Eating Disorders

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Overview of Eating Disorders

Eating disorders (EDs), which include anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), are serious psychological, medical, and public health issues (Smink, van Hoeken, & Hoek, 2012). EDs are linked with chronic duration and a wide variety of medical complications including bone loss, gastrointestinal issues, and nutritional abnormalities (Mitchell & Crow, 2006). EDs are also linked with substantial psychosocial impairment and comorbid psychopathology (Smink et al., 2012).

There are a number of risk factors that have been associated with the development and maintenance of eating disorders including body dissatisfaction, perfectionism, and weight stigma. Body dissatisfaction, which is conceptualized as negative cognitions, subjective perceptions, and overevaluation of body shape, size, and weight, is considered central in the development and maintenance of ED pathology (American Psychiatric Association, 2013; Fairburn, 2008). Notably, individual perceptions of body image and dissatisfaction with one's body have been shown to contribute to ED pathology (Perez & Joiner, 2003). Similarly, perfectionism has been shown to be an influential risk factor for the development of AN and BN (Chang, Ivezaj, Downey, Kashima, & Morady, 2008; Hewitt, Flett, & Ediger, 1995). In addition, perfectionism has been found to strengthen the relationship between body dissatisfaction and ED pathology (Welch, Miller, Ghaderi, & Vaillancourt, 2009). Like body dissatisfaction and perfectionism, weight stigma is associated with the development of ED pathology (Puhl, Moss-Racusin, & Schwartz, 2012). Weight stigma is defined as negative or stigmatizing attitudes toward and discrimination against individuals perceived to carry excess weight or fat (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). Weight stigma is experienced in a variety of domains and often consists of verbal bias, such as negative comments, insults, etc. (Brochu & Morrison, 2007; Puhl et al., 2008). While weight stigma is more commonly experienced by individuals with perceived overweight or obesity, research suggests that weight stigma actually occurs across most weight categories (Puhl, Peterson, & Luedicke, 2013).

Currently, there are a number of established evidence-based treatments for EDs. However, these evidence-based treatments have been largely developed for the treatment of EDs in White female populations, and as such, their validity and utility with racial/ethnic minorities, males, and LGBT individuals are unknown (Smolak & Striegel-Moore, 2001). Nonetheless, for AN there are strong research support for family-based therapy (see Bulik, Berkman,

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Brownley, Sedway, & Lohr, 2007; Couturier, Kimber, & Szatmari, 2013 for a review) and modest research support for the use of cognitive behavioral therapy for post-hospitalization relapse prevention (Pike, Walsh, Vitousek, Wilson, & Bauer, 2003). For BN, there are strong research support for cognitive behavioral therapy and interpersonal therapy (Hay, Bacaltchuk, Stefano, & Kashyap, 2009; Spielmans et al., 2013) and modest research support for family-based therapy (Le Grange, Crosby, Rathouz, & Leventhal, 2007). For BED, there is strong research support for cognitive behavioral therapy and interpersonal therapy (Iacovino, Gredysa, Altman, & Wilfrely, 2012; Wilson, Wilfley, Agras, & Bryson, 2010).

Historically, ED pathology has been largely characterized as culture-bound and conceptualized as primarily affecting middle- and upper-class Caucasian females in the USA (Striegel-Moore & Bulik, 2007). Among Caucasian samples, nationally representative epidemiological research indicates that lifetime prevalence rates are 0.60% for AN, 1.00% for BN, and 2.80% for BED in the USA (Hudson, Hiripi, Pope, & Kessler, 2007). However, more recent research indicates that ED pathology occurs across a wide variety of populations. For example, research shows that EDs occur among racial and ethnic minorities in the USA (Alegria et al., 2007; Marques et al., 2011; Taylor, Caldwell, Baser, Faison, & Jackson, 2007), among males (Striegel-Moore et al., 2009), LGB (i.e., lesbian, gay, bisexual) individuals (Austin et al., 2009; Austin, Nelson, Birkett, Calzo, & Everett, 2013; Katz-Wise et al., 2015), and transgender individuals (Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015).

Work to assess the prevalence of ED pathology across diverse demographic groups is of great importance and utility (e.g., Austin et al., 2013; Schaefer et al., 2018; Striegel-Moore et al., 2009). However, there are significant challenges to conducting research on minority populations with eating disorders. First, eating disorders have lower base rates when compared to other mental disorders such as depression, anxiety, or substance use. Further, due to stereotyped beliefs regarding populations affected by EDs, the etiology of EDs has been largely conceptualized using White, middle- to upper-class females (Striegel-Moore & Bulik, 2007). This narrow conceptualization of EDs may contribute to inaccurate nosology informing current diagnostic guidelines for EDs across diverse populations. Additionally, many studies exploring prevalence rates of EDs lack sufficient power to accurately detect ED subtypes. Finally, racial/ethnic minorities in the USA have been shown to seek mental health services and treatment less frequently than Whites do, which results in biased literature dependent upon patient sample demographics (Kessler et al., 1996).

Despite these challenges, however, it is evident that ED pathology impacts individuals across diverse groups and populations (Hudson et al., 2007; Perez & Plasencia, 2017). Accordingly, this chapter aims to summarize the literature across racial/ethnic minorities (e.g., Blacks, Latinx, Asian Americans), males, and LGBT (i.e., lesbian, gay, bisexual, and transgender) individuals and the cultural factors relevant to each group.

Prevalence Rates, Clinical Presentation, Risk Factors, and Evidence-Based Treatment Among Minority Populations

Black Americans

Research on EDs among Black populations in the USA indicates that in general, Blacks exhibit lower prevalence rates of AN compared to White populations (Striegel-Moore et al., 2003; Taylor et al., 2007). Although existing research on BN in Black populations is mixed when compared to white individuals, BED is the most common ED reported in this population (Marques et al., 2011; Striegel-Moore et al., 2003; Taylor et al., 2007). Taylor and colleagues found that the lifetime prevalence rates for AN are 0.17%, 1.49% for BN, and 1.66% for BED among Black individuals (Taylor et al., 2007).

Some important differences in the clinical presentation of EDs exist among Black populations.

First, while the prevalence of AN among Black populations is low compared to that of Whites, the average age of onset of AN among Black individuals is 14 years old (Taylor et al., 2007) compared with 15.4 years among Whites (Striegel-Moore et al., 2003). In regard to BN, Black individuals present with many similarities to Whites, including similar functioning and severity; however, the literature has identified some key differences. For example, Black individuals with BN have been found to have shorter episode durations (1–7 years) than White individuals (average of 8.3 years, Hudson et al., 2007; Taylor et al., 2007). Among individuals seeking treatment for BN, Blacks may have higher body mass indexes (BMIs) and higher rates of depression than White individuals (Chui, Safer, Bryson, Agras, & Wilson, 2007). Finally, Black females with BN may have higher rates of reported sexual abuse but lower rates of substance use and self-harm behaviors compared with White females (Dohm et al., 2002). For BED, overall, research suggests similarities between Black and White individuals in clinical presentation. These similarities include mental, physical, and psychosocial functioning, comorbidity, ED attitudes, frequency of binge eating episodes, and rates of metabolic syndromes (Elliott, Tanofsky-Kraff, & Mirza, 2013; Franko et al., 2012; Udo et al., 2015). However, Blacks with BED may have shorter episode duration compared with other racial/ethnic groups (Taylor et al., 2007) and are more likely to report stress related to school/work and critical comments about weight, shape, or eating from others as preceding events to disorder onset (Pike et al., 2006).

When examining the literature on risk factors for eating disorders, both body dissatisfaction (a universal risk factor for eating disorders) and acculturative stress (a unique ethnic minority group risk factor) have some empirical support. In both the psychological literature and popular culture, ethnic/racial minorities, especially females, have been thought to have lower levels of body dissatisfaction compared with White females (Grabe & Hyde, 2006). Indeed, research suggests that Black females may have more positive body image and lower rates of body dissatisfaction than White females (Barry & Grilo, 2002; Wood, Nikel, Petrie, & Trent, 2010). However, some research suggests that differences in body dissatisfaction that exist between Whites and ethnic/racial minorities are much less substantial than historically believed and perhaps are decreasing across time (Grabe & Hyde, 2006). Indeed, research has demonstrated that once body dissatisfaction is present, it is associated with eating disorder symptoms among Black women (Perez & Joiner, 2003).

Acculturative stress has also been linked with ED pathology, particularly among racial/ethnic minority groups (Cachelin, Veisel, Barzegarnazari, & Striegel-Moore, 2000; Davis & Katzman, 1999; Perez, Voelz, Pettit, & Joiner, 2001). Acculturation is defined as the process of adaptation and assimilation of a different culture to one's own (Berry, 1998). Consequently, acculturative stress is conceptualized as the psychosocial stress associated with this process. Acculturative stress may increase risk for EDs through two distinct pathways. First, acculturation is linked with increased exposure to and adoption of Western values, including those regarding attractiveness (e.g., thin body ideal and muscular body ideal). Perceived differences between acculturated body ideals and one's own body may lead to increased body dissatisfaction, an empirically supported risk factor in the development of EDs (Gordon, Castro, Sitnikov, & Holm-Denoma, 2010). Indeed, increased acculturation has been shown to be associated with body dissatisfaction and ED pathology (Davis & Katzman, 1999; Perez et al., 2001). Second, the acculturative process may generate stress. ED behaviors, such as binge eating or restriction, may be used as coping strategies to tolerate experienced stress and distress (Perez et al., 2001). Indeed, acculturative stress has been linked with the development of BN (Perez et al., 2001) and general ED symptomatology among Black women (Gordon et al., 2010).

The evidence-based treatment literature for Black individuals with EDs is scarce. A randomized controlled trial comparing cognitive behavioral therapy and interpersonal therapy for BN included analyses with minority individuals

(Chui et al., 2007). Although both effective, CBT produced lower rates of engagement in binge eating and purging behaviors; thus, the authors suggest that CBT should be the preferred treatment for Black individuals with BN (Chui et al., 2007). Among Black women who engage in binge eating, those with moderate scores had significant symptom reduction during an intervention designed to increase physical activity and healthy eating (Mama et al., 2015). However, reductions in binge eating were not seen among those with severe scores.

Latinx Americans

Among Latinx populations, rates of ED pathology have been shown to be roughly similar to those reported by White populations (Alegria et al., 2007). Lifetime prevalence rates of EDs among Latinx within the USA are 0.08% for AN, 1.61% for BN, and 1.92% for BED (Alegria et al., 2007). Similar to Blacks, BED is the most prevalent ED in this group (Marques et al., 2011) and Latinx report fewer cases of AN compared with White populations (Alegria et al., 2007).

The clinical presentation of EDs among Latinx has some unique aspects. First, Latinx with AN may be less likely than Whites are to report fear of gaining weight or body dissatisfaction, leading to a potential underrepresentation of Latinx with AN in epidemiological research (Alegria et al., 2007). In regard to BN and BED, obesity, which is a growing issue among some Latinx populations (Kuba & Harris, 2001), may serve as a specific trigger for binge eating behavior among these individuals. Indeed, one study found that Latinx individuals with severe obesity were four to six times more likely to report an ED than those without obesity (Alegria et al., 2007).

Cultural values may also differentially affect the presentation of EDs among Latinx. For example, some research suggests that among Latinx females, slender but curvaceous figures, colloquially referred to as "gordibuena" (Perez, Ohrt, & Hoek, 2015), are idealized in contrast to the thin female ideal body commonly valued by European American females (Romo, Mireles-Rios, & Hurtado, 2015). In addition to differences in body ideals, eating is also considered an important familial bonding experience and food is highly valued. Consequently, Latinx individuals with EDs may experience additional guilt and shame in regard to their symptoms. Latinx females, in particular, who are not only encouraged to celebrate curvaceous figures and consume traditional foods in abundance but who also may feel societal pressures to achieve thinness, may struggle with eating, weight, and shape concerns in an attempt to concurrently adhere to multicultural pressures and societal standards of beauty (George & Franko, 2010).

Similar to the Black literature, both body dissatisfaction and acculturative stress have some empirical support. The body dissatisfaction literature is mixed with some studies indicating lower levels of body dissatisfaction (Barry & Grilo, 2002; Franko & Herrera, 1997), while other studies suggest comparable levels of body dissatisfaction between White and Latinas (Cachelin, Rebeck, Chung, & Pelayo, 2002; Shaw, Ramirez, Trost, Randall, & Stice, 2004). However, the examination of body dissatisfaction among Latinas is complex. Focus groups with Latinas reveal women grapple with the American standards of beauty (i.e., an ultrathin ideal) and with cultural ideals of beauty that promote a curvy hourglass figure (Franko et al., 2012). Regardless, when discrepancies between ideals and body shape occur, this is associated with eating disorder symptoms (Gordon et al., 2010).

Acculturative stress has been shown to contribute to the development of ED pathology among racial and ethnic minorities. More specifically, acculturative stress has been linked with the development of BN (Perez et al., 2001) and general ED symptomatology among Latinx individuals (Cachelin et al., 2000; Gordon et al., 2010). While much of the research addressing the influence of acculturative stress on ED pathology has examined this risk factor among females, acculturative stress has also been linked with body dissatisfaction and endorsement of Western media among Latinx males (Warren & Rios, 2013). Overall, a growing body of research suggests that acculturation is a substantial risk factor

for the development of EDs among racial/ethnic minority groups in the USA.

Within the literature, reporting of use of evidence-based treatments is starting to occur. Both patients and therapists report that the core components of cognitive behavioral therapy apply to Latinas for BN and BED. Adaptations of the treatment include providing additional therapy sessions and psychoeducation with the family, particularly if the patient endorses high degrees of the family members as referents and high interdependent values (i.e., belief that the needs of the group or family are more important than the need of the individual; Reyes-Rodriguez, Baucom, & Bulik, 2014; Shea, Cachelin, & Uribe, 2012). Additional adaptations include the structuring of meal plans to include foods consistent with the culture and food availability based on the economic sector of the patient. Both therapists and patients report the most problematic module of cognitive behavioral therapy is the body image interventions (Shea et al., 2012). The focus on the thin ideal is not as applicable for Latinas who report needing assistance with navigating the discrepant ideals of American culture and the norms of their own culture. Finally, adaptation to treatment includes an emphasis on acculturative stress issues that occur within the family (Perez, 2017; Shea et al., 2012). Binge eating among Latinas can occur more frequently during family meals than in isolation due to familial pressures to eat (Perez, 2017; Shea et al., 2012).

Asian Americans

In regard to Asian Americans in the USA, there are currently mixed epidemiological findings on the prevalence of EDs. To demonstrate, some studies suggest prevalence rates of ED pathology may be lower among Asian Americans than among other racial and ethnic groups (Regan & Cachelin, 2006; Tsai & Gray, 2000). However, other studies have found similar rates of EDs among Asian Americans when compared with other racial and ethnic populations (Franko, Becker, Thomas, & Herzog, 2007; Shaw et al., 2004). Epidemiological research has reported lifetime prevalence rates of 0.10% for AN, 1.50% for BN, and 1.24% for BED among Asian Americans, all of which are similar to rates of EDs among Whites (Marques et al., 2011).

The existing literature on the clinical presentation of EDs among Asian Americans suggests that EDs may present uniquely in these individuals. For example, BMI prior to ED onset may be lower among Asian Americans than among Whites (Lee & Lock, 2007). Additionally, some research suggests that subclinical and atypical EDs are more common among Asian Americans than among other racial/ethnic groups (Smart, Tsong, Mejia, Hayashino, & Braaten, 2011). Furthermore, Asian Americans may report less compensatory behaviors typically associated with ED pathology than other populations (Lucero, Hicks, Bramlette, Brassington, & Welter, 1992). Instead, Asian Americans may endorse complaints of bloating and lack of appetite, as well as more bulimic symptoms than their White counterparts (Lee & Lock, 2007). Asian Americans may also report different types of body dissatisfaction, often focusing on facial features, arms, breasts, height, or skin tone rather than simply body size or weight (Mintz & Kashubeck, 1999). Finally, EDs among Asian Americans, in particular, women, may be linked with emotional distress. Specifically, EDs have been conceptualized as a way to express distress without violating cultural norms of emotional restraint typical in many Asian cultures (Jackson, Keel, & Lee, 2006).

Among the risk factor literature, acculturative stress and perfectionism contribute to the development and maintenance of EDs. Acculturative stress has been shown to be associated with idealization of Western beauty norms among Asian Americans (Smart et al., 2011) and general eating disorder symptomatology (Gordon et al., 2010). While perfectionism has been shown to predict ED pathology across a diverse range of racial/ethnic groups, cultures, and communities (Hewitt et al., 1995), in particular, some research suggests that perfectionism may occur at high rates among Asian Americans (Wang, 2010). Smart and colleagues partially attribute this disparity to the way

in which Asian Americans are often portrayed negatively in comparison to the dominant White culture in the USA (2011). Asian Americans may feel a responsibility to correct negative perceptions of their culture in the USA by working diligently to be "perfect" (Smart et al., 2011). A qualitative study of ED-trained therapists with experience treating Asian Americans highlighted intense pressure observed among Asian Americans to achieve in academics, career, and in appearance (Smart et al., 2011). Importantly, perfectionism has been shown to predict EDs in both females (Hewitt et al., 1995) and males (Grammas & Schwartz, 2009) and may be a notable risk factor when considering Asian American populations.

Similar to the other ethnic groups, the treatment literature with Asian Americans is scant. In one case study adapting cognitive behavioral therapy (Fairburn, 2008) for an Asian American women, the core concepts of the treatment were maintained (Smart, 2010). Additional therapy sessions were offered to include the family. In these sessions, treatment targets were issues of stigma, shame, and hierarchy of the family system. Acculturative stress as it relates to gender roles, perfectionism, self-esteem, and interpersonal relationships was also targeted (Smart, 2010). The therapist highlights using an empathic but authoritative approach to the therapeutic relationship.

Males

Historically, EDs among males have been perceived as rare (Murray et al., 2017). Notably, however, EDs have been reported in males for as long as they have been reported in females (Murray et al., 2017). Indeed, recent research suggests that while females exhibit higher rates of EDs than males do, a substantial portion of the US male population will suffer from a clinically significant ED in their lifetime (Wade, Keski-Rahkonen, & Hudson, 2011) and males are an important population of consideration in the ED field. Overall, prevalence rates for EDs among males have been shown to be 0.30% for AN, 0.50% for BN, and 2.00% for BED (Hoek, 2006; Hudson et al., 2007).

Interestingly, recent evidence suggests that these rates are likely underestimates (Murray et al., 2017). For example, one nationally representative study found that males accounted for one in four cases of AN and BN (Hudson et al., 2007). Overall, however, research addressing EDs in male populations is substantially lacking, with less than 1% of contemporary peer-review literature relating specifically to male presentations of AN (Murray, Griffiths, & Mond, 2016). Given these findings, it is no longer reasonable to assume that EDs among males are uncommon. On the contrary, males make up a substantial population of consideration and warrant greater research and attention.

In considering EDs among male populations, there are some notable differences of consideration. First, research generally suggests that, compared with females, EDs among males are more likely to present as comorbid with other psychiatric disorders (e.g., substance use, psychotic symptoms; Carlat, Camargo, & Herzog, 1997; Striegel-Moore, Garvin, Dohm, & Rosenheck, 1999). Compared with females, EDs in males are also more likely to present at a later age of onset and are more commonly reported in later adolescence (Guegen et al., 2012; Mitchison & Mond, 2015). In considering AN, BN, and BED, research suggests males may exhibit different symptomatology compared with females. For example, males with AN have been found to be oriented toward achieving leanness and improving musculature, rather than thinness (Murray et al., 2017). Males with BN may be less likely than females are to engage in laxative use or vomiting, but may be more likely to engage in non-purging compensatory behaviors such as extreme dietary restriction and excessive exercise (Striegel-Moore et al., 2009). Finally, males with BED may be less likely to report experiencing loss of control during binges than females are (Lewinsohn, Seeley, Moerk, & Striegel-Moore, 2002).

Males may also be more likely than females are to demonstrate muscle dysmorphia, which is understood as a fear around being insufficiently muscular as well as an overwhelming desire for muscularity (Pope, Phillips, & Olivardia, 2000). Muscle dysmorphia is linked with the muscular

male body ideal popular in Western culture (Pope et al., 2000). The muscular male body ideal is characterized by a high degree of upper body muscularity and a low degree of body fat (McCreary & Sasse, 2000). Muscle dysmorphia can elicit muscularity-oriented disordered eating, characterized by distinct eating periods oriented toward gaining muscle and cutting body fat. These behaviors are also associated with the overregulation of protein consumption and dietary restriction to build muscle and achieve a caloric deficit, respectively (Griffiths, Murray, & Touyz, 2013). Muscle dysmorphia is also linked with excessive exercise and use of supplements and anabolic steroids (Calzo et al., 2015; Labre, 2002).

Less research exists addressing body dissatisfaction among males than among females (McCabe & Ricciardelli, 2004). In general, research indicates that females report higher levels of body dissatisfaction than do males (Tiggemann & Pennington, 1990). However, it is likely that comparing body dissatisfaction between males and females is more nuanced. Some studies have found similar levels of body dissatisfaction between males and females (Silberstein, Striegel-Moore, Timko, & Rodin, 1988). Furthermore, another research suggests that while males and females may not differ substantially in degree of body dissatisfaction, directionality and nature of body dissatisfaction may vary between males and females. In other words, males may be more likely to desire to be heavier or more muscular, whereas females are more likely to desire to be thinner (Silbertstein et al., 1988). Indeed, males are more likely to adhere to muscular body ideals and may exhibit body dissatisfaction through the use of excessive exercise, supplements, anabolic steroids, as well as muscularity-oriented disordered eating (Calzo et al., 2015; Labre, 2002). Among males, it also seems that these behaviors may evolve over time as well as over the life course. More specifically, during adolescence and young adulthood, males may be equally divided between wanting to lose weight and wanting to gain weight. However, in older adulthood, adult males report a stronger desire to lose weight (McCabe & Ricciardelli, 2004). These differences may be attributed to changes in perceived deviation from male body ideals throughout the life course.

Weight stigma is a particularly salient predictor of ED pathology among males. Research indicates that males with EDs are more likely than females are to have a previous history of overweight or obesity (Andersen, 1999; Strother, Lemberg, Stanford, & Turberville, 2012). Additionally, males with EDs are also more likely to have experienced weight-related teasing than females with EDs (Carlat et al., 1997; Guegen et al., 2012). As such, a history of overweight or obesity, weight stigma, weight-based teasing, or weight-related bullying is of noteworthy consideration in addressing EDs, especially EDs in male populations.

As previously discussed, clinicians working with male clients should recognize that EBTs for EDs have largely been developed with female populations. As such, EBTs for EDs may differ in their utility and relevance in male populations (Smolak & Striegel-Moore, 2001). Clinicians and readers should also take into account the ways in which current ED diagnostic frameworks may affect and impact accurate diagnoses of EDs among males (Murray et al., 2017). Finally, as EDs have been stereotypically considered a "female" problem both in psychological practice and within popular culture, stigma has been shown to be a problematic barrier among males with EDs (Murray et al., 2017). Shame and stigmatization associated with conceptions of compromised masculinity may result in prolonged illness duration and negative treatment outcomes (Murray et al., 2017). In working with males with EDs, clinicians are encouraged to educate male clients about myths and misconceptions regarding populations affected by EDs to reduce feelings of shame and improve treatment outcomes.

Lesbian, Gay, Bisexual, and Transgender Individuals

LGB (i.e., lesbian, gay, bisexual) individuals are another population of consideration in the ED field. Importantly, LGB individuals as a group may exhibit rates of ED pathology greater than or

at least comparable to those of heterosexuals (Austin et al., 2013; Diemer et al., 2015). Within specific sexual minority groups, different rates of ED pathology may exist. For example, research suggests that gay males report greater incidence of ED pathology and attitudes compared with heterosexual males (Williamson & Hartley, 1998; Yager, Kurtzman, Landsverk, & Wiesmeier, 1988) and, in some cases, heterosexual and lesbian females (Yelland & Tiggemann, 2003). Among females, findings are mixed with some studies indicating that lesbian and bisexual females report lower (Moore & Keel, 2003), similar (Davids & Green, 2011), and higher rates of ED pathology compared with heterosexual females (Diemer et al., 2015).

ED pathology has also been shown to affect transgender individuals (Guss, Williams, Reisner, Austin, & Katz-Wise, 2017). Transgender individuals identify with a gender different from their sex assigned at birth, whereas cisgender individuals identify with a gender that is concordant with their sex assigned at birth (Guss et al., 2017). Recent research suggests that transgender individuals may be particularly susceptible to developing ED pathology due to high rates of body dissatisfaction and distress associated with gender dysphoria, which is conceptualized as conflict between an individual's assigned gender and the gender with which they identify (American Psychiatric Association, 2013; Witcomb et al., 2014). Research on prevalence rates of EDs among transgender individuals is lacking; however, extant research suggests that transgender individuals have much higher rates of EDs than cisgender individuals do. To illustrate, one study of nearly 290,000 students from universities across the USA found that transgender young adults had two times greater odds of a past-year diagnosis of AN or BN compared with cisgender females (Diemer et al., 2015). Additionally, the same study found that transgender young adults were over twice as likely to report using diet pills, laxative, or vomiting compared with cisgender females (Diemer et al., 2015). Given these findings, it is evident that LGBT individuals make up a notable population of consideration in ED research and clinical practice.

Research on the clinical presentation of EDs among LGB individuals highlights that ED behavior may differ among sexual minority group. For example, in one study, LGB individuals demonstrated higher rates of binge eating than their heterosexual counterparts did (Austin et al., 2013). Bisexual individuals may also be more likely to report purging than gay, lesbian, and heterosexual individuals (Austin et al., 2009; Robin et al., 2002).

In regard to transgender populations, little research currently exists examining the clinical presentation of EDs among transgender individuals. However, the literature suggests that body dissatisfaction may be an especially salient predictor of ED pathology among these individuals. Body dissatisfaction among transgender individuals may be linked with gender dysphoria and can be experienced in relation to specific body parts, especially body parts that do not align with gender identity (e.g., breasts, body hair, stomach, hips, etc.; American Psychiatric Association, 2013; Cuzzolaro, Vetrone, Marano, & Garfinkel, 2006). EDs among transgender individuals may be linked to a desire to suppress unwanted body features and accentuate features of one's identified gender (Algars, Alanko, Santtila, & Sandnabba, 2012). Indeed, some research has shown that transgender individuals with EDs often describe a desire to change their bodies in an attempt to suppress features associated with their biological sex (e.g., muscularity) or accentuate features of one's identified gender (e.g., thinness associated with feminine ideals; Algars et al., 2012). Additionally, transgender individuals are more likely to report fasting, using diet pills, and taking laxatives to lose weight than their cisgender counterparts are (Guss et al., 2017).

Research addressing body dissatisfaction among LGBT individuals has yielded interesting findings. Generally, research suggests that gay males report more body dissatisfaction than their heterosexual counterparts do (Beren, Hayden, Wilfley, & Grilo, 1996; Morrison, Morrison, & Sager, 2004). However, among females, findings are mixed (Beren et al., 1996; Morrison et al., 2004). It seems that, overall, sexual orientation may be more influential in predicting body dissat-

isfaction among males than among females (Morrison et al., 2004). It has been suggested that gay culture's presumed emphasis and focus on physical appearance may elicit increased body dissatisfaction among gay males (Beren et al., 1996; Yelland & Tiggemann, 2003). On the other hand, due to normative sociocultural pressures affecting females, discontent and scrutiny with one's body are a normative experience for heterosexual, lesbian, and bisexual females (Cogan, 1999).

Among transgender individuals, body dissatisfaction is common source of substantial distress (Cuzzolaro et al., 2006; Jones, Haycraft, Murjan, & Arcelus, 2016) and may contribute to heightened risk of developing EDs compared to the general population. As gender dysphoria is linked with body dissatisfaction, it follows that transgender individuals may experience greater distress associated with their physical appearance. Transgender individuals may specifically feel distressed about body parts that do not align with their identified gender (e.g., breasts, penis, body hair, stomach, hips, etc.; Cuzzolaro et al., 2006; Witcomb et al., 2014).

Another notable risk factor in considering ED pathology is minority stress. Minority stress theory postulates that LGBT individuals are at increased risk for physical and mental health problems, including EDs, as a result of social stress, stigma, and discrimination targeting their minority status (Meyer, 2003). This psychosocial stress may be attributed to lack of social acceptance, expectation of prejudice, perpetration of harassment, and even physical violence (Berlan, Corliss, Field, Goodman, & Austin, 2010; Coker, Austin, & Schuster, 2010).

Research has shown that, among LGB individuals, minority stress has been linked with ED symptomatology (Brewster et al., 2014; Watson, Grotewiel, Farrell, Marshik, & Schneider, 2015; Wiseman & Moradi, 2010). It is possible that LGB individuals may use maladaptive coping behaviors, such as binge eating or restriction, to deal with minority stressors (Katz-Wise et al., 2015). These findings have been shown to occur among both males and females. For example, minority stress has been linked with increased binge eating among lesbian and bisexual females (Mason & Lewis, 2015). Among males, minority stress has been linked with body dissatisfaction and ED symptomatology (Kimmel & Mahalik, 2005).

Among transgender individuals, the role of minority stress in the development and perpetuation of EDs is less established; however, minority stress likely plays a similar role (Watson, Veale, & Saewyc, 2016). Indeed, transgender individuals have been found to be nearly five times as likely to report an ED diagnosis compared with cisgender females (Diemer et al., 2015). Notably, social connectedness and support have been linked with lower odds of ED pathology among transgender individuals (Watson et al., 2016).

In implementing EBTs in work with LGB clients, readers and clinicians are encouraged to review the American Psychological Association practice guidelines for work with lesbian, gay, and bisexual clients (American Psychological Association, 2012). Clinicians should recognize that while LGB individuals make up several groups of sexual minorities, sexual orientation is often conceptualized along a spectrum and sexual minority clients may not identify as belonging to a specific sexual orientation or category. Clinicians should recognize that LGB clients are at heightened risk of social stressors and stigmatization (Meyer, 2003) which may impact practice and application of EBTs as well as treatment outcomes.

In adapting EBTs for work with transgender individuals, clinicians are encouraged to refer to the American Psychological Association guidelines on psychological practice with transgender and gender nonconforming individuals (American Psychological Association, 2015). Clinicians should recognize that mental health problems, including EDs, experienced by transgender individuals may be related to gender-related concerns or gender dysphoria or may be indirectly influenced by way of minority stressors (Meyer, 2003). However, mental health problems in this population may also be unrelated to gender identity or gender-related concerns. Within the last two decades, there has been a substantial increase in research and knowledge about this community, and guidelines and recommendations for gender-affirming care are updated frequently.

Future Directions

While there is a growing body of literature addressing ED pathology across diverse racial/ethnic groups, cultures, communities, and genders, there still remain substantial gaps in empirical research in these areas. First, there is a great need for research on the development and validation of accurate and culturally relevant measures assessing ED pathology. Additionally, evaluation of the utility of EBTs in diverse groups has valuable implications for clinical science, intervention efficacy, and treatment outcomes. Work to determine specific and unique risk factors for EDs affecting different racial/ethnic groups, cultures, communities, and genders is warranted to increase understanding of the etiology of EDs. Research incorporating these ideas in an intersectional framework, considering the ways in which multiple forms of identity (e.g., race/ethnicity, sexual orientation, and gender identity) interact and differentially affect EDs, is essential to move toward a greater and more complete understanding of etiology, treatment, and outcomes in health and well-being. Psychotherapy research on the implementation of empirically supported treatments, treatment outcome, rates of recovery, and quality of life is urgently needed to improve and guide the care of minority populations with eating disorders.

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