EATING DISORDERS IN GENDER-DIVERSE POPULATIONS

Advocacy Toolkit

Contents

About this resource

This publication, designed for transgender people and their allies, is a short overview of strategies to effect change at the institutional, organizational, and governmental level. This resource should be considered an informational overview of terminology, data, and suggested best practices for creating change in access to quality eating disorder treatment.

Key Terms

Transgender – Describes a person who identifies as a gender other than the one that was predicted for them at birth.

Cisgender – Describes a person who identifies with the gender that was predicted for them at birth.

Intersex – Describes people who have chromosomal, gonadal, hormonal, or reproductive traits that differ from typical male and female characteristics.

Endosex – Describes a person whose physical traits are aligned with what is perpetuated as “normal” for male and female bodies.

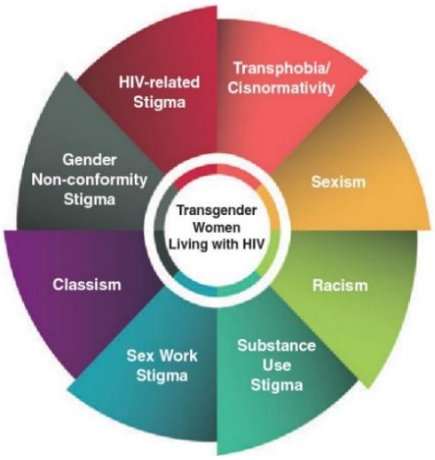
Eating Disorder – A mental health condition which impacts an individual's relationship with food and/or their body, which can contribute to, or be propagated by issues with physical health. Examples of eating disorders can include but are not limited to Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorders, ARFID (Avoidant Restrictive Food Intake Disorder), Pica (an abnormal desire to eat inedible items) and OSFED (other specified feeding or eating disorder).

Background

Eating disorders are health conditions that have a high mortality rate compared to other health conditions. While popular discourse depicts eating disorders as almost solely effecting white, cisgender, thin, heterosexual, affluent women and girls, data shows that **eating disorders disproportionately impact transgender people.** There is little evidence-base for what effective treatment looks like for any population, and even more limited information about which treatment approaches would be most helpful for transgender people. Additionally, **very few treatment centers have developed policies, treatment content, or admission criteria that is inclusive of transgender people.** Treatment is exceedingly difficult to access in general, as admission criteria is based on archaic diagnostic benchmarks. For people who have public insurance and/or are living in poverty, both of which are more common for transgender people, there are more barriers which prevent access to equitable care.

When examining the root causes of why treatment is inaccessible and often harmful, it becomes clear that there is a **lack of funding available for researchers to investigate effective and affirming treatment approaches for underrepresented populations.** Eating disorders have a high mortality rate that can be reduced with more intentionally focused research and care. Prevention and intervention can have lasting positive effects. By addressing the intersections of transphobia, fatphobia, ableism, and racism through research and practice, this multi-billion-dollar treatment industry can set a new standard for programs to be inclusive of and effective for *all* people. There is a workforce of people who are invested in identifying the most effective treatment methods. With the right support and attention, we can both fund and find solutions.

While there is a lack of research at this intersection, this is certainly a health equity issue. The research that exists about treatment outcomes in gender-diverse populations coupled with the lived experience of gender-diverse communities emphasize a need for improved care. Transgender young adults have elevated rates of compensatory behavior and a four-times increased rate of past-year eating disorder diagnosis (Diemer et al., 2015.) It has been shown that transmasculine people and transgender women of color have an increased risk for engaging in eating disorder behaviors when compared to people with other gender identities. Strive for thinness has served as an underlying attempt to suppress and/or accentuate features of one's self-identified gender. To that end, gender affirmative surgery has been shown to alleviate the severity of eating disorder symptomatology. Meanwhile, most surgeons who perform gender-affirmative procedures have strict BMI limits in place and encourage weight loss without screening for a history or presence of eating disorder behaviors. Intersecting stigmas such as HIV stigma, racism, transphobia, and classism can put people at greater risk for developing an eating disorder (Lacombe-Duncan, A., 2016.)



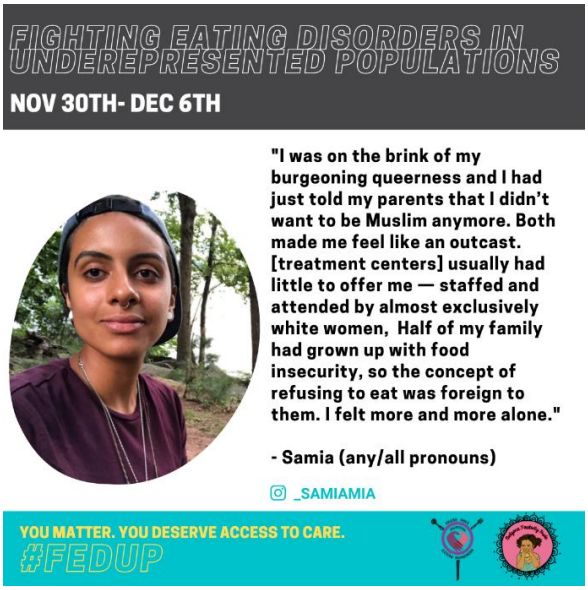
As rates of past-year non-suicidal self-injury, suicidal ideation, and suicide attempts are elevated in transgender people with eating disorders (74.8%, 75.2%, and 74.8%, respectively), there is a clear relationship between eating disorder pathology and suicidal ideation in transgender people (Duffy et al., 2019.) Emerging research has shown the inefficacy of treatment for eating disorders in transgender populations as being due to deficits in "clinician's gender competence, resulting in beliefs that treatment was ineffective, sometimes harmful" (Duffy et al, 2016**.) In a study of over 80 transgender youth, zero participants reported having a positive treatment experience.** It has also been found that gender affirmative medical intervention reduces experiences of discrimination which increases body satisfaction, thereby decreasing eating disorder symptomatology (Testa et al, 2017.) It is noted that bodily autonomy is essential to decrease gender dysphoria & eating disorder behaviors, "even if affirmation from the external world is unchanged." Eating disorders are negatively impacted

by fatphobia, diet culture, colonization, eurocentrism, racism, poverty, our carceral systems, and trauma. Transgender people tend to experience these oppressions more often which are perpetuated within the eating disorder treatment field. Transgender people deserve access to quality care.

What kind of advocacy is needed for equitable treatment?

In order to improve the health disparity that exists between transgender people and cisgender people with eating disorders, public education, provider education, equitable access to treatment, and more funding for research are necessary. There are several approaches that can be taken in advocacy for equitable treatment.

- *Organize: Build power as a coalition.* A group of clinicians, advocates, researchers, and supporters of people with eating disorders have come together to intentionally divest from popular eating disorder organizations that continue to perpetuate both overt and covert harm.
- *Educate legislators: Emphasize the importance of legal mandates.* The Eating Disorder Coalition (EDC) regularly advocates for legislative policy changes at the national level. The fight for Medicare to cover more levels of care has been ongoing for several years, as well as extending treatment benefits to veterans. EDC publishes fact sheets annually that show were public officials stand on each legislative effort. Additionally, at the statewide level, there is a bill in New York that was passed and then vetoed which would have required all insurers in the state to cover every level of care (outpatient, intensive outpatient, partial hospitalization, residential, and inpatient.) Putting pressure on Governor Cuomo may be helpful. Anybody can meet with a legislator or their staff by contacting their office and asking for an appointment. Your voice matters!



- *Educate the public: use social media as a tool.* Advocates, researchers, people with lived experience, and clinicians all use social media to connect with one another, capacity build, and have their voices heard. **Hashtags can serve as a powerful tool to create a cohesive narrative around certain issues.** For example, #WeAreFEDUP was used to run a social media campaign in the Fall of 2020 to indicate that people of underrepresented populations were aggravated with not having access to adequate treatment or being included in discourse around who eating disorders impact.
- *Research: Advocate for funding towards Eating Disorder research in transgender populations.* Currently, for every person impacted by an eating disorder in the United States, $.93 is devoted to research focusing on all aspects of eating disorder epidemiology and care. A total of $28 million per year is given towards eating disorder research, meanwhile $505 million (18x) is given towards alcoholism research, $328 million (12x) is given towards Depression research, and $105 million (4x) is given towards Attention Deficit and Hyperactivity Disorder (ADHD) research.
- *Organizational Advocacy: Put pressure on eating disorder institutions.* The focus of advocacy within organizations is to encourage treatment facilities and professional organizations to update their policies so that care for all is prioritized. This can be non-discrimination policies for clients and employees, admission criteria for clients, or funds required from employees for professional organization memberships.
- *Trainings and Conferences: Host an event.* **You do not have to be an expert** to host an event that calls attention to the health inequities in the eating disorder field. Embody Carolina, an advocacy group in North Carolina, hosted a comedy fundraiser called “Eating Disorders Aren’t Funny” which was presented by transgender people to call attention to the health disparities that exist. If you have lived experience, you can think about doing a live chat on social media with another advocate to share your story. Personal insight goes a long way!

Health Effects

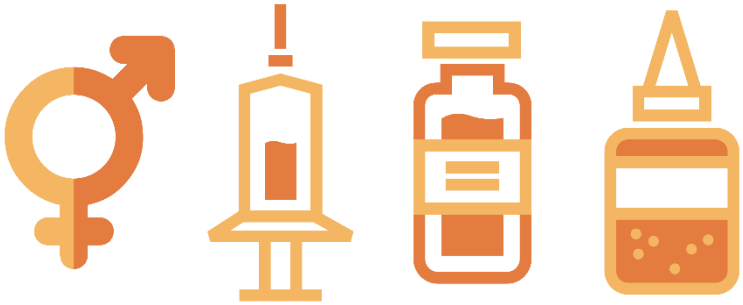
Health effects occur with all eating disorders regardless of the person's size, shape, weight, or Body Mass Index (BMI.) **An individual's BMI is not an indicator of health.**

Common possible symptoms of eating disorders may include restrictive eating, compensatory behaviors (i.e., purging, overexercising, laxative use), chewing & spitting out food to avoid consumption, binge-eating, avoidance of specific food ingredients or macros without any medical reason, fear of weight gain, distorted body image, denial of severity, changes in social activity, wearing baggy clothes to conceal one's body, heightened PTSD symptoms, and heightened OCD symptoms.

Bodily health effects of eating disorders may include emaciation, anemia, lanugo, scurvy, infertility, esphageal tears, cardiac arrythmias, cognitive changes, organ failure (especially the heart and kidneys), malnutrition and electroyle imbalances, low blood pressure & orthostatic vitals, bowel disturbances (including obstructions), swollen lymph nodes, dental decay, gastric reflux, dehydration, bone density loss, and hormonal abnormalities (such as delayed puberty or lack of hormone production.)

Health Effects in Transgender People

Transgender people who use exogenous hormones for medical transition may be at a higher risk for certain medical complications. This includes estrogen which can lead to phosphorous deficiency and requires close monitoring to assess for refeeding syndrome, which leads to electrolyte imbalances. Additionally, sprinolocatone is another exogenous hormone prescribed to transgender people and can cause excessive urination, dizziness, and lightheadness which warrants close monitoring of blood pressure and hydration levels. Potassium should also be monitored due to elevations associated with hormone regimens.



Lack of hormone synthesis is a point that should be discussed with transgender people who are using their eating disorder to navigate through the distress of gender dysphoria. If a transgender person is restricting their eating or experiencing malnutrition while complying with a hormone regimen and not seeing results, health education should be provided about the necessity of the body having the tools it needs to synthesize the hormones taken.

If a client who is living in an area without access to affirming health care providers and vocalizes a desire to undergo hormone therapy to alleviate gender dysphoria, subscription services like Folx Health and Plume can be helpful resources. Fenway Health and Callen Lorde are excellent resources for further information on effects of hormone replacement therapy, including a timeline for expected changes and which effects of hormones are reversible versus irreversible.

Demographics Impacted

Eating disorders do not discriminate. They can impact anybody regardless of identity.

Non-binary people often restrict due to the thin body ideal perpetuated by the media of what an androgynous body looks like. Additionally, transgender college students report experiencing disordered eating at approximately four times the rate of their cisgender peers. **56% of transgender people believe their eating disorders are not related to their physical body**, combatting the idea that gender dysphoria is the cause of eating disorders and that alleviating gender dysphoria through transition will also prove to terminate eating disorder symptoms (Mulheim, L., 2020.) However, 32% of transgender people have reported using their eating disorder to modify their body in the absence of gender-affirming medical intervention (Duffy, et al., 2016.) About one-fourth of over 1,000 transgender respondents to The Fat Census reported being misgendered due to their size as well as being denied hormone replacement therapy or gender-affirming surgery (Shackelford, 2017.) **Both the rates of eating disorders and rates of denying medical care based on BMI are thought to be vast underestimates in gender-diverse communities, likely due to how these research questions are being asked.** Black, Indigenous People, and People of Color (BIPOC) folks are less likely to be screened for eating disorder symptoms and are half as likely to be diagnosed or receive treatment (Becker, A.E., et al., 2003.) This is compounded for transgender BIPOC folks. Additionally, 20-30% of adults with eating disorders also have autism (Solmi, F., et al., 2020.) With autism being more prevalent in the transgender community, this is a notable intersection.

Cost to Healthcare System

When focusing on cost to the healthcare system, it is important to look at the cost to medical institutions, taxpayers, and those who are directly impacted.

Inpatient stays for eating disorders were found by Owens et al. (2019) to be **the costliest at a hospitalization cost of $19,400 per admission** and longest type of stays for mental and substance use disorders, with an average length of stay of 13.6 days. This compared to costs of $8,900 for schizophrenia, and $8,800 for alcohol-related disorders. The below findings are from The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders (Deloitte Access Economics, 2020.)

Key findings

- The total health system costs associated with EDs in the US were estimated at $4.6 billion in 2018 19. OSFED accounted for the largest share of costs ($1.5 billion), followed by BED ($1.2 billion), AN ($1.1 billion), and BN ($0.8 billion). The estimated average cost per person was highest for individuals with AN ($2,615), followed by those with BN ($1,335).
- Overall, the total costs of EDs outside the health system was estimated to be $60.2 billion in the US in 2018-19, or $10,977 per American with an ED. Including health system costs, the financial costs of EDs in 2018 19 were estimated to be $64.7 billion, or $11,808 per person with an ED. The largest share of these costs was accounted for by OSFED ($22.8 billion, or 35%), followed by BED ($19.4 billion, or 30%), BN ($11.4 billion, or 18%) and AN ($11.2 billion, or 17%).
- Productivity losses for people with EDs were estimated to be $48.6 billion. Of the productivity losses, reduced employment accounted for $15.2 billion (31%), and premature mortality, absenteeism and presenteeism accounted for $8.8 billion (18%), $6.4 billion (13%) and $18.2 billion (37%), respectively (Chart 4.2). Of the total productivity costs, 37.9% was borne by individuals, 28.6% was borne by government and 33.6% was borne by employers.
- The total cost of informal care due to EDs was calculated to be $6.7 billion in 2018-19, which equated to an average annual cost of $1,228 per person with an ED. Efficiency losses were estimated at $4.8 billion, or an average annual cost of $875 per individual with an ED in 2018-19.

Current State of Eating Disorder Treatment

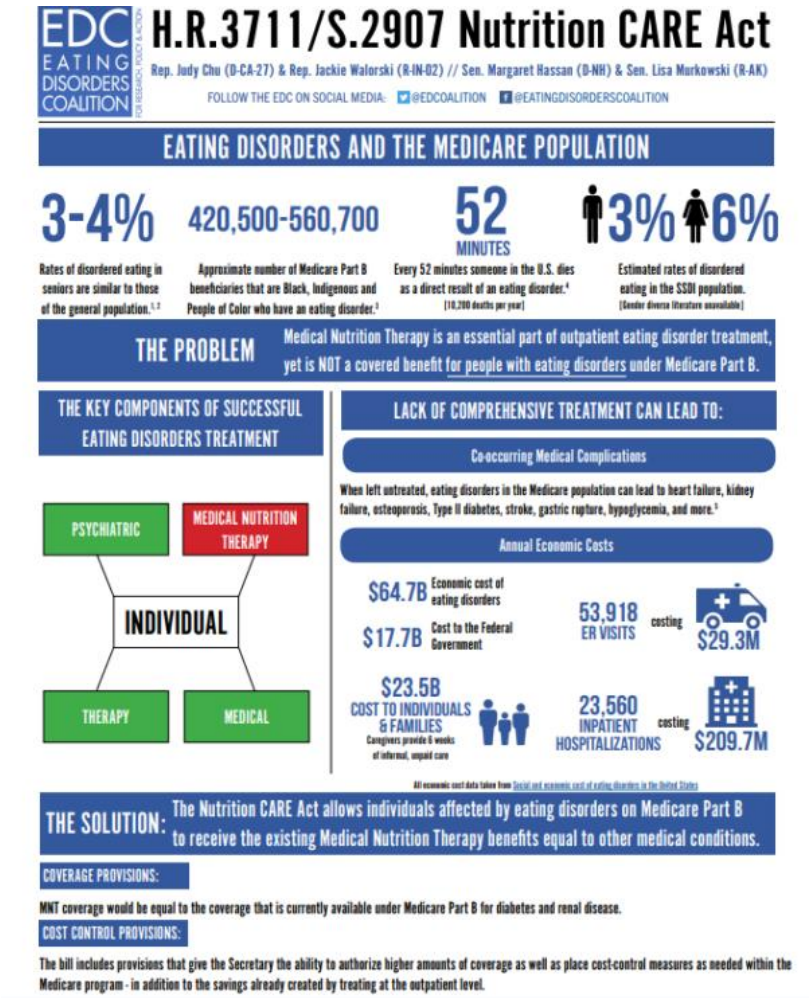
The Eating Disorder treatment industry is comprised of outpatient, intensive outpatient, partial hospitalization, inpatient, and residential levels of care.

- Access Issues
  - Many treatment centers do not have accessible spaces for people with visible or invisible disabilities. Additionally, many are poorly equipped to care for people with multiple conditions, such as PTSD or Autism.
- Admission Criteria
  - **Admission criteria is ableist, classist, and outdated.** Typically, a person's body weight and BMI are considered to determine if they are eligible for treatment according to the treatment facility and/or insurance company. Additionally, most treatment facilities do not accept public insurance which is common among people who are living in poverty.
- Lack of inclusivity
  - Treatment centers typically provide group and individual therapies. Group therapy does not ordinarily consider intersectional approaches. **Gendered language used in treatment is often binary with a bias towards words like "women" and "girls."**
- Treatment Approaches
  - For youth in particular, family-based therapies and the Maudsley Method are often promoted. This can be an issue for transgender youth who do not have supportive family of origin.
- Institutionalization
  - In most cases, inpatient care is considered psychiatric hospitalization regardless of the primary focus being nutritional rehabilitation. As such, patients relinquish their rights to discharge upon admission. There are inherently **power & privilege imbalances** in this model of care where the course of treatment is directed by staff and lack of adherence is punished by removing contact with loved ones.
- Aftercare
  - Most treatment centers do not check to see if the referrals they use are culturally sensitive to transgender people. Additionally, there are a lack of resources for people on Medicare & Medicaid beyond the inpatient setting.

Policy Environment

Under-diagnosis is a systemic issue caused by there being no mandatory education for health care providers on how to screen for eating disorders properly as well as what risk factors are for developing eating disorders. Lack of access to interventions at the appropriate level is related to policy around Medicare and Medicaid, which more transgender and intersex people use for insurance than cisgender people due to increased disability & poverty rates in the transgender and intersex communities. These insurances typically only cover an inpatient level of care and the admissions criteria for inpatient usually require that the patient be clinically underweight and suffering from medical complications. This leaves little to no opportunity for aftercare or proper discharge planning, which leads to repeated relapse. All of this ends up costing the government more money. Which would be less burdensome, paying for three months of residential at $90,000 or paying for five inpatient stays at $120,000 each? The policy in place does not make any sense. **These relapses cost the individual and the government more money and put further pressure on admissions. When three months of residential costs $90,000 and *each* inpatient stay costs $120,000, the policy in place should be reconsidered to meet the needs of patients and to provide relevant care that is sustainable upon discharge.**

The Nutrition CARE act has been in committee for two years at the federal level. This bill would require dietetic services to be covered for Medicare recipients. The New York State Senate and Assembly passed a bill (S4929/A4929) that would have required all levels of care to be covered within New York State. This would be an incredible piece of legislation if passed, but Governor Cuomo vetoed it. Lobbying can continue by putting pressure on Governor Cuomo to reverse his veto.



The policy battlefield is likely best suited to be statewide in terms of comprehensive eating disorder care. New York is a progressive state which should be a lobbying advantage in encouraging representatives to vote in the affirmative, ultimately setting the bar for other states to follow suit. **At least 1 in 10 people experience an eating disorder at some point in their lifetime and at least one person dies from an eating disorder every hour.** Policy changes are crucial.

Organizational Policy

Example: Center for Discovery – Director of Gender Affirming Care
Example: Renfrew – Empowering adolescent girls and women to change their lives

Eating disorders are severely debilitating, all-consuming, dangerous health conditions that put affected people in jeopardy of malnutrition, increased risk of suicide, hypokalemia, and cardiac abnormalities. There are over 250 treatment facilities in a multi-billion-dollar industry in the United States focused on helping people with eating disorders – particularly the 9% of cisgender and white people who have been surveilled as having an eating disorder at some point in their life. There is a lack of data about eating disorders in transgender people. The bulk of research centering transgender people with eating disorders focuses on transgender youth. It has been found that transgender youth experience eating disorders at four times the rate of their cisgender peers, with that percentage rising when including transgender people of all ages. Greater than 99% of evaluations assessing the efficacy of clinical interventions only look at "females", typically under 30 years old. How can we know if these clinical interventions are effective for transgender people if transgender people do not meet inclusion criteria for such studies? Additionally, fat people are often excluded. According to The Fat Census, published by Free Figure Revolution, 24% of transgender people reported being denied HRT, 26% of transgender people reported being denied surgery, and 79% of fat people contemplate suicide. There are policies attempting to be passed that have the potential to be explicitly harmful to transgender people – from anti-transgender health bills (140 currently being debated) to a push by Harvard STRIPED Lab to pass legislation prohibiting the sale and use of liquid silicone for cosmetic injections, ultimately impacted transgender women disproportionately.

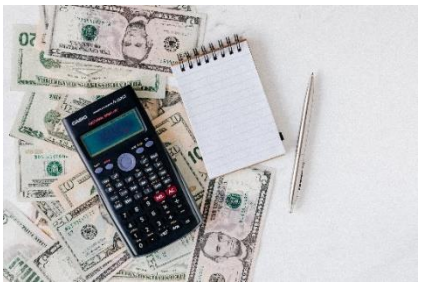
One might ask, "why are eating disorders so prevalent in the transgender community?" There is myriad of reasons. Fear of violence, discrimination, and lack of safety in public spaces (i.e., work, school) may lead to avoidance of eating in public spaces, desire to be physically strong or try to not be seen, or shame and danger associated with not being perceived as their identified gender. There are restrictive Body Mass Index limits for most gender-affirming surgeries, despite there being evidence that points to those who are underweight being more at-risk for complications. In rural areas, transgender people may experience isolation from queer community and utilize their eating disorder as a coping mechanism. Gender dysphoria (discomfort or distress related to the self-perceived gendered appearance of one's body) coupled with body ideals that are perpetuated due to cissexism, ableism, and Anglo beauty standards have an impact on how safe and affirmed transgender people feel moving through the world. For those who struggle with suicidal ideation, an eating disorder can serve as a "slow suicide" – self-harm without obvious scars. In many places, it is legal for health care workers to discriminate against transgender people, and in places where it is illegal, most health care workers do not receive training in how to best attend to the needs of transgender people. This encourages transgender people to avoid seeking treatment and to avoid being honest about their behaviors with food and/or body. When there is a lack of acceptance from family members, dating partners, or others in the community, transgender people may manipulate their bodies to achieve what they perceive to be love. Of course, in the age of social media, we are inundated with gendered eating, exercise, and body expectations. This can negatively impact transgender people who have a body size or shape that is deemed atypical by wider society. According to the United States Transgender Survey, transgender people experience higher rates of financial insecurity, employment discrimination, and housing discrimination. This can greatly impact the ability to afford food and gender-affirming medical intervention. Lastly, identity erasure (not seeing transgender people reflected in a positive light in popular media) can be exhausting and disenfranchising. Even when a transgender person desires to and can access hormones, they cannot pick or choose which changes happen and when which is inherently destabilizing.

"For some binary and nonbinary people, there is no desire to pass, beyond the necessary need to do so at times to survive…This challenges cisnormative ideas of what it means to be beautiful. But challenging what beauty means has never been an easy task. I can't count the number of times I've been called a 'monster,' an 'it,' ugly, etc. I can, however, count the number of times I have been seen as desirable. I needed something to hold on to, to give me the ability to say I am desirable and worthy and loveable, setting the stage for my then disordered eating to morph into an eating disorder."
- Alithia Skye Zamantakis (they/them)

What can be done to address this public health issue and protect the valued lives of transgender people? The eating disorder industry must first and foremost listen to the needs expressed by transgender people. Oftentimes, impacted populations know what feels affirming for them. There are also transgender clinicians and collectives who provide training to all types of health care providers. Below are ten action items that must be incorporated into organizational policy going forward:

1. Accessibility – many treatment centers are inaccessible to wheelchair users, autistic people, Deaf people, and people with other disabilities. Most treatment centers are still "women-only" with invasive requirements for admission (i.e., genital exams) and rooming situations do not feel always feel safe if going by expressed gender (i.e., a transgender man rooming with a cisgender man.)
2. Coming out by force or being outed to other patients and staff happens frequently. This is an invasion of privacy and can put the client in danger of harassment or other harm. Always ask a transgender client what their preferences are with regard to disclosing their gender identity.
3. There is a lack of transgender staff coupled with uneducated therapists/support staff who participate in microaggressions and misgendering. Hire transgender people and people with other minoritized identities and pay them equitably. Require transgender competency training on a regular basis.
4. In most treatment settings, there is a lack of access to gender-affirming supplies (hormones, clothing, makeup, shaving.) Ensure that hormones are carried in your pharmacy and that the treating physician makes written allowances for transgender people to attend to their personal grooming needs. Require that all staff be informed of these allowances.

5. Brochures only featuring white/cisgender appearing models are isolating, as well as the use of binary gendered language and no explicit statements about cultural competence Include these things in marketing materials, but only if you have the capacity to follow through in the treatment setting.
6. Most transgender people with eating disorders are given an automatic diagnosis of gender dysphoria which leads to pathologization and ineffective treatment approaches. Only diagnose someone with gender dysphoria in an eating disorder treatment setting if they meet the criteria and recognize that gender dysphoria and eating disorder symptomatology need to be addressed alongside one another.



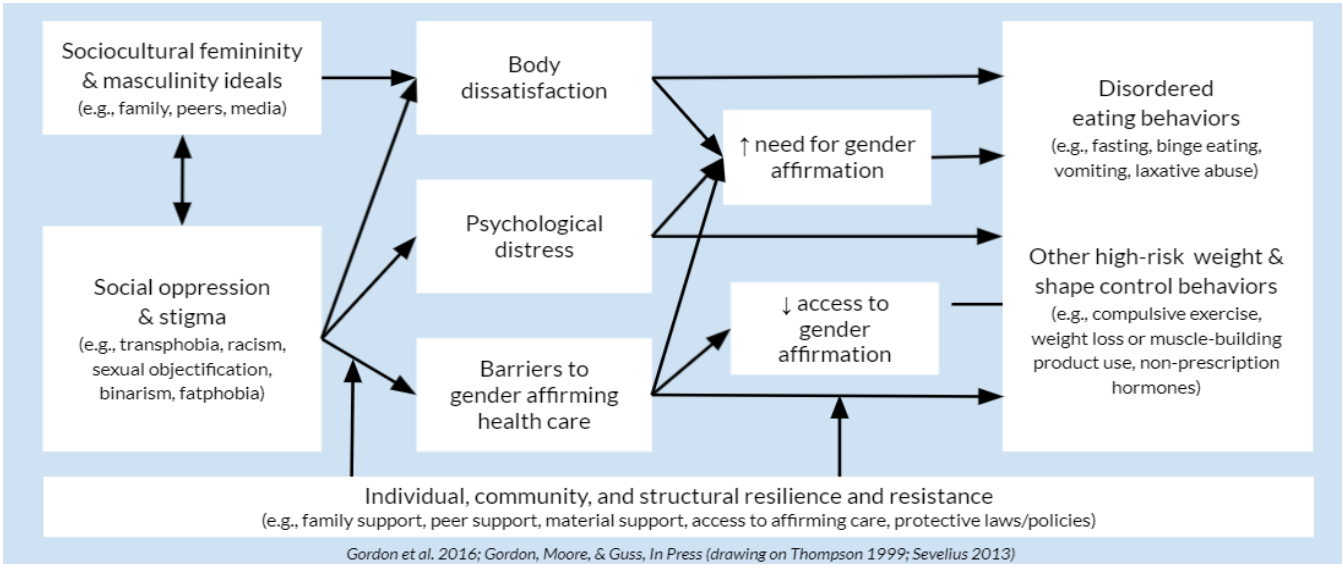
7. Treatment cost is a prohibitive factor for most transgender people. A high percentage of transgender people are enrolled in Medicare and Medicaid or experience financial instability. Sliding scale is often still out of budget and community organizations which supply scholarships are underfunded. Commit to contracting with Medicare and Medicaid, even if reimbursement will be lower. Create scholarship opportunities within your program. Have a list for your clients of resources for food aid and housing assistance.
8. Lack of family support can negatively impact a transgender person's experience as a patient, largely due to the way programs are structured (family groups, Maudsley Method, Family Based Therapy.) Involve chosen family whenever possible and resist requiring transgender clients to attend groups in which they would feel excluded.
9. Historical trauma is often present for transgender people, particularly transgender people of color. This can impact their trust in authority/people with power in medical environments. Pursue training on trauma-informed approaches to care.
10. When patients are discharged, aftercare can sometimes fall wayside, especially for transgender people with Medicare of Medicaid. Ensure that you have a referral list of affordable trans-competent providers to best support your clients.

The overarching advocacy objective is to create more inclusive and accessible treatment environments, improve health care provider competency, and increase awareness about this health disparity. Potential partners for advocacy include the Eating Disorder Coalition, Senator Alessandra Biaggi, Alliance for Eating Disorders, the National Eating Disorder Association, Center for Discovery, and Eating Recovery Center.

Key communication activities can include capacity and coalition building via social media campaigns, distribution of the advocacy toolkit, meeting with state legislators, and forming additional partnerships with social justice oriented eating disorder treatment centers.

Framing

In advocating for equitable access to eating disorder care for transgender people, framing is an important element of an impactful message. It is important to understand that eating disorders in transgender people are a result of social oppression, gendered body ideals perpetuated by patriarchy & colonization, trauma, biologic predisposition, and psychological distress. Protective factors include strong support systems, access to resources, and non-discrimination policies. Below is a chart showing pathways to eating disorder pathology.



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Roles, Responsibilities and Timeline

To create effective change, multiple activities need to occur simultaneously. This will help reach the most amount of people who have the power to change the eating disorder landscape for transgender people. While this advocacy work technically does not require funding, applying for grants or buy-in from investors can be resources worth exploring. Examples of activities include contacting eating disorder treatment centers for commitments to reform their policies and practices, meeting with state and federal legislators, and emphasizing the need for training programs for all health care providers.

Deliverables

A variety of approaches can be taken to effect change.

Coalition Building

Divestment from eating disorder institutions and organizations that cause harm *can* happen if enough professionals in the field understand anti-racist and trans- affirming praxis. Part of this movement work is a commitment to #DropIAEDP, or not renew the certified eating disorder specialist credential as a means to show the International Association of Eating Disorder Professionals dissent from their current organizational structure.

Direct Action

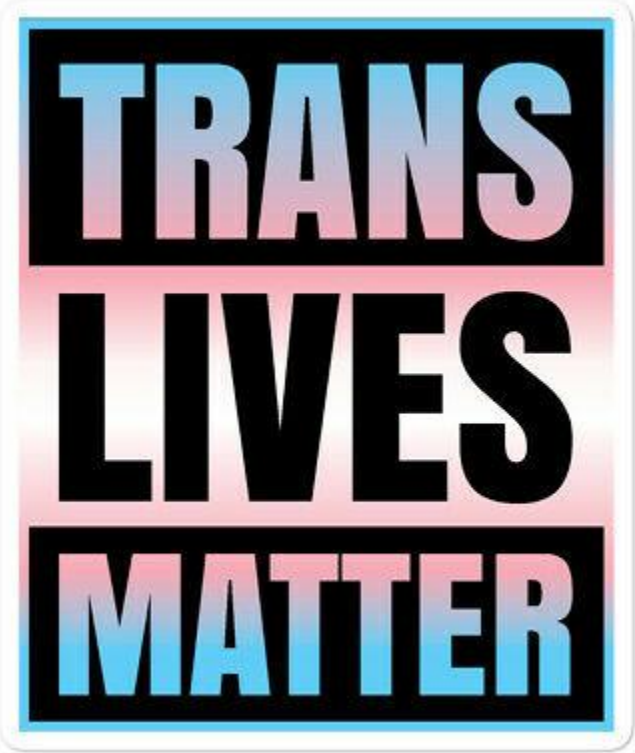
While call-out culture has been given a negative reputation by the far-right, when eating disorder organizations, institutions, or independent providers refuse to unlearn harmful behaviors, call outs and call ins can be an effective tool and providing an impetus for change.

Scripts

-  Eating Disorders impact transgender people disproportionately. Learn more at fedupcollective.org
-  Did you know that transgender people experience eating disorders at elevated rates? Find out how you can give or receive help at fedupcollective.org
-  Did you know that eating disorders impact more people than just cisgender, white, affluent women and girls? #WeAreFEDUP with the false popular narrative that is pushed upon us by large eating disorder organizations and popular culture.
-  My name is _____ and I live in _____. I am concerned about the lack of funding available for eating disorder research. Eating disorders are the most common mental illness, second to opioid addiction. Yet, eating disorder research is severely underfunded and the vast majority of treatment options that exist are for-profit. For an illness that takes so many American lives each year, I am asking that you consider earmarking additional funds for eating disorder researchers – particularly looking at eating disorders in underrepresented populations. Please look at the data – I assure you that you will find that this area of public health has been neglected for some time. I appreciate your attention. Thank you, _____.

Takeaways

- Eating Disorders are public health and social justice issues that disproportionately impact transgender people.
- The eating disorder industry is for-profit and capitalizes on the continued relapse of those they serve.
- Gender dysphoria is often a factor in the transgender experience of an eating disorder but is not typically the primary cause.
- Societal gender norms cause harm to transgender people in influencing perception of their bodies as “faulty.”
- There are ways to improve the current state of eating disorder treatment through inclusive treatment policies.
- Divestment from harmful eating disorder institutions and organizations makes a difference.



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