexual women and model of lesbian-specific factors. *Body Image.* 2013;10(4):524–534. https://doi.org/10.1016/j.bodyim.2013.06.002.
19. Austin SB, Nelson LA, Birkett MA, Calzo JP, Everett B. Eating disorder symptoms and obesity at the intersections of gender, ethnicity, and sexual orientation in U.S. high school students. *Am J Public Health.* 2013;103(2):e16–e22. https://doi.org/10.2105/AJPH.2012.301150.
20. Mason TB. Binge eating and overweight and obesity among young adult lesbians. *LGBT Health.* 2016;3(6):472–476. https://doi.org/10.1089/lgbt.2015.0119.
21. Testa RJ, Rider GN, Haug NA, Balsam KF. Gender confirming medical interventions and eating disorder symptoms among transgender individuals. *Health Psychol.* 2017;36(10):927–936. https://doi.org/10.1037/hea0000497.
22. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med.* 2011;8(8):2276–2283. https://doi.org/10.1111/j.1743-6109.2010.01943.x.
23. Rosen DS. American Academy of Pediatrics Committee on Adolescence. Identification and management of eating disorders in children

and adolescents. *Pediatrics.* 2010;126(6):1240–1253. https://doi.org/10.1542/peds.2010-2821.

24. Rome ES, Ammerman S, Rosen DS, et al. Children and adolescents with eating disorders: the state of the art. *Pediatrics.* 2003;111(1):e98–e108. https://doi.org/10.1542/peds.111.1.e98.
25. Campbell K, Peebles R. Eating disorders in children and adolescents: state of the art review. *Pediatrics.* 2014;134(3):582–592. https://doi.org/10.1542/peds.2014-0194.
26. McClain Z, Peebles R. Body image and eating disorders among lesbian, gay, bisexual, and transgender youth. *Pediatr Clin North Am.* 2016;63(6):1079–1090. https://doi.org/10.1016/j.pcl.2016.07.008.
27. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *J Child Adolesc Psychiatr Nurs.* 2010;23(4):205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x.
28. Pachankis JE. Uncovering clinical principles and techniques to address minority stress, mental health, and related health risks among gay and bisexual men. *Clin Psychol.* 2014;21(4):313–330. https://doi.org/10.1111/cpsp.12078.
29. Blashill AJ, Safren SA, Wilhelm S, et al. Cognitive behavioral therapy for body image and self-care (CBT-BISC) in sexual minority men living with HIV: a randomized controlled trial. *Health Psychol.* 2017;36(10):937–946. https://doi.org/10.1037/hea0000505.
30. Pachankis JE, Hatzenbuehler ML, Rendina HJ, Safren SA, Parsons JT. LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: a randomized controlled trial of a transdiagnostic minority stress approach. *J Consult Clin Psychol.* 2015;83(5):875–889. https://doi.org/10.1037/ccp0000037.
31. Brown TA, Keel PK. A randomized controlled trial of a peer co-led dissonance-based eating disorder prevention program for gay men. *Behav Res Ther.* 2015;74:1–10. https://doi.org/10.1016/j.brat.2015.08.008.
32. U.S. National Library of Medicine. ClinicalTrials.gov. The Pride Body Project (PBP). https://clinicaltrials.gov/ct2/show/NCT03451513. Accessed August 14, 2018.