# COULD IT BE AN EATING DISORDER?
# THE REALITY OF DIVERSE ED PRESENTATIONS

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## EATING DISORDERS - DSM CRITERIA

EATING BEHAVIOURS

- Persistent disruption of eating behaviours that results in the altered consumption of food, or persistent energy intake restriction e.g. restrictive eating, binge eating, inappropriate compensatory behaviours (AN, BN, OSFED)

BODY IMAGE DISRUPTION

- Disturbance in the way one's body weight or shape is experienced, fear of gaining weight, or self evaluation unduly influenced by body shape and weight. Restrictive or compensatory behaviours are intended to prevent weight gain

IMPACT

- Significantly impairs physical health and psychosocial functioning
- Marked distress around eating

SEVERITY

- Based on frequency of binge or compensatory behaviours, or weight for AN

## BIAS IN HEALTHCARE

**Stigma** occurs when an individual or group is viewed in a negative way or treated differently because of a particular characteristic they posses.

**Weight Stigma** refers to discrimination against people based on body weight and size. This stigma is a result of weight bias, which involves prejudicial attitudes and beliefs about people based on their weight.

Weight stigma in health professionals is associated with:

- Poorer patient-provider communication
- Loss of trust and rapport
- Decreased patient engagement in care
- Missed and delayed diagnosis, worsening outcomes
- Greater avoidance of healthcare

(Lee & Pause, 2016)

## WHY WE NEED A PARADIGM SHIFT

- Limited numbers of clients are seeking treatment- also impacted by bias and stereotypes
- Current treatments have been developed & researched on stereotypical presentations (one size does not fit all)
- Current treatment outcomes have limited & short-term efficacy
- We need an intersectional paradigm shift so we do no harm and increase access to support

# INTERSECTIONAL FORMULATIONS

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- Assess and treat the function of the ED within the societal systems- for each individual
- Eating disorders can provide a sense of control, meaning or avoidance when faced with structural and systemic disempowerment
- To assess for an ED need to be mindful of possible functions, in addition to symptoms and/or behavioural presentations

## GENDER

1. >30% of trans and gender diverse people screen positive for ED symptoms (Keski-Rahkonen, 2023)
2. 18% of trans young people reported an eating disorder diagnosis in the past year, which was significantly higher than cisgender young people (Duffy, Henkel & Joiner, 2019)
3. Significantly higher rates among trans men compared to trans women

## GENDER: UNIQUE ED FUNCTIONS

- Reduce gender dysphoria & associated distress
- Suppress secondary sex characteristics
- Numb or punish oneself associated with internalised transphobia & impacts on self-worth
- Meet cisnormative & gendered beauty ideals
- Pressure to 'pass' and be perceived congruently with gender identity for both authenticity and safety
- Compensate for lack of/ delayed/ reduced access to gender affirming care

## SEXUALITY

1. Lesbian, gay and bisexual adults have higher rates of EDs compared to their heterosexual peers (Parker, 2020)
2. 14% of gay men have been diagnosed with an ED (Nagata, Ganson & Murray 2020)
3. Cost of appearance ideals report showed highest body dissatisfaction amongst bi & other-sexuality identifying groups (KPMG Analysis, 2025)

## SEXUALITY: UNIQUE ED FUNCTIONS

- Heightened stereotypical gendered body ideals e.g. high muscularity for queer men
- Body ideals associated with specific queer sub-groups e.g. bear, twink, or for queer & bisexual people to meet multiple conflicting body ideals
- Perceived need to restrict/fast prior to some sex acts
- Potential for increased body comparisons with queer or same-sex partners
- Reduce internalised shame & anti-queerness, or to reject/ punish self
- Create sense of belonging, in the context of increased bullying and exclusion

## AGE

1. Among adults aged 40+ years, up to 7.7% of women and 1% of men met criteria for an ED (Mangweight-Matzek et al (2023)
2. In a systematic review of people aged 65+ years, 56.4% of EDs were reported as late onset (after age 40; Mulchadani et al., 2021

## AGE: UNIQUE ED FUNCTIONS

- Meet ageist beauty culture which centres youth & thinness
- In response to menopause in AFAB people- significant hormonal impacts on mental health
- Alter/reduce natural body changes with aging which are perceived as 'wrong or unhealthy'
- Reduce heightened fears around health, wellness and death
- Provide a sense of security during periods of change in roles e.g. children moving out of home, caring for elderly parents, relationship status changes, retirement

## NEUROTYPE

1. 70% of Autistic people can experience eating related challenges (Dickerson & Zickgraf, 2019)
2. 30-40% of people with EDs are Autistic (Inoue et al., 2021)
3. ADHDers have 3-6x increased risk of developing an eating disorder (Svedlund et al., 2017)
4. AuDHDers show highest rates of ED behaviours- both avoid & approach patterns

## NEUROTYPE: UNIQUE ED FUNCTIONS - AUTISM

- Genuine sensory preferences or aversions
- Interoceptive differences
- Eating rituals
- Movement for stimming or self-regulation
- Eating behaviours as masking or way to connect socially
- Diet/exercise as special interests

## NEUROTYPE: UNIQUE ED FUNCTIONS - ADHD

- Sensory stimulation/ to support focus
- Interoceptive differences
- Rebound eating following unintentional restriction or stimulant medication
- Executive functioning impacts e.g. forgetting to eat
- Dopamine & emotion regulation

## BODY SHAPE AND SIZE

1. <6% people w EDs are considered 'underweight', >50% of all people with an eating disorder are in larger bodies (Wong & Lowe, 2024)
2. Much higher prevalence rates are recorded for Atypical Anorexia Nervosa (20%) vs Anorexia Nervosa (1%) (da Luz et al., 2017)
3. Atypical AN associated with equal or more severe psychopathology compared to typical AN (Wong & Lowe, 2024)

## BODY SHAPE AND SIZE: UNIQUE ED FUNCTIONS

- Avoid or reduce discrimination from health professionals, loved ones and strangers
- Meet beauty ideals associated with thinness & muscularity
- Reduce distress associated with internalised anti-fatness or to reject/punish the body for being 'wrong'
- Access services that have systemic barriers e.g. surgery with BMI limits
- Beliefs re losing weight to improve comfort in body e.g. to reduce pain, increase fitness, promote body autonomy
- To feel a sense of belonging & inclusion
- Medically induced EDs following bariatric surgery

## RACE AND ETHNICITY

1. Large-scale studies have demonstrated that rates of all eating disorders are the same or higher among all racial and ethnic groups, including among Aboriginal and Torres Strait Islander peoples (Cheng et al, 2019, Burt et al., 2020)
2. Generally higher rates for binge/purge presentations among First Nations peoples
3. 28% of Indigenous high school students have an eating disorder compared to 22% of general population students (Burt et al., 2020)

## RACE AND ETHNICITY: UNIQUE ED FUNCTIONS

- Ongoing effects of colonisation, genocide and intergenerational trauma
- Racism at the core of anti-fatness, plus specific cultural beauty ideals
- Food scarcity, lack of food sovereignty & disruption to traditional food practices
- Material disadvantages e.g. financial, educational & health disparity
- Internalised racism and shame
- Enforced Western health (appearance) ideals at the expense of holistic and interconnected cultural wisdom

# PROVIDING AFFIRMING AND INCLUSIVE ED CARE

## SCREENING AND ASSESSMENT: 'COULD IT BE AN ED?'

- Always assess relationship with food, body and movement- regardless of presenting issue or intake form. Be mindful of assumptions & not selectively screening
- Many screening measures have not been designed, researched or validated among marginalised communities- be mindful of interpretation
- Importance of clinical assessment and individual formulation. Please refer on if this is not within your scope

## INCLUSIVE PRACTICE

- Collaborative & individualised formulation & treatment approach- cannot do 'one size fits all'
- Trauma informed, gender & neurotype affirming, weight inclusive etc
- Evidence-based treatment have not researched or validated on marginalised communities
- Evidence comes from listening to your clients = feedback informed therapy
- Know when to refer on safely

## HOW MIGHT TREATMENT LOOK DIFFERENT?

- Treat the function- not just behaviour change/cessation
- Moving away from narrow ideals of 'being recovered'
- Balancing clinician's & client's goals
- Harm reduction- avoids taking away someone's primary coping skills until they have others in place
- Acknowledgement & integration of intersectionality e.g. explicitly addressing weight stigma
- Advocacy for clients navigating systemic barriers e.g. supporting access to gender affirming care
- Therapeutic stance of humility, collaboration & client as the expert on their own lived experience

Table 1
LGBQ-Affirmative Principles of the Adaptation Model

| | |
|---|---|
| Principle 1 | Highlight how symptoms of depression and anxiety can be normal responses to minority stress |
| Principle 2 | Acknowledge how early and ongoing experiences with minority stress can teach sexual minority individuals powerful, negative lessons about themselves |
| Principle 3 | Empower sexual minority individuals to effectively cope with the unfair consequences of minority stress |
| Principle 4 | Help sexual minority individuals build supportive, authentic relationships |
| Principle 5 | Highlight sexual minority individuals' unique strengths |
| Principle 6 | Understand intersecting identities as a source of stress and resilience |

Proposed model for adapting existing evidence-based treatments designed to be broadly applicable across treatment modalities.
Could be adapted for different identities & intersections.

Pachankis et al (2023)

## ONGOING WORK

- Seek to learn directly from those with marginalised identities - 'nothing about us without us'
- Cultural humility & cultural safety (Boswell et al, 2025)
- Understand and take accountability for our own privilege and bias, via therapy and/or professional supervision

*"Awareness of the issue is not sufficient.*
*We must be held accountable for the potential harm of our actions and actively intervene at multiple levels if we hope to improve health equity and ED treatment."*

*(McEntee, Phillip & Phelan, 2023)*

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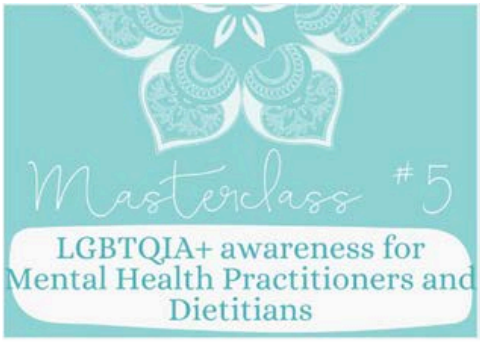
# Mind Body Well Professional Development and Supervision




## LGBTQIA+ Awareness

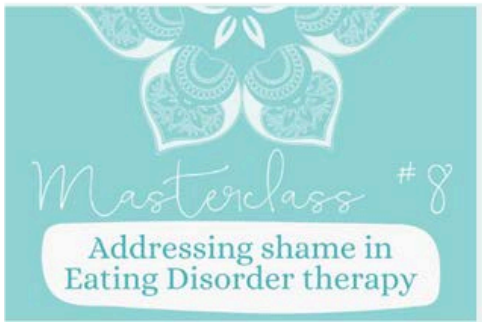
Masterclass #5 provides information for therapists to develop their understanding of issues relevant to working with clients from LGBTQIA+ communities, including language, identities, and issues of body expression. The webinar also focuses on the principles of inclusive, respectful care for clients with diverse perspectives.

**Presenter:** Tom Scully (Dietitian Team Leader), Mind Body Well

## Wellbeing not Weight

Masterclass #6 explores the concept of weight inclusive care, which prioritises equitable access to health care for all people regardless of body size. The webinar also focuses on alternatives to the dominant weight-centric heath paradigm, with a focus on weight stigma and weight bias.

**Presenter:** Janet Lowndes (Director and Principal Psychologist), Mind Body Well


## Addressing Shame in ED Therapy

Masterclass #8 provides an overview of strategies for addressing shame in Eating Disorder therapy, with a particular focus on self compassion and cognitive behavioural approaches. The webinar focuses on how shame can manifest, and how it can be directly targeted in therapy.

**Presenter:** Fran Beilharz (Clinical Psychologist), Mind Body Well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