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DISORDERED EATING AMONG NONBINARY INDIVIDUALS

by

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B.S., University of California, Davis, 2014

M.A., Southern Illinois University, 2017

A Dissertation

Submitted in Partial Fulfillment of the Requirements for the
Doctor of Philosophy Degree

School of Psychological and Behavioral Sciences
in the Graduate School
Southern Illinois University Carbondale
December 2020

DISSERTATION APPROVAL

DISORDERED EATING AMONG NONBINARY INDIVIDUALS

by

Marilyn (Mar) Chung

A Dissertation Submitted in Partial

Fulfillment of the Requirements

for the Degree of

Doctor of Philosophy

in the field of Psychology

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TITLE: DISORDERED EATING AMONG NONBINARY INDIVIDUALS

MAJOR PROFESSOR: Dr. Kathleen Chwalisz Rigney

Research on influences of eating disorders have informed diagnosis and treatment of eating disorders, particularly for White cisgender women. A Perfect Biopsychosocial Storm is a theory of influences of disordered eating development: sociocultural influences of rigid body shape and size ideals, high rates of trauma and violence, experiences of objectification and sexualization, and biological changes (Maine & Bunnell, 2010). For transgender individuals, recent findings suggest disparities and negative mental health outcomes such as elevated prevalence of disordered eating, body image concerns, and self-reported disordered eating. For transgender men and women, researchers found that disordered eating may be related to attempts to masculinize/feminize the body, through effects like suppression of weight and secondary sex characteristics. For nonbinary individuals, motivations are unclear regarding masculinization/feminization. Further, while previous research has implicated experiences of marginalization in reduced body appreciation, impact on disordered eating behaviors in nonbinary individuals have yet to be explored. This study addressed gaps in research regarding experiences of nonbinary individuals with disordered eating. Through Grounded Theory qualitative analysis, I developed a framework to understand disordered eating among nonbinary individuals. Disordered eating was the surface-level manifestations of experiences such as trauma, distress surrounding bodily changes in puberty, and marginalization. Repeated marginalization, like misgendering and identity erasure, created conditions of shame to be associated with identity and self. Shame is a universal emotion that occurs when one does

something they perceive as social transgressive and, thus, prevents connection. Shame motivates individuals to reduce socially transgressive behavior to increase connection with others. When one experiences marginalization and repeated shame surrounding identity, identity and self then can be experienced as a social transgression that prevents belonging. For example, participants described feelings of shame in comparison to the stereotypical image of a nonbinary person (White, masculine-leaning/androgynous, thin, tall). Disordered eating facilitated emotional coping, and, for some participants, helped achievement of gender presentation. Disordered eating also was associated with consequences of further shame around eating behaviors, and feelings of lack of control. Recovery and healing was supported through combating shame and disempowerment: being seen and empowerment through choice.

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Thank you to my family and friends for supporting me throughout the process of writing this dissertation. Without the talks, meals, and just space to be, I don't think I could have done it. Thank you to my participants for your openness and willingness to do this project, to share with me a bit of you. And thank you to my committee members and graduate program, for letting me hop on the train of education and access.

DEDICATION

I dedicate this work to everyone who is on this same boat of being a work in progress. Through getting to hear folks' stories, reflecting on my own, writing this dissertation, I have come to see the power of acceptance of that—of letting go of who I thought I and others should be. So, perhaps I dedicate this project to everyone, including myself.

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CHAPTER 1

INTRODUCTION

Understandings of eating disorder symptomology and etiology have been well developed (Bordo, 2003; Fallon & Lannon, 2016; Gordon, Austin, Krieger, Hughto, & Reisner, 2016; Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015). Scholars of eating concerns describe the multi-layered influence of sexism as well as general gender bias on the development and assessment of eating disorders. Biopsychosocial conceptualizations on the development of eating disorder behaviors help to strengthen treatment approaches and inform culture that influences their development.

In recent years, eating disorder researchers have increasingly studied transgender (trans; individuals whose assigned sex at birth is different from their gender [Serano, 2007]) populations, due to the possible comorbidities of disordered eating, body image concerns, and gender dysphoria (Couturier, Pindiprolu, Findlay, & Johnson, 2015). Initial studies focused on case studies and one qualitative study of trans men and women. Authors noted themes of use of disordered eating to manage physical characteristics related to secondary sex characteristics, and gender dysphoria. Authors reported benefits of gender transitioning in alleviating symptoms (Ålgars, Alanko, Santtila, & Sandnabba, 2012; Couturier et al., 2015; Vocks, Loesner, & Legenbauer, 2009). They explained etiology and maintenance of symptoms as related to attempts to either control secondary sex characteristics to fit one's identified gender (e.g., minimize the appearance of possible sexed characteristics), and/or to fit cultural expectations for identified gender.

Researchers in initial case studies did not discuss the influence of stigma or cissexism. Cissexism is the systematic privilege and normalization of cisgender identity (cis; individuals

whose assigned sex at birth is the same as their expected gender; [Serano, 2007]), and oppression and delegitimization of trans identities (Serano, 2007). Without analysis of these experiences, the symptoms of eating disorders in trans individuals may be overly individualistic in their explanation (Tabaac, Perrin, & Benotsch, 2018). This individualization of cultural problems may represent a form of oppression, in which marginalized individuals' identities are problematized, rather than the sociocultural context that marginalizes one's identities. For instance, restriction to control body shape and size may be adaptive for a trans adolescent who does not have access to gender affirming hormone therapy, and fears being outed and bullied as trans-identified in their high school. Without exploration and attention to the individual's surroundings—in this case, a hostile school environment—the person's attempts to cope and survive may be pathologized. Therefore, expanding the understanding of sociocultural context and environmental stressors can be a form of advocacy, giving a more holistic image of trans people's lives, and ways to prevent experiences of oppression at the group level (Matsuno & Israel, 2018).

Some studies emphasized: prevalence of disordered eating behaviors related to anorexia nervosa (anorexia) and bulimia nervosa (bulimia), experiences of stigma, general mental health outcomes, and/or dissatisfaction of body image in the United States and internationally. Researchers found that trans individuals may have an elevated prevalence of disordered eating behaviors and attitudes compared to healthy cis populations (Witcomb, Bouman, Brewin, Richards, Fernandez-Aranda, & Arcelus, 2015; Diemer, Hughto, Gordon, Guss, Austin, & Reisner, 2018) (I will refer to studies from various countries given the lack of research of disordered eating among trans people). For example, Cella, Iannaccone, & Cotrufo (2013) compared samples of gay cis, heterosexual cis, and male-to-female trans participants from Southern Italy. They found that heterosexual cis men had the lowest reported disordered eating

symptoms, whereas the trans women had the highest reported disordered eating behaviors and attitudes. These studies appeared to be inconsistent regarding prevalence rates. Researchers also did not include nonbinary (individuals whose gender identities are outside definitions of male or female, and/or may be fluid [McNabb, 2018]) populations in either sample. Witcomb and colleagues (2015) in the United Kingdom utilized a larger sample that compared trans participants without eating disorders, cis participants with eating disorders, and cis participants without eating disorders (the control group). They found that, overall, cis participants with eating disorders scored the highest on a measure of disordered eating behaviors and attitudes. Trans participants reported greater body dissatisfaction than the control group, and trans males had body dissatisfaction scores comparable to cis males with eating disorders. Both cis females and trans females reported higher drives for thinness, and trans males and trans females reported high levels of dissatisfaction with body parts related to gender (i.e., secondary sex characteristics, genitalia) and body shape and weight.

From these studies, there seem to be possible inconsistencies regarding existence of higher prevalence of eating-disorder symptoms. Further, nonbinary trans groups were not included. Both Cella et al. (2003) and Diemer et al. (2015) used explanations of socialization as female (i.e., assigned female at birth) and/or feminine orientation would thus lead to higher endorsement of the thin ideal and greater risk for disordered eating behaviors. However, eating disorder measures and arguably, anorexia and bulimia diagnoses have been critiqued as influenced by cultural definitions of femininity, and, therefore, underdiagnose those who may not present as feminine (Bunnell, 2010). Further, explanations focused solely on socialization and femininity or masculinity reinforces binary perceptions of gender. By explaining symptoms as motivated by wanting to appear more “feminine” or “masculine,” or suppress sex

characteristics, researchers may miss other influences of external forces that can shape these symptoms, such as oppression and pressure to “pass” as cis for safety. This can have negative effects in later research and treatment that may propagate overly simplistic theory of disordered eating in trans people. This may be especially the case for nonbinary individuals who may not ascribe to feminine or masculine gender roles (Matsuno & Budge, 2017) (though trans men and trans women may also be feminine and masculine, a combination of both, or feel they are neither). Though Algars et al. (2012) found in their qualitative study reducing gender dysphoria as a motivation for half their participants, researchers did not include nonbinary individuals, so it is unclear how or if gender dysphoria plays a role for disordered eating in the case of this population.

Disordered Eating Behaviors Research on Nonbinary Populations

Studies on trans nonbinary individuals, have increased in the last two years. Nonbinary participants seem to have increased odds of eating disorder diagnosis compared to cis people (Diemer et al., 2018). Like patterns of results conducted with cis persons with eating disorders/disordered eating, some scholars have found correlates with anxiety, depression, and low self-esteem (Tabaac et al., 2018). Watson, Veale, and Saewyc (2017) and Tabaac et al. (2018) measured experiences of discrimination, harassment, and other forms of stigma (negative experiences related to a marginalized identity), and found that these were positively correlated with disordered eating behaviors and reduced body image/body appreciation (respect and approval for one’s body). Therefore, oppression seems to be correlated with disordered eating behaviors. While Watson and colleagues (2017) implicated strivings for increased femininity/masculinity in the body as motivations for disordered eating, they did not include any assessment for these constructs in their participants. Tabaac et al. (2018) created a mediation

model, which indicated that harassment/rejection lowers self-esteem and satisfaction with life, leading to reduced body appreciation. Assessment of gender dysphoria was not included, nor were questions regarding pursuit of gender transitioning (e.g., social transitioning, medical), so it is unclear if, like the case of some trans women and men, access to transitioning may help alleviate symptoms. These three studies show important possible correlates and constructs that may be associated with disordered eating behaviors, such as experiences of harassment and discrimination. They also indicate the need for further research to elucidate not only correlates to disordered eating behaviors, but conceptualization specific to nonbinary individuals, given the lack of differentiation of these symptoms across nonbinary people, trans men, and trans women.

Disparities, Mental Health Outcomes, and Body Image

Experiences of oppression have been repeatedly found to be positively correlated with disordered eating for nonbinary individuals. Although there is increased acceptance and visibility for trans people in the United States, they continue to experience higher risk of negative mental health outcomes, as well as other influential social disparities. Trans people in the United States report elevated rates of harassment, violence, economic instability and hardship, and psychological distress (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Trans people of color and/or undocumented trans people have reported more severe harassment, unemployment, and health disparities than their White and/or legally documented peers (James et al., 2016). Of a sample of over 27,000 trans people in the United States, 30% reported significant psychological distress within the month prior to completing the study (compared to 5% of the general U.S. population) (James et al., 2016). In the same study, 40% reported a suicide attempt in their history (compared to 4.6% of the general population). Given these staggering reports, it is important to consider the implications of these experiences on disordered

eating, including the effects of multiple marginalized identities.

Risk of body image concerns has been linked to discrimination, and other mental health outcomes such as anxiety and depression, which are also strong correlates for disordered eating in cis populations (Fallon & Lannon, 2016) as well as trans populations (Tabaac et al., 2018). Body image develops in childhood, where social and somatic experiences continue to shape body image after development (Costin, 2010). It consists of three components: 1) image in one's mind of their self-perception, 2) the perception of what the person believes others see, and 3) what it is like to live in one's respective body (Ressler, 2010). Inherent in the treatment of eating-disorder symptoms is disturbance in body image; if left untreated, relapse is likely (Ressler, 2010). In cis heterosexual women, the culture of sexism that leads to media objectification, and messages of women's worth equates to attraction of men contributes to body image dissatisfaction (Maine & Bunnell, 2010). Although body image and related constructs appear to play a role in disordered eating for nonbinary populations (Tabaac et al., 2018), it is unclear how or if experiences related to *being* nonbinary contribute to body image. Due to these discrepancies of nonbinary identity influence in and understandings of disordered eating in nonbinary populations, this study will provide further analysis and qualitative research regarding this population.

CHAPTER 2

LITERATURE REVIEW

Research on trans individuals and eating-disorder-related symptoms have increased in the last 10 years (Jones, Haycraft, Murjan, & Arcelus, 2015). The similarities in body image disturbance and comorbidities of anxiety, depression, substance use disorders, and PTSD may contribute to the higher prevalence of eating disorder symptoms (Couturier, Pindiprolu, Findlay, & Johnson, 2015). Therefore, in this chapter, I will emphasize discussion of eating disorder symptoms (which may include disordered eating, body image concerns, and other related correlates), etiology in cis men and women, and in trans and then more specifically, nonbinary people. Gender-based discrimination will then be covered, discussing examples of enacted stigma that may influence disordered eating in nonbinary populations. Lastly, the purpose of this study will be reviewed.

Eating Disorders and Disordered Eating

Eating disorders are defined as mental disorders characterized by eating habits that lead to significant distress and impairment (American Psychiatric Association, 2013). In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), eating disorders and feeding disorders are categorized together. DSM-V eating disorders include anorexia nervosa (anorexia), bulimia nervosa (bulimia), binge eating disorder, other specified feeding and eating disorder, and unspecified feeding or eating disorder (American Psychiatric Association, 2013). Anorexia is characterized by an intense fear of “being fat” and distorted body image/self-perception of body shape/weight, which leads to attempts to become (or perceive oneself) as thinner via food restriction, dieting, and obsessions/rituals based on the preoccupation of food (Fallon & Lannon, 2016). Disturbance in perception of body shape and/or weight is often

connected to the individual's self-evaluation (American Psychiatric Association, 2013). Criteria for anorexia nervosa include "significantly low body weight" compared to what is expected for the individual's age, sex, expected development, and physical health. Severity is based on body mass index (BMI), the ratio of body weight to squared height that is moderately correlated with direct measures of body fat (Garrow & Webster, 1985). Symptoms associated with anorexia nervosa begin in adolescence for females, whereas males often present with symptoms later in life (Fallon & Lannon, 2016).

As noted in the DSM-V, bulimia consists of symptoms of recurrent binge eating episodes (i.e., amount of food larger than most individuals in a two-hour time period, eating more rapidly than typical, eating until uncomfortably full, eating alone due to embarrassment over amount of food, feelings of disgust with oneself or depressive feelings/guilt after eating) followed by inappropriate compensatory behaviors to prevent weight gain (such as fasting, vomiting, excessive exercise) (American Psychiatric Association, 2013). These behaviors must persist for a minimum of three months, and must occur at least once a week to meet criteria for diagnosis of bulimia. Like anorexia, bulimia is often associated with self-evaluation associated with body shape and weight, but the disturbance does not occur during an episode of anorexia.

Development of the disorder typically begins in adolescence and early adulthood. Individuals cross-over between bulimia and anorexia in about 10-15% of cases, and bulimia can cross over to binge eating disorder if the individual ceases compensatory behaviors (American Psychiatric Association, 2013). Binge-eating disorder consists of binge eating episodes without any compensatory behaviors. Binge-eating behaviors are often connected to various eating habits and emotions related to eating (American Psychiatric Association, 2013). Binge-eating disorder is the most common eating disorder in the United States; there is common prevalence across racial and

ethnic groups, and men and women.

Other specified feeding or eating disorder consists of symptoms of other eating disorder diagnoses. However, symptoms do not meet full criteria for any of the feeding or eating disorders. Significant social and occupational roles must be affected (American Psychiatric Association, 2013). Unspecified feeding or eating disorder is like other specified in that symptoms do not fully meet any disorder. However, the diagnosing clinician has chosen not to state specific reasons why. In the previous edition of the DSM, “eating disorder not otherwise specified” was used as a “catch-all” for eating disorder symptom presentation that did not fit anorexia or bulimia (American Psychiatric Association, 2013).

In the defined eating disorders, understanding of each is based on individuals’ context, including sex. Statistics include those of males and females. Trans individuals are not included in these descriptions or statistics, nor are cisgender individuals labeled as such. Explanation of sex and manifestation of eating disorders in trans people are not stated. In other words, trans individuals are excluded in diagnosis, and cisgender indiv. This leaves the burden of conceptualization on the clinician, with no research or comparison to guide a clinician’s work with a trans individual exhibiting disordered eating.

Rates of Eating Disorders in the United States

The prevalence of eating disorders has been difficult to pinpoint, and current numbers may underestimate actual prevalence of eating disorders and related symptoms. Prior to the change to eating disorder categories to include binge eating disorder in 2013, the diagnosis of “eating disorder not otherwise specified” (EDNOS) was most common (Smink, van Hoeken, & Hoek, 2012). This was related to the common heterogeneity of symptoms found in eating disorders. Eating disorders are also often underreported and general practitioners and other care

providers may miss symptoms, leading to the common underestimates of eating disorder prevalence (Smink, van Hoeken, & Hoek, 2012). Smink, van Hoeken, and Hoek (2012) in their review of epidemiological research on eating disorders noted that anorexia is increasingly common in young women, with an increase of incidence in 15 to 19-year-old girls, who, prior, already had higher risk. However, this finding may be due to earlier detection or perhaps earlier onset. Anorexia may affect approximately 1% of adult women, and 0.2% of adult men in the United States, though these rates can vary by gender, culture, ethnicity, and social class (Smink, van Hoeken, & Hoek, 2012; Fallon & Lannon, 2016). Researchers have claimed eating disorders to be culturally-bound to White people in industrialized nations, but disordered eating behaviors and eating disorders have increasingly appeared in samples of people of color (Smink, van Hoeken, & Hoek, 2012). Marques et al. (2011) conducted a prevalence study of binge eating disorder and anorexia from national survey data of non-clinical individuals who were 18-years-old or older. The data included 3750 African Americans, 2554 Latinos, 2095 Asians, and 891 non-Latino Whites in the United States, and respondents reported similar prevalence of anorexia and binge eating disorder (Marques et al., 2011). Bulimia in the United States and Western European countries was reported to have the prevalence of 0.9% to 1.5% for women and 0.1% and 0.5% in men. Marques and colleagues (2011) compared data from a national US sample of men, and found bulimia had a higher prevalence in Latinos and African American men compared to (non-Latino) White men. Binge eating disorder was found to occur in 1.9% of women and 0.3% of men in large samples across the United States (Smink, van Hoeken, & Hoek, 2012). Therefore, both women and men may have eating disorder prevalence of under 2%, though this may be underestimates for both groups. Authors do not explicitly assess whether participants are trans or cis, nor are gender categories outside women and men included, so it is unclear if rates

may be different for trans individuals.

Changes in Diagnoses of Eating Disorders

In the United States, criteria of eating disorders have changed over time, with the publication of DSM-5 bringing the most recent changes (American Psychiatric Association, 2013). One of the driving forces for these changes was clinical experience that showed that numerous clients with eating disorders did not fit into categories of anorexia and bulimia. For example, a diagnosis of anorexia required amenorrhea, which excluded individuals without menstrual periods (unrelated to the disorder), as well as individuals who exhibited anorexic symptoms, but continued to menstruate. Because of exclusions like these, criteria for anorexia and bulimia were made less stringent, and binge eating disorder was added (American Psychiatric Association, 2013).

While these changes have led to greater inclusion, the DSM authors may continue to exclude people who suffer from symptoms related to disordered eating, but may not fit criteria for an eating disorder diagnosis. Clients with eating disorders tend to minimize symptoms or avoid seeking services for eating disorders (Smink & van Hoeken, & Hoek, 2012). Further, criteria in the current DSM excludes those that exhibit disordered eating behaviors (such as binge eating and restricting) due to their subthreshold nature. For instance, an individual may binge eat regularly and exhibit compensatory behaviors (i.e., exercising or purging), but may not do so at least 1 hour/week, a current criterion of bulimia in the DSM-5 (American Psychiatric Association, 2013). Further, eating disorders often ebb and flow over time—one with anorexia nervosa may have a decrease in symptoms, only to have those symptoms increase at a later point (von Ranson, Klump, Iacono, & McGue, 2005). Individuals may also move between diagnostic categories as well (Fallon & Lannon, 2016). An individual may experience subthreshold

symptoms, but may benefit from addressing these symptoms prior to developing symptoms that meet criteria. Therefore, use of eating disorder diagnosis as a screening criterion may exclude individuals who may be in partial remission, or have a high likelihood of developing an eating disorder, due to the categorical nature of diagnosis and variety of disordered eating. Due to these reasons, disordered eating will be used as an inclusion criteria, rather than solely history of diagnosis for eating disorder(s).

Regarding terminology like disordered eating vs. eating disorder, I initially used eating disorder symptoms or eating disorder behaviors, and the title of the document was Nonbinary Populations and Eating Disorder Symptomology. Use of eating disorder symptoms in this literature review is reflective of scholars' language, and to also encompass wider range of behaviors outside of eating behaviors. Following participants sharing their preference for disordered eating and personal reflection, I have adapted my terminology to disordered eating to use less stigmatizing and more inclusive language within the results and discussion. Further, focus of this research was on disordered eating, rather than other aspects of eating disorders, such as specific symptoms regarding BMI, or view of self (APA, 2013). I have also changed the title of the document to Disordered Eating Among Nonbinary Individuals to reflect the focus of this study.

Etiology of Eating Disorders in Cis Women and Men

There are many influences to the development of eating disorders in women. For example, cultural beauty ideals for cis women include having light skin, a thin and young body, and straight hair, and these ideals influence eating disorder development in women (Bordo, 2003). Other influences of eating disorder development in women include: disproportionate rates of violence and trauma which lead to increased risk of negative mental health outcomes; distress

and difficulty understanding biological change in adolescence; and objectification and sexualization that leads to an external self-view and self-worth (Maine & Bunnell, 2010; Davis, 2009). Eating disorder researchers and theorists described the development of disordered eating as biopsychosocial (Maine & Bunnell, 2010). For women, the physical changes in adolescence can increase self-consciousness, related to the changes in how they are treated in their environment (Maine & Bunnell, 2010). Girls on average increase 10 inches in height and 40-50 pounds in weight (Maine & Bunnell, 2010). Social limitations in education on how to understand changes in body, sexuality, and others' reactions to these changes, can lead to distress and confusion. This distress, in tandem with a stressful life event, often precedes development of eating disorder behavior.

Further, with the sociocultural norms around body shape and size in the United States, adolescent girls may be influenced to cope with the distress through dieting (Davis, 2009; Maine & Bunnell, 2010). They may receive reinforcement regarding the behavior, particularly with the objectification and fixation on women and girl's bodies in the United States. Maine and Bunnell (2010) name objectification and sexualization as factors that contribute to external self-view and worth. With the sexism embedded in United States culture, girls and women may taught to see their self-worth based on appearance and the judgments of others, particularly surrounding perceptions of their bodies. They may struggle with identifying internal aspects like emotions, wants, beliefs, and instincts, if they are consistently taught to view themselves from the outside. When an individual feels they fail to meet cultural ideals, in this case, a thin ideal, this may lead to intrusive thoughts, self-criticism, and poor self-esteem. This body dissatisfaction is often correlated with disordered eating. As dieting and changes become less effective over time in coping with the initial issue, disordered eating may become a separate source of distress (Davis,

2009). When addressing treatment for eating disorders, attention to the eating disorder, consideration of the precipitating event, exploration of gender, identity, and the fear of ambiguity are needed (Maine & Bunnell, 2010; Davis, 2009). These nuanced and biopsychosocial understandings of eating disorder symptom development help to contextualize and destigmatize symptoms.

Previous literature has shown that cis women are the most commonly researched population in eating disorder literature (Diemer et al., 2015), and further research is needed on other groups. In the aforementioned theory and research development, authors did not label whether they were referring to all women (cis and trans) or just cis women. Bunnell (2010) indicated that in males (whether cis or trans, or both, was not indicated), the increasing dissatisfaction in body image, fear of loss of power in an increasingly gender equitable Western world, and the lack of male-gender-informed diagnosis and treatment have led to increasing rates of disordered eating and underestimates of eating disorders in men. Bunnell reported that physicians more often look for symptoms in women, overlooking manifestations of symptoms in men. Further, men are more likely to show lower drive for thinness, body dissatisfaction, and harm avoidance, whereas these characterize symptoms for women. Men may be more likely to over-exercise, binge and purge to appear “lean” rather than thin, and thus, the drive for thinness commonly associated with anorexia nervosa in eating disorder screenings may overlook men. And while the prevalence for bulimia in females may range between 0.9% and 1.5% vs. 0.1% and 0.5% in males, bulimic symptoms and body dissatisfaction in gay men was found to be 14% in a sample of gay men in the United States (Russell & Keel, 2002). Sexual minority men may be disproportionately overrepresented in studies assessing eating disorder rates. In one study, of adolescent boys and girls, gay/bisexual boys reported higher body image disturbances, more

usage of purging and diet pills, greater concern and investment in looking like idealized media images of men, and higher bingeing rates compared to heterosexual boys (Austin et al., 2004). Murray and Touyz (2013) argued that gender role orientation may be more indicative of eating disorder symptom risk. They noted that men with a masculine gender role orientation may be more driven toward muscularity, whereas men with a feminine gender role orientation may be driven toward thinness. In the case of cis men, symptom development and treatment may require different approaches, depending on gender role orientation. In the case of gay/bisexual men, experiences of marginalization may increase risk for disordered eating and correlates.

Physicians may also be more likely to overlook symptoms in racially marginalized groups. A common stereotype is that body image ideals are different in Black and Latinx communities, and they are therefore protected from disordered eating/eating disorders which are based on White cultural body ideals (Gordon et al., 2006). Gordon et al. (2006) found in their study of eating disorder diagnosis that clinicians were more likely to diagnose White women's over Hispanic and Black women's eating behaviors as concerning, despite the vignettes only differing in race of the client (whether the women discussed were referring to cis or trans women or both was not stated). Multiplicity of experiences of oppression shape body image and dissatisfaction, i.e., the environmental stressors related to facing intersections of racism and sexism can negatively influence body image (Capodilupo & Kim, 2014). Adolescent boys of color may also have elevated rates of disordered eating symptoms compared to White boys (Austin et al., 2011). In their sample of 16,798 female and male adolescents (whether cis or trans or both was not assessed) in Massachusetts, Black, Hawaiian/Pacific Islander, American Indian/Alaskan Native, Latino, Multiethnic Black and White, and "other" were more likely to report disordered weight-control behaviors compared to the White referent group in the study

(e.g., vomiting, use of laxatives, or diet pills). Further, people of color may be less likely to receive help regarding disordered eating, despite similar rates of eating disorders across racial identities (Marques et al., 2011).

Correlates with Common Disordered Eating Behaviors

Psychiatric comorbidity with disordered eating are very common. In a national sample of over 9,282 individuals, over 50% of individuals with anorexia, 95% of individuals with bulimia, and 77% of individuals with binge eating disorders also met criteria for an axis I disorder or substance use disorder (based on the DSM-IV)—primarily anxiety and depression (Hudson, Hiripi, Pope, & Kessler, 2007). Those diagnosed with anorexia or bulimia also reported a lifetime prevalence of mood disorders of 50-75%, with women more likely to have posttraumatic stress disorder, and men more likely to have comorbid substance use (Fallon & Lannon, 2016). Although it is unclear whether the comorbid disorder symptoms precede or follow eating disorder symptoms, eating disorder symptoms nearly always include body dissatisfaction, which has been shown to influence self-esteem and mood (Fallon & Lannon, 2016). For anorexia and bulimia, previous research has shown a range of comorbidity of anxiety symptoms, ranging from 25-75% (Fallon & Lannon, 2016). Compared to anorexia and bulimia, binge eating disorder appears to have lower rates of reported anxiety, based on a sample of 925 eating disorder patients (Brewin, Baggott, Dugard, & Arcelus, 2014). Substance use disorders have wide, unclear estimates of comorbidity, ranging from 3% to 55% (Holderness, Brooks-Gunn, & Warren, 1994). Researchers noted important experiential similarities between substance abuse and disordered eating, where an individual with eating disorder symptoms may experience craving, preoccupation, self-destructive behavior, and medical issues (Mann et al., 2014). Therefore, depressive symptoms, anxiety symptoms, trauma symptoms, and substance use are all correlated

with eating disorder symptoms.

Various personality characteristics like perfectionism and a tendency toward shame may also be closely related to eating disorder symptoms. Those with reported high perfectionism may be geared toward investment of self-worth in narrow and inflexible parts of the self, such as thinness, in the case of many with eating disorder symptoms (Fallon & Lannon, 2016). Shame and criticism are also implicated in eating disorder development and maintenance (Gee & Troop, 2003). Shame is the internal evaluation of self-aspects that are perceived as unacceptable, and may lead to experiences of rejection (Pinto-Gouveria, Ferreira, & Duarte, 2014). When an individual experiences intense shame and criticism, they may experience self-contempt, and attack themselves harshly. This shame can manifest as body dissatisfaction, with comparing idealized images in an individual's environment. In studies regarding shame and eating disorders, self-blame and lack of self-affirmation was positively correlated with disordered eating (Forsén Mantilla, Bergsten, & Birgegard, 2014).

Eating disorders have also been linked to experiences of trauma. History of child sexual abuse, childhood mistreatment, poverty, neglect, and other childhood adversity has been linked to higher risk for eating disorders in both females and males (Fallon & Lannon, 2016). Oppression also appears to increase risk for negative mental health outcomes. In the case of women, sexualization and objectification can lead to disconnection from one's body and needs, attempts to control body shape and size through dieting to fit rigid ideals of women's bodies, and increased risk for experiences of trauma (Maine & Bunnell, 2010; Fallon & Lannon, 2016; American Psychological Association, 2007).

Researchers and theorists have provided complex understandings of eating disorders in women and men. From critique of sexism in society to idealized and rigid body ideals, authors

have provided an in-roads for further research and informed treatment. Understanding correlates and comorbidities can support effective treatment that addresses the complexity of treating disordered eating. In this research, there may have been trans individuals included, but these identities were not assessed. Therefore, further research is needed to understand how experiences as trans individuals may affect disordered eating, manifestations, and treatment, if at all.

Eating Disorder Symptoms in Trans Populations

In the previous sections theories regarding eating disorder development in women and men, trans people are not mentioned. However, there may be similarities across symptom manifestations, comorbid disorders, and higher prevalence of disordered eating behaviors in trans populations compared to cis populations (Witcomb et al., 2015; Diemer et al., 2018). Trans minority stress may be implicated in the higher prevalence of eating disorders. Trans minority stress is negative mental health outcomes due to experiences of prejudice and discrimination related to being a trans individual (Hendricks & Testa, 2012). Further, the intersections between body dissatisfaction and gender dysphoria (incongruence between gender and assigned gender) may put trans individuals at increased risk. However, not all trans people experience gender dysphoria. Research findings have also shown conflicting results on whether the prevalence in disordered eating exist.

Some research indicates that trans women and men may be at greater risk of disordered eating than cis women and men. Diemer et al., (2015) conducted a study of 289,024 college students in the United States. The authors compared eating disorder behaviors across cis heterosexual, sexual minority, and “unsure” sexual orientation women and men with trans individuals. The researchers used logistic regression to estimate odds of eating disorder symptom outcomes. Cis heterosexual women were the referent group given they were the largest subgroup

and cis heterosexual women are the most studied population in eating disorder literature (Diemer et al., 2015). Researchers found that trans students had the highest prevalence of eating disorder diagnosis (bulimia or anorexia), past month use of vomiting or laxatives to prevent weight gain, and past month use of vomiting/laxatives across groups. Cis sexual minority men and women also had elevated rates of self-reported eating disorder diagnosis compared to cis heterosexual women. The authors noted that trans women and men may be using disordered eating behaviors to control gendered features, but did not include an explanation for possible nonbinary individuals in their sample. The authors also indicated that disordered eating behaviors may be used to cope with minority stress for trans and sexual minority cis participants.

Body Dissatisfaction and Gender Dysphoria

Disordered eating in trans populations are often explained as maladaptive coping with gender dysphoria. In other words, behaviors such as restricting food intake are used to suppress secondary sex characteristics. For trans women, striving to become more thin and stereotypically feminine, and for trans men, striving to minimize secondary sex characteristics like chest size. These explanations initially stemmed from case studies on trans individuals (Ålgars, Alanko, Santtila, & Sandnabba, 2012; Couturier et al., 2015; Vocks, Loesner, & Legenbauer, 2009). Couturier and colleagues (2015) discussed two case studies with two adolescents in treatment for anorexia. In both cases, weight restoration led to increased gender dysphoric feelings. The authors noted that weight gain may have led to accentuated secondary sex characteristics, and increased awareness of gender dysphoria. The authors indicated that common experiences associated with anorexia like body uneasiness, body dissatisfaction, and compulsive self-monitoring may also be manifestations of gender dysphoria. Therefore, they recommended attention to the possible overlap of symptoms in treatment. The patients were both recommended

to a gender clinic post treatment, and the authors noted the importance of addressing safety and life-threatening problems prior to treatment for gender dysphoria.

Body dissatisfaction, a common correlate with disordered eating, appears consistently in studies with trans women and men and may be a manifestation of gender dysphoria. Vocks, Stahn, Loenser, and Legenbauer (2009) conducted a study in Germany, Austria, and Switzerland comparing 88 trans women, 43 trans men, 72 cis individuals with eating disorder diagnoses, and 163 cis participants without eating disorder diagnoses. Trans individuals reported higher body dissatisfaction compared to cis participants without eating disorders, but lower body dissatisfaction compared to cis participants with eating disorders. Becker and colleagues (2015) conducted a study in Germany with 135 trans men, 115 trans women, and 235 cis female and 379 cis male controls. They found that body dissatisfaction specific to sex characteristics were higher in trans individuals than other body parts unrelated to sex or secondary sex characteristics. Witcomb and colleagues (2015) in the United Kingdom supported Vocks and colleague's (2009) findings with a sample of 200 transsexual individuals, 200 eating disorder patients, and 200 (cis) healthy controls. Although trans participants reported greater body dissatisfaction than the control group, cis individuals with eating disorder diagnosis reported the greatest body dissatisfaction. Like Becker and others' (2015) study, trans individuals reported body dissatisfaction was related to secondary sex and primary sex characteristics. Cis and trans women both reported higher drive for thinness than cis and trans males. This may be due to drives to fit cultural standards for women to be thin (Davis, 2009). Trans males however reported higher scores of body dissatisfaction, similar to those of cis males with eating disorder diagnosis. The authors explained femininity as a risk factor for body dissatisfaction; therefore, trans men are negatively affected by their "socialization as female," whereas "socialization as male" was

protective for the trans women and cis men in their study. This explanation is contradictory to the finding that trans women and cis women reported greater drive for thinness. Further, researchers did not assess for participant experiences surrounding gender socialization, experiences of minority stress, gender dysphoria, gender role orientation, or other possible variables that have been used in previous studies to give further context for similar findings. Although one's socialization as a particular gender could be an explanatory variable, the authors assumed that a trans person who may not identify with their assigned gender has the same gender experiences as someone who does identify with their assigned gender. To assume this without any supporting evidence supports transphobic beliefs that trans people's genders are not as valid as cis people's genders.

To test whether medical treatment for dysphoria could also alleviate body dissatisfaction, Testa, Rider, Haug, and Balsam (2017) sought to understand the influence of gender-confirming medical intervention on eating disorder symptoms. They hypothesized that individuals that have had gender-confirming medical intervention(s) would also report greater body satisfaction and therefore, fewer eating disorder symptoms. Researchers noted that previous research on body image in trans individuals did not distinguish among types of body dissatisfaction; if certain body dissatisfaction was tied to parts of the body related to gender dysphoria, then gender-confirming medical interventions may alleviate this dissatisfaction and associated disordered eating. The authors also noted the important aspects of ways social pressures may influence internal dissatisfaction (trans minority stress). In other words, if a trans individual is in a nonaffirmative environment, this may increase internalized stigma, and then lead to negative mental health outcomes, which may include body dissatisfaction and disordered eating. They noted that because gender nonconformity increases this risk for minority stress, gender-

confirming medical interventions may lead to more conformity, less negative interactions, and less minority stress (although shifting the environment to be more affirming would theoretically provide similar outcomes).

Testa and fellow researchers (2017) included 304 participants from the United States and Canada. They measured body satisfaction (through the Body Satisfaction Scale), which gender-confirming medical interventions participants considered/pursued, gender nonaffirmation (a measure regarding how unaffirmed they felt in their gender), and an eating disorder symptoms and psychological characteristics measure (Eating Attitudes Test-26). Majority of participants were White (89.6%), had completed high school (47.4%), made less than \$30,000 (42.9%), and lived in a suburb/close to a city (42.9%). Researchers split participants into two groups, based on gender assigned at birth: trans feminine for assigned male at birth ($n = 154$), and trans masculine for assigned female at birth ($n = 288$). From the data, the researchers created a mediation model. When controlling for education level, age, and household income, they found that gender-confirming medical interventions and disordered eating had no direct relationship. However, nonaffirmation and body satisfaction mediated the relationship between gender-confirming medical interventions and disordered eating. From these findings, it appeared that environmental affirmation may not be the sole factor influencing disordered eating—that perhaps individuals feeling satisfied with their bodies also played an important role for gender-confirming medical interventions serving as an effective intervention in reducing disordered eating.

Testa and colleagues' (2017) study produced similar findings to Kozee, Tylka, and Baurband's (2012) study of 342 participants in the United States. They developed the Transgender Congruence Scale that measured trans congruence: the extent to which a trans person feels authentic and comfortable with their appearance and trans identity. Researchers

found that trans congruence was negatively correlated with body dissatisfaction—the more congruent they felt in their identity and appearance, the less dissatisfied (or more satisfied) they felt with their bodies. From these two studies, external and internal acceptance of self can influence the effectiveness of treatment for gender dysphoria.

Femininity: A Risk Factor for Disordered Eating in Trans People?

Some researchers hypothesize that rather than identity, feminine gender role orientation may be a risk factor for disordered eating. Cella, Iannaccone, & Cotrufo (2013) conducted a study with a sample of 132 gay (cis) people, 178 heterosexual (cis) people, and 15 trans women. They wanted to research how gender role orientation, as measured by the Bem Sex Role Inventory (BSRI), would correlate with self-report eating disorder symptomology (as measured by the Eating Disorder Inventory-2), and body image. Researchers also recorded “biological gender” (sex), sexual orientation, occupational level, and whether the individual had sex reassignment surgery. They hypothesized that respondents with high femininity (as measured by the BSRI) would have higher eating-disorder-related psychological characteristics and behaviors. Scholars found that in general, heterosexual cis men reported the lowest disordered eating and trans women reported the highest. They found that scores of low masculinity positively correlated with reported body dissatisfaction, and eating disorder traits of ineffectiveness, interpersonal distrust, and social insecurity. Scores of high femininity positively correlated with eating-disorder-related psychological characteristics of drive for thinness, the trait of interoceptive awareness, and bulimic behaviors. However, participants that reported both high femininity and high masculinity had lower scores on the eating disorder measure than individuals who solely reported high femininity. The authors reported that their findings supported their hypothesis that “hyperfemininity” is linked to anorexia. Although high femininity was positively

correlated with drive for thinness, androgyny (high femininity and high masculinity) was not. The researchers claimed masculinity is thus a protective factor regarding eating disorders. However, eating disorders may be culturally biased toward stereotypically feminine presentations, and thus may underdiagnose other forms of presentations (Bunnell, 2010). The study included only 15 trans women who had gender-confirming medical interventions, and, therefore, may not be representative.

The aforementioned studies illuminated important possible connections between gender dysphoria, body dissatisfaction, and disordered eating. However, nonbinary participants were not included. Some nonbinary individuals do experience gender dysphoria but not all report this experience, nor do all seek medical transitioning (McNabb, 2018). Gender-confirming medical interventions, body satisfaction, and greater affirming environments could also alleviate gender dysphoria and disordered eating in nonbinary populations, but this is inconclusive given the limited samples. Some nonbinary individuals may identify as feminine at times or may have been assigned female at birth, and possibly “socialized female” and perhaps may be at higher risk of disordered eating behaviors. Nonbinary individuals may also be using disordered eating behaviors as forms of coping for mental health concerns. However, there has not been comprehensive research on nonbinary individuals thus far to support these findings. Therefore, it may be important to further explore what nonbinary identity is as well as what eating disorder literature exists on nonbinary individuals.

Nonbinary Gender Identity

Nonbinary gender identity is a category of gender identity where one’s gender may not fit into the Western binary identities of man or woman (Webb, Matsuno, Budge, Krishnan, & Balsam, 2015). A nonbinary person may identify as a mixture of both, a gender identity outside

of these categories, without a gender identity, or more than a single gender identity (James et al., 2016). Nonbinary individuals may also move between or outside gender categories, and others may not (Chang, Singh, & Rossman, 2017). Given that nonbinary people identify differently than the gender assigned at birth, they may fall under the transgender (trans) umbrella (McNabb, 2018). However, not all nonbinary individuals may identify themselves as trans (Singh & dickey, 2017). Examples of nonbinary gender identity include: neutrois, genderqueer, agender, bigender, gender expansive, and gender-fluid (Webb et al., 2015; McNabb, 2018). Genderqueer has also been used as an umbrella term for individuals outside the gender binary, and as a gender identity under the umbrella of nonbinary (Gordon, Austin, Krieger, White Hughto, & Reisner, 2016; dickey, Reisner, & Juntunen, 2015; Webb et al., 2015). In this paper, nonbinary will be used as an inclusive term for all gender identities that fall outside of man and woman.

Western psychology's recognition of nonbinary people has expanded in recent years. For example, some nonbinary individuals may experience gender dysphoria, which has several variations in definitions. The American Psychiatric Association (2013) in the most recent version of the DSM-V defines gender dysphoria as:

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the

anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, and other important areas of functioning

The definition includes nonbinary individuals, in its inclusion of “some alternative gender different from one's assigned gender.” Compared to DSM-IV-TR (2000), the fifth edition expands from binary definitions of gender, and from categorization of trans identities broadly as symptoms, to instead focusing on gender dysphoria and possible clinical-level dysfunction associated with symptoms. However, several inherent assumptions in the diagnosis of gender dysphoria can be exclusionary, such as hormone treatment and gender reassignment surgery equating to “posttransition.” Further, diagnostic features adhere to the “trapped in the wrong body” narrative of trans lives, in which trans individuals express stereotypical gender presentations and interests not expected of their assigned sex at birth, e.g., he was assigned female at birth but always liked blue and showed interest in “rough-and-tumble” play. The narrative can be reductive and reinforcing of cissexist beliefs surrounding gender development and identity, and can lead to gatekeeping surrounding gender-confirming medical procedures,

requiring individuals to fit into this narrative to receive access to medical transitioning (Spade, 2003). McNabb (2018) simplifies the definition of gender dysphoria as intense distress related to misgendering from others and/or “one’s sexed body not being aligned with one’s gender” (pp. 10). In this definition, McNabb also includes the social and institutional interactions that can lead to gender dysphoria, whereas the DSM focuses primarily on the individual and the person’s reactions to one’s own body. And, as the author indicates, gender dysphoria is not a requirement to be authentically trans.

Nonbinary People and Disordered eating

Nonbinary individuals may have increased odds of eating disorder diagnosis. Three studies have explicitly explored disordered eating in nonbinary individuals. Watson, Veale, and Saewyc (2017) used data from the 2014 Canadian Trans Youth Health Survey. Participants ages ranged from 14 to 25, with average age of being 20. The majority of participants identified as White Canadian (74%), and nearly 10% identified as Aboriginal (Inuit or Metis). Participants were categorized as trans girls/women, trans boys/men, or non-binary. Experiences of enacted stigma (discrimination, harassment, bullying, violence due to being trans), protective factors (social support, school connectedness, and family connectedness), and disordered eating behaviors (in the past months, whether the respondent binge ate, or attempted to control weight via fasting, diet pills, laxatives, and/or vomiting). A majority of participants (46%) did not report disordered eating behaviors. Twenty-six percent reported one disordered eating behavior in the past year, and 18% reported more than one disordered eating behavior. Fourteen to eighteen-year-old boys reported fewer incidences of vomiting compared to nonbinary individuals of the same age group. Nonbinary individuals 19-25 reported fewer fasting behaviors compared to trans women. Forty-two percent of 14-18-year-old trans youth reported bingeing at least one time in the

previous 12 months; 48% reported fasting, 7% used diet pills, 5% used laxatives, and 18% reported vomiting to control weight. In general, of the 19-25-year-olds, 27% reported fasting, 4% used diet pills, 3% used laxatives, and 5% vomited to control weight. Researchers found that enacted stigma experiences were associated with disordered eating behaviors, whereas protective factors were negatively correlated with these same behaviors. Family connectedness was of particular importance for youth 14 to 18, since it was significantly correlated with less disordered eating behaviors. These statistics are elevated in comparison to the general youth population where 27% report binge eating, and 5% report vomiting. The authors noted that participants may be motivated to attain more masculine or feminine appearance through disordered eating behaviors, in line with previous researchers' explanations. However, assessment of why participants exhibited disordered eating behaviors was missing.

Diemer et al. (2018) sought to explore differences of disordered eating across gender identities and included a nonbinary sample (which they categorized as gender-nonconforming). Researchers conducted a study with 452 healthy trans adults in Massachusetts, ages 18 to 75. Most participants were White (79.3%) and had completed a four-year college degree (33.9%). They categorized participants as trans men, trans women, gender-nonconforming participants assigned male birth, and gender-nonconforming participants assigned female at birth. They assessed if participants had been diagnosed with anorexia or bulimia and conducted a logistic regression analysis. Gender-nonconforming assigned female at birth participants were the largest group and thus used as the referent category. Of the total sample, 7.5% reported eating disorder diagnosis. The authors noted that the general population, 0.3% of cis males and 0.9% of cis females reported diagnosis of anorexia, and 0.5% of cis males and 0.9% of cis females reported diagnosis of bulimia. Nonbinary individuals in the study had 3.16 times the odds of self-reported

eating disorder diagnosis compared to trans women and men. The authors concluded that nonbinary individuals may have elevated eating disorder diagnosis compared to “binary” trans individuals due to heightened risk of enacted stigma as visibly gender-nonconforming. They noted this stigma likely leads to worsened mental health and subsequent manifestations of eating disorder diagnosis. The authors did not assess for enacted stigma/experiences of oppression, nor did they assess participants’ understanding of their gender presentation, so reasons for these increased odds are unclear.

Tabaac and colleagues (2018) sought to understand possible links between anti-trans discrimination, mental health, and body appreciation. Seventy-eight participants were recruited from the United States to complete an online survey. Trans women, men, and nonbinary individuals were included in the study. Participants were White (61.5%), 12.8% were multiracial/multiethnic, 10.3% were Asian/Asian-American/Pacific Islander, 9% were Black/African-American (non-Latino), 2.6% were Latino/Hispanic, 1.3% were American Indian/Native American, and 2% identified as “other.” Forty-one percent identified as queer, 15.4% as bisexual, 15.4% as heterosexual, 12.8% as bisexual, and 15.4% as other. Regarding education, 35.9% reported some college, 34.6% reported a bachelor’s degree, 14.1% reported a master’s degree, 7.7% reported a 2-year associate’s degree, 6.4% reported a high school diploma/GED, and 1.5% reported a doctorate degree. Most were employed full-time (34.6%), 20.5% were employed part-time, 19.2% were attending college/university and employed, 14.1% were college students, and 11.5% were unemployed. Participants were asked to complete a measure of discrimination based on being lesbian, gay, bisexual, transgender, and/or queer (LGBTQ), measure of depression and anxiety, self-esteem, satisfaction with life, and body appreciation (an individual’s approval and respect for their body). Results indicated that

experiences of harassment/rejection as an LGBTQ person had a negative correlation with body appreciation whereas self-esteem and satisfaction with life had a positive correlation with body appreciation. Using a regression analysis, the authors tested a mediational model. Self-esteem and satisfaction with life fully mediated the association between harassment/rejection and body appreciation. In other words, without the effects of self-esteem and satisfaction with life, there would be no significant association between harassment/rejection and body appreciation. The authors posited that experiences of harassment/rejection reduce a trans individual's self-esteem and satisfaction with life, which then reduces body appreciation. The groups were not compared, so differences among trans women, men, and nonbinary individuals in this study were unclear. Further, although the authors noted that gender dysphoria and concerns for appearing cis (passing) may affect body image, this was not assessed.

All three studies that explicitly included nonbinary individuals implicated gender dysphoria, experiences of oppression as trans individuals, and concerns with appearing either more feminine or masculine as influencing disordered eating behaviors and/or one's relationship with their body. Studies also included primarily White samples, and did not include consideration of how other aspects of experiences and identities may influence disordered eating and body image. Appearance strivings were not assessed, nor was gender dysphoria. Further, there lacks research on how nonbinary individuals relate or differentiate from findings on trans women and men. Nonbinary individuals may have elevated rates of disordered eating, but research has yet to show why. Minority stress may be implicated in the manifestation of disordered eating.

Cissexism and Influence on Disordered eating

Cissexism is the systemic oppression of trans individuals and privileging of cis

individuals (Serano, 2007). Cis privilege is social advantage based on the normalization of cis identities and othering of trans identities. Trans identities are thus delegitimized, leading to an array of harmful outcomes on the mind, body, and spirits of trans people. One model of explanation of mental health outcomes is the Minority Stress Model, derived from Meyer's (1995) work regarding mental health outcomes for LGB individuals (Hendricks & Testa, 2012). Hendricks and Testa (2012) pinpoint experiences of oppression (in forms of violence, rejection, discrimination) lead to greater rates of negative mental health outcomes.

Minority Stress Among Trans People

To understand the impact of oppression on trans individuals, Hendricks and Testa (2012) expanded Meyer's (2003) minority stress model for LGB individuals to trans individuals. Meyer's (1995) original model described experiences of prejudice and discrimination as direct influences on negative mental health outcomes for marginalized groups. Meyer noted that higher rates of mental health struggles in LGB groups were related to marginalizing environments, which increase minority stress, excessive stress related to one's marginalized position. Minority stress can occur through three processes: 1) external events, like being misgendered (i.e., identified as the wrong gender, via pronouns, gendered honorifics, etc.), 2) anticipation of these events, such as anxiety when walking into a bathroom, and 3) society's negative beliefs and attitudes are internalized, like believing one is misgendered because their gender is not "real" enough (Hendricks & Testa, 2012; Matsuno & Israel, 2018; Meyer, 2003). Types of stressors are broken down to distal and proximal stressors in which distal are external stressors (i.e., the external events) and proximal stressors are stressors that are essentially reactions from distal stressors (i.e., the anticipation and internalization of transphobia) (Hendricks & Testa, 2012; Matsuno & Israel, 2018; Meyer, 2003). Individuals that embody multiple marginalized identities

face oppression on multiple levels, increasing risk for exposure to minority stress (Hendricks & Testa, 2012). Therefore, for example, a racially marginalized trans feminine person may face greater risk of negative mental health outcomes because of environmental stressors associated with being a trans feminine person of color.

External events: Distal stressors. Trans visibility and rights in the United States have increased, and trans people continue to face many barriers. The Report of the 2015 U.S. Transgender Survey reflected the growing awareness and openness of trans individuals, and also showed the continued discrimination and harassment many trans people face (James et al., 2016). Sixty-percent of the participants who were out to their families they grew up with described their families as generally supportive, compared to 18% that reported their family was unsupportive, and 22% that said neither supportive or unsupportive. Those supported also tended to reported less economic strain and negative experiences related to health compared to those who reported unsupportive families. Regarding documentation, 89% of participants did **not** have all their documents match their gender and name, with over 68% reporting that none of their IDs matched their gender. Twenty-three percent of participants reported housing discrimination in the past year, with 12% reporting experiencing homelessness in the past year due to being transgender. One in five participants reported that at some time in their lives, they participated in the underground economy, i.e., criminalized work such as sex work and drug sales. Respondents reported mistreatment from police, with over 30% of Black trans women and multiracial trans women reporting that police often assumed they were sex workers. Most participants (57%) reported discomfort going to the police for help. Of those arrested, held in jail or juvenile detention centers, they were five times more likely to be sexually assaulted by staff and nine times more likely to be sexually assaulted by other inmates than the general U.S. population in

jail.

A majority of participants indicated that none of their IDs had their preferred name and gender. For trans youth out in their respective schools, 77% reported experiencing mistreatment such as verbal harassment, barriers to dressing in a gender-confirming manner, discipline for defending themselves, and physical attacks. Of participants that reported employment, 30% noted gender-related discrimination in the form of barriers to promotion, being fired, or other forms of mistreatment. Forty-six percent reported cissexist verbal harassment in the past year, and 9% reported cissexist physical attack in the past year. In the sample, those who reported sex work, experiences of homelessness, and/or disabilities were more likely than other respondents to have reported sexual assault in their life. Twenty-four percent reported severe physical violence by an intimate partner, compared to 18% in the general U.S. population. Thirty-one percent reported at least one form of mistreatment in a public accommodation space, such as public transportation, retail store, and crisis centers. Twenty percent reported avoidance of at least one place of public accommodation from fear of harassment/mistreatment as a trans person. In the context of restrooms, even prior to the national media attention in 2016 in the United States, 9% of respondents reported denial of restroom access in the last year, 12% reported verbal harassment, 1% physical attack, and 1% sexual assault. A large proportion of participants, 59%, reported restroom avoidance out of fear of harassment; 32% limit food and liquid intake to reduce restroom use; and 8% reported medical complications like kidney infections from restroom avoidance.

Associated with these distal stressors, a large proportion of participants reported mental health concerns and distress. Thirty-nine percent of participants reported serious psychological distress, in comparison to the 5% in the general US population. While 4.6% of the general US

population have reported suicide attempts in their lifetimes, 40% of the participants in the study have. Lastly, in the past year of the study (2014), 7% have attempted suicide, in contrast to 0.6% of the US population.

A distal stressor that may be common to some trans people is misgendering: the misclassification of one's gender. In a cissexist world, this is a form of enacted stigma, shaping how a trans person may feel and evaluate and their social identity (McLemore, 2015). McLemore (2015) conducted two studies and assessed both frequency of misgendering and how devalued the participant felt when misgendered. In the first study, there were 115 trans participants, median age 36 ($M = 37.93$, $SD = 14.18$). Participant racial demographics were: 85.2% European-American, 6.1% mixed race/ethnicity, 5.2% Latin@-American, 2.6% Asian-American, and 0.9% Middle Eastern. Regarding gender, all participants either identified as trans or genderqueer. They were then asked based on a list of available genders, which label they most often used, such as transgender, transgender man, transgender woman, FtM (female-to-male), MtF (male-to-female), female, male, genderqueer, or something else. Participants were also asked their sexual orientation, in which options were: heterosexual, bisexual, gay or lesbian, queer, homosexual, or something else. Frequency of misgendering was assessed using the question "How often do people 'misgender' you?" and respondents answered through a 5-point Likert scale of (1 = *Never*, 5 = *Always*). Next, participants were asked to respond again to a 5-point Likert scale (1 = *Never*, 5 = *Always*) regarding the statement "I feel stigmatized (looked down upon) when I am misgendered." They were also asked how they perceived cis people felt toward trans people. To assess the influence of the frequency and/or feelings of stigmatization, participants were also asked to respond to self-report measures regarding self-esteem, affect, and authenticity. Participants also answered a measure of identity strength, importance, and congruence to

understand how important gender was to overall self-concept.

The results of the first study showed that while frequency of misgendering was not significantly associated with negative affect, feeling stigmatized was. The data showed that more frequent misgendering was associated with more negative assessments of one's appearance (i.e., appearance self-esteem). Higher feelings of stigmatization were associated with more negative feelings about one's appearance, but more favorable assessments of oneself in social situations. However, feeling stigmatized when misgendered was not significantly correlated to identity strength, importance, or congruence, but feeling more stigmatized did positively correlate with feeling less authentic. Participants that reported more frequent misgendering also reported more identity importance, but less identity congruence and strength compared to participants who reported lower frequency of misgendering. The second study replicated the first on several items, and the author sought to compare genderqueer, trans men, and trans women. In the second study, genderqueer participants reported higher rates of being misgendered compared to trans men and women. The three groups did not differ in felt stigma, though all three reported that when misgendered, they felt moderately stigmatized. Greater feelings of stigma when misgendered related to feelings of shame, whereas frequency did not. More frequent misgendering appeared to be associated with a person's desire for correct identity-appraisal, and felt stigma seemed to be associated with a respondent's desire to be seen more generally favorably. The researcher noted that the studies supported the importance of being accurately seen as one's identity, even if that identity is a marginalized identity.

From these findings, it appears that how a trans person understands the experience of misgendering, over how often misgendering occurs, is associated with the person's affect, self-evaluation, and self-esteem (McLemore, 2015). For example, if a trans woman were to perceive

a friend using the wrong pronoun on accident, she may not be as strongly affected. However, if she were to perceive another individual intentionally using the wrong pronoun to diminish her identity, her affect, self-evaluation, and self-esteem may be more affected. In relation to minority stress, misgendering can be a strong contributing factor to negative affect, particularly if the individual perceives enacted stigma when misgendered (McLemore, 2015).

Nonbinary individuals may face unique challenges as individuals with genders that are outside the binary. In James and colleagues' (2016) national survey, 44% of nonbinary participants reported usually allowing others to assume their gender was in the binary. A majority of the nonbinary participants (86%) reported that others often do not understand, so they do not attempt to explain, 82% report that it is easier not to let others know, and 62% of nonbinary individuals in the study reported their genders were dismissed (63%). Of the nonbinary portion of the sample, 6% reported others could always tell they were trans, compared to 32% who reported sometimes, and 62% who reported rarely or never. In consideration of McLemore's (2015) study, the lack of acknowledgement of nonbinary people's gender identities may be a form of minority stress, negatively influencing affect, self-evaluation, and self-esteem.

In consideration of the negative experiences in numerous realms of life such as home, school, public spaces, bathrooms, work, criminalized labor, and generally being in public, trans individuals may internalize these experiences, leading to negative mental health outcomes, including disordered eating and body image concerns. Proximal stressors occur when an individual learns to avoid and protect themselves from distal stressors through: internalizing transphobic messages, learning to expect rejection/harm/discrimination, and concealing their identities. This internalization, expectation of general negativity from others, and concealment of identity can then lead to various mental health symptoms like anxiety, depression, suicide

attempts, and substance use (Matsuno & Israel, 2018). Greater risk of body image concerns has also been linked to discrimination, and other mental health outcomes (anxiety and depression) (Tabaac et al. 2018). Therefore, attention to minority stress is necessary to better understand disordered eating in nonbinary populations.

Oppression and Body Image

Disordered eating behaviors, body image concerns, and eating disorder diagnoses appear to be higher in individuals from marginalized groups. In Cella, Iannaccone, and Cotrufo's (2013) study, heterosexual cis men had the lowest reported disordered eating, whereas trans women had the highest. Fallon and Lannon (2016) note that while eating disorder causes are complex and multilayered, there appears to be a link with experiences of childhood maltreatment, such as poverty, and neglect. In consideration with the elevated rates of discrimination, harassment, and violence toward trans individuals in the United States, experiences of oppression may influence possible eating disorder symptom rates in trans individuals.

Current Study

From what is available in the eating disorder and nonbinary research literature, specific influence of discrimination and oppression is unclear. There lacks a comprehensive theory for understanding etiology and maintenance of disordered eating in nonbinary people, influence of developmental experiences and how an individual understands their body, whether gender dysphoria plays a role, whether gender transitioning ameliorates symptoms, and what about the individual's environment is implicated in exacerbation of symptoms. It may be that current theories developed for cis women are applicable; however, additional research is needed to clarify.

With the attention to experiences of oppression, and lack of depth known regarding

disordered eating in the nonbinary population, qualitative methodology can assist in addressing these gaps in literature (Warner, 2004; Corbin & Strauss, 2015). Previous qualitative studies have shed light on disordered eating in trans populations (Algars et al., 2012). The researchers' rationale continues to inform and shape studies on disordered eating and trans populations. With the lack of understanding of the higher than average prevalence of disordered eating in nonbinary samples, participant perspectives and lived experiences may be a key. Grounded theory (Glaser & Strauss, 1967) was used to better understand the phenomenon of eating disorder symptomology (e.g., disordered eating behaviors, body image disturbances) in nonbinary individuals. With the diversity among nonbinary individuals, particularly in masculinity, femininity, or neither (Matsuno & Budge, 2017), prevailing theories regarding cis women and men and eating disorder symptom development may not fully encompass, or fail to give voice to, this population's experiences. Therefore, the current study served to address this gap in literature and answer the following research questions:

1. How does disordered eating function in nonbinary individuals?
2. What are the possible influences of gender dysphoria, oppression, mental health, and other identities in experiences of disordered eating?
 - a. Are there specific experiences of oppression nonbinary individuals experience that may contribute to higher disordered eating behaviors?
3. How do participants understand body image concerns as a nonbinary individual?
4. How do pressures to pass, present masculine, and/or feminine influence body image and possible disordered eating?
5. What are possible areas of resilience that may be protective of disordered eating?

CHAPTER 3

METHOD

Inclusion Criteria

Inclusion criterion regarding gender identity was: self-report nonbinary identity, meaning a gender that may be fluid, and/or not fit the categories of Western binary genders of man or a woman (Webb et al., 2015); any history of restricting, bingeing, or other disordered eating behaviors; age 18 or older; and fluency in English. In previous studies of trans people and disordered eating, the category of trans people outside of trans women and men have been labeled nonbinary (Duffy, Henkel, & Earnshaw, 2016; Watson, Veale, & Saewyc, 2017). Although there are those who may identify with terminology which fall under the gender diverse umbrella, they may not identify as trans, e.g., a person who states they are gender nonconforming and cisgender (Moe, Bower, & Clark, 2017). Participants' understanding of their genders were assessed to clarify these self-identifications during the interview.

Due to the common exclusion related to the categorical nature of eating disorders, exclusion criteria were more broad than current diagnosis of an eating disorder. Individuals with disordered eating may move between diagnostic criteria, or present with behaviors like bingeing, restriction, purging (vomiting, using laxatives, exercise, etc.), and weight loss and gain, but not meet full criteria for an eating disorder (Fallon & Lannon, 2016; von Ranson et al., 2005). Some participants reported history of symptoms, since eating disorder behaviors can ebb-and-flow; therefore, remission of symptoms did not preclude participants.

Measures

Demographics Portion of Interview

Participants shared their age, assigned sex, pronouns, definition of gender, their own

genders, and how they felt others perceived their respective genders during the interview. Other demographic information gathered included: sexual orientation, racial/ethnic identity, and financial situation now and growing up. Some participants chose to disclose disability status and mental health concerns.

Disordered Eating

Individuals who self-identify as having history or current disordered eating pattern qualified for the study. Participants responded to an open-ended question to describe their disordered eating pattern prior to the interview (Appendix B) and to a modified eating disorder scale (Appendix C). Eating disorder scales have not been tested for validity or reliability with trans individuals. Questions regarding these behaviors and history were developed from the Stanford-Washington University Eating Disorder Screen (SWED) and Watson et al.'s (2017) study (see Appendix C).

The SWED is used by the National Eating Disorder Association (Graham et al., 2018). SWED was validated using a sample of 549 women, ages 18-25 from St. Louis, Sacramento, and San Francisco Bay Area. In the sample, 56% identified as White with average age being 20.6 years ($SD = 1.97$). Other demographics were not included. Men, actively suicidal individuals, and those with a "severe psychiatric disorder" (like bipolar disorder or psychotic disorders) were excluded. The SWED contains 11 questions and several follow-up questions about demographics, height and weight, eating disorder behaviors, concern about weight, and shape, and impairment. The SWED was adapted from the Eating Disorder Examination-Questionnaire (Fairburn, & Beglin, 1994) and the Eating Disorder Diagnostic Scale (Stice, Telch, & Rizvi, 2000). The SWED had an acceptable sensitivity (0.80) and specificity (0.82) for identification of anorexia, bulimia, and binge eating disorder diagnosis, and similarly high sensitivities for

subthreshold diagnoses. Of the screening questions of the SWED, questions regarding specific disordered eating behaviors were included, such as using laxatives/diuretics, excessive exercise, bingeing, eating restriction, and history of eating disorder diagnosis, in line with previous research that focused solely on disordered eating behaviors in nonbinary individuals (Diemer et al., 2018; Tabaac et al., 2018; Watson et al., 2017),

Watson and colleagues' (2017) study consisted of 923 trans individuals, with 86% identifying as being born in Canada. Seventy-six percent spoke English only in their home, 74% identified as White only, and almost 10% identified as Aboriginal (First Nations, Inuit, or Métis). They assessed binge eating behavior as a single yes/no item: "During the past 12 months, have you eaten so much food in a short period of time that you felt out of control (binge eating)?" They also assessed loss of weight through fasting, diet pills, laxatives, and vomiting through the question: "Have you done any of the following to lose weight or control your weight?" From Watson et al.'s (2017) study, questions regarding the behavior done in the last 12 months were included.

Interview Protocol

I used a semi-structured interview (see Appendix D). I developed the questions from previous research and the gaps noted in the previous chapter, and with feedback from Dr. Tawanda Medley-Greer (my dissertation chair at the time). Based on Corbin and Strauss's (2016) suggestions regarding unstructured interviews, the questions were intended to loosely guide the interview, to give participants space to share their experiences as fully as they feel comfortable. However, I ended up following the questions closely, though I also had some follow-up questions, depending on the participant. This was due to my inexperience with qualitative research, and avoidance and fear surrounding this project. I combatted with the fear of

making a mistake/perfectionism throughout doing the project, which inadvertently led to mistakes being made. I piloted questions with a nonbinary peer with history of disordered eating. From there, I edited questions based on this peer's and Dr. Greer's feedback. The primary feedback included that the questions were technical and not accessible. From there, I changed the language of the questions to be more general, less-leading, and less technical.

Procedure

Participants found the study through Facebook groups, online communities, friends, and e-mail listservs from their university (one participant shared the study to their respective university organizations). Interested participants completed the online questionnaire to confirm history or current disordered eating, and left their contact information and availability. I then reached out to them individually to schedule an interview. A total of 27 people expressed interest in participating through completing the online questionnaire. Of those 27, 15 participated in the interview portion. Participants were initially compensated through entry into a raffle for \$50. Prospective participants shared feedback that the compensation may not be equitable, considering the emotional labor involved in participating in research as nonbinary people. Through reflection of this feedback, and later, a change in my financial background following the start of a postdoctoral fellowship, I chose to reward participants who completed the interview \$15, in addition to an entry into raffle for \$50.

I conducted interviews through Zoom, where some participants opted for video, and others opted for audio-only. Interviews were done from February 2020 to April 2020, after the start of the COVID-19 pandemic. Prior to the interview, I gave participants the consent form regarding their rights and the nature of the study, and information regarding the IRB approval. Upon meeting, participants provided a signed consent form and verbal consent to participate.

Participants were initially given letters as pseudonyms, and later asked their preference for pseudonyms. Participants did not share a preference for pseudonyms, so I ended up choosing names for them. I recorded the interviews and transcribed them manually for the first 11 interviews, and used TEMI transcription service for the final four. For resources and debriefing, I provided participants with a handout with information from the National Eating Disorders Association (NEDA), Trans Folx Fighting Eating Disorders (T-FFED), and two articles from the literature review of this study. NEDA provides methods to find local eating disorder treatment as well as over-the-phone and texting crisis line. T-FFED is an organization by trans and gender diverse people who seek to increase awareness and disrupt the prevalence of eating disorders in trans and gender diverse people, using a social-justice-informed approach. They provide resources, training, and community resources. I debriefed participants about the study, and allowed for participants to ask questions about the study and me. I shared my contact information and the Human Subjects Committee contact if they had questions or concerns at a later point.

Data Analytic Strategy

Data were analyzed using the grounded theory method, developed by Glaser and Strauss (1967), following the procedures and techniques from Corbin and Strauss (2015). Interviews were transcribed word-for-word and included laughter and pauses. After initial interviews, data analysis began to allow for editing hypotheses and comparison of emergent themes. I wrote memos to track thought processes and biases. Writing memos also helped track cumulative thinking of the project, and organize analysis (Corbin & Strauss, 2015).

Open Coding

There are three stages to development of this grounded theory (Corbin & Strauss, 2015). Open coding comprised of the categorization and conceptualization of data, in this case, the

transcription from the interviews. The data were broken into discrete thought units, which consisted of incidents, ideas, events, and acts (Corbin & Strauss, 2015). These units were given names to represent concepts. Concepts were then sorted to form categories based on similar properties. More data were then collected and analyzed to saturate these categories, continuing until conceptual saturation (Corbin & Strauss, 2015). Saturation occurs when new categories are developed regarding properties and dimensions; for theory building, saturation occurs when relationships between concepts are determined (Corbin & Strauss, 2015). New data were compared to previous concepts and similar data coded the same. As categories emerged, the auditor gave feedback regarding changes to categories and meaning of chosen concepts. Auditors provide investigator triangulation to strengthen dependability of the study. Denzin (1978) described triangulation as a method to strengthen dependability of a study. Investigator triangulation uses auditors to analyze and interpret the data. One auditor was used, providing different perspectives for the same data. The auditor facilitated attention to researcher biases, as noted in the statement of subjectivity. The auditor was a Latinx cisgender peer, who has experience using Grounded Theory. She reviewed axial coding and categories. Her feedback was that certain title of categories did not appear rooted in the data and were not apparent in their meaning. She also gave suggestions for other categories that emerged, such as Developmental Contributors to disordered eating.

Axial Coding

The next stage of grounded theory was axial coding (Corbin & Strauss, 2015). In this stage, categories developed in the previous stage were connected, and data reorganized in new ways. Categories were connected by attending to the conditions, phenomena context, actions/interactional strategies, and consequences (Corbin & Strauss, 2015). I reviewed emerging

themes across the open-coding level categories by attending to overlapping participant experiences, motivations, context, and circumstances that facilitated their actions surrounding the primary research topics of disordered eating and nonbinary identity. I reorganized the data multiple times as I began to write the axial-level categories. Through writing, it became apparent that the axial-level codes had more overlap than I previously assumed. For example, I initially coded experiences related to shame as *Underlying*. However, through auditor feedback, and writing, I realized that shame was an emotion and motivator across experiences of both disordered eating as well as experiences surrounding identity.

Selective Coding

The last stage of grounded theory was selective coding (Corbin & Strauss, 2015). From this stage, a core category (or categories) was chosen through the systematic connection of other categories. These connections were validated through the data, and any categories that were needing further development were refined. The core category is “the central phenomenon around which all the other categories are integrated” (Straus & Corbin, 1990, p. 116). This integration of categories becomes the theory.

CHAPTER 4

RESULTS

I explored disordered eating and gender through analysis interviews with fifteen nonbinary individuals. In this chapter, I have presented resulting axial-level categories: *Make the Feelings Go Away*, *Intersectionality*, and *Healing*. See Table 1 for open-level codes grouped by axial-level codes. Within the process of writing these chapter, axial-level categories shifted and open-level codes shifted and changed, a process of Grounded Theory described by Corbin and Strauss (2015). Throughout each category, I have include participant quotes to demonstrate the phenomena.

Participant Profiles

In this section, I introduce these participants and provide some information about each of their stories, as context for the findings of this study. To protect participant privacy, I gave the participants pseudonyms and altered or masked information regarding specific details of their lives and location. Following interview with Aidan, I realized the importance of giving participants options for pseudonym; thus Aidan and IB were given the choice of choosing their name. Other participants had not replied to an e-mail regarding pseudonym preferences, so I assigned them names based off the solar system—planets and moons. Fifteen individuals were interviewed for the study; I did not know participants prior to this study. See Table 2 for table of participant pseudonyms, pronouns, age, gender, assigned sex, racial and cultural identities, sexual orientation, and whether the interview was done using video or audio. The table does not include more qualitative descriptions of ethnic/cultural identity, class, and other salient identities that some participants shared, e.g., size and disability.

Each participant and I had different dynamics which varied based on transference,

countertransference, time of day, and understandings of our roles and the situation, among other factors. For example, with participants of size (participants who experience size oppression), my identity as a thin/straight size person may have impacted our respective interview dynamics.

Interviews were conducted from February 2020 to April 2020, during which I was in the midst of my clinical internship for my doctoral degree. Because of this concurrent clinical training, and honestly, whom I have become as a person, I approached the interviews in hopes of providing a safe and therapeutic space for participants to discuss these issues. With that said, there were some participants that I struggled to connect with due to our respective expectations for the interview, transference and countertransference, and my own level of burn out at the times of certain interviews. Further there were likely participant factors I was unaware of that may have impacted their presentation during the interview. This time period also corresponded with the start of the COVID-19 pandemic in the United States, which may have led to increased anxiety.

Through conducting this study, I have also used my lens as a tool to understand participant experiences. I have come to learn through engaging with participants and self-reflection, that I have similar experiences of disordered eating as a nonbinary person. To understand and illustrate results, I will also interweave my own experiences, as another participant. I have also written about my participant profile as a subjectivity statement.

A note regarding use of terminology: I have chosen to reflect participants' language in referring to themselves. My use of language has also evolved in the process of doing this project. For example, I have used the term fat in reference to participants' self-descriptions. With that said, as someone with thin/straight size privilege, I am conscious my use of the word, though intended to be neutral and descriptive, can be hurtful, given historical and ongoing size oppression. Thus, for this document, I have used terminology that reflects participants' words,

whether that is fat, person of size, etc.

Mar

My engagement in this project and writing is from my subjective perspective—they do not reflect a single truth. I am shaped by my history and circumstances during each step of this process. I identify as a member of Teochew diaspora from Vietnam, and identify as multiethnic, monoracial. I'm 28-years-old, queer, and nonbinary, and use they/them pronouns, and sometimes he/him. I was born in the San Francisco Bay Area and was raised lower middle class. Since reaching adulthood, my family and I have been upwardly mobile, e.g., I have a postgraduate degree. I have had straight size privilege my entire life, and across genders I have experienced.

I had experienced anxiety most of my life, and experienced various forms of rejection in family and socially when I began to recognize my queerness as an adolescent. During this developmental time period, I began to struggle with my relationship with my body and eating. I observed close family members criticize their bodies, and use food and exercise to manage their body negativity. I would fluctuate between feeling good about my body due to my thinness, and inadequate. At times, I felt not womanly enough, not pretty enough, not thin enough, and generally not enough. I perceived my appearance negatively, and consistently compared myself to others. I exercised to points of injury, and used my control of eating to feel good, which often required feeling better than others in various domains. In college, these behaviors focused on orthorexic tendencies where I felt pride in eating only foods I deemed healthy, and felt guilt and shame when I ate foods I deemed unhealthy. I continued to exercise out of fears of losing social capital and losing my sense of self-worth tied to thinness.

At the end of college, I began to dress more masculinely and subconsciously flattened my chest. I fluctuated with my feelings toward my chest, but I thought surgery was extreme. I also

had little awareness of trans identities, and felt strongly that while I wanted to appear androgynous, I was cis. It was not until my early 20s where I closely befriended a nonbinary person, that I (a) learned what nonbinary was, (b) began to consider that identity for myself. However, I was resistant to nonbinary terminology because it felt like it was reserved for White individuals. This change in gender coincided with my racial identity development in Southern Illinois and graduate school, where I experienced greater awareness of my racial identity and experiences of racism. I began to use they/them pronouns exclusively at this time. I felt both a sense of congruence in recognizing I was not a woman, and a tension when others misgendered me.

Up until my mid-20s, I ebbed-and-flowed in my consideration of hormone therapy and top surgery. Following learning of another trans person's experiences of gender-affirming procedures, I had an overwhelming realization that I may actually want those things. I then began to medically and socially transition, i.e., change my name. It was also during these times that I supported a close friend through an eating disorder and learned about fatphobia from a different friend. From these salient relationships, I had to reconcile my internalized thin privilege, a place I relied on for self-worth. I recognized that if I continued to rely on my privilege to feel good, I would be choosing to rely on something that was based on the marginalization of those close to me. This inadvertently led me to become more conscious about my relationships with and my motivations regarding food and exercise.

As a researcher in this project, I relied heavily on my clinical experience. I have provided therapy for the past six years in preparation to become a psychologist, and worked full-time as a clinician since August 2019. From these experiences, I entered each interview and analyzed the data. With each interview, I experienced self-reflection and sometimes even reconsideration of

my own identity as a trans person and relationship with food. For example, since meeting participants of color, and exploring my own resistance to the term nonbinary, I have come to embrace the term nonbinary. Also, through this project, I have come to identify history of disordered eating and challenges with body image in my life.

Mercury

Mercury was a 23-year-old Biracial (Asian and White) queer/bisexual nonbinary agender person who was assigned female and used they/them pronouns. They described their class background as fluctuating and something they were still trying to reconcile. Raised middle class, they experienced poverty in college. They left college before receiving a degree, and they expressed plans to return to become a psychologist. At the time of the interview, they described moving out of this poverty when they began to live with their partner. They were born in an East Asian, occupied land, and in their childhood moved to a primarily White and religious community. Racism and racial dynamics at home impacted their relationships with others, food, and themselves.

Regarding disordered eating, Mercury described their childhood and what led to their disordered eating in their teens. As a child, they noted their body felt encroached on. Examples of that encroachment included experiences of their White male classmates sexually harassing them and the ways their parents talked about their body. Mercury learned bingeing and purging in their family of origin. With these circumstances, they began to restrict, binge, and purge food in their early teens. Food and exercise became manifestations of punishment, and a place of feeling “strong” if they were able to restrict their eating. Toward the end of high school, they found support which they identified as helping them reduce these behaviors. When they started college, the stress of that change, a toxic (racist, ableist, sexist) school environment, and an experience of

trauma led to resurgence of disordered eating. They described feeling a “deep need to have control again” during this period. By their second semester of college, they entered therapy. At the time of the interview, they felt they had strong support through queer and trans community, having left the university environment, and going to therapy. They also noted changing their social media to include marginalized body types and listening to intuitive eating podcasts (e.g., Food Psych). From these various changes in circumstances and their efforts toward recovery, they shifted their relationship with food.

As a child, Mercury felt their assigned gender felt imposed on them, and that they never identified with a gender. They began to feel distress around their assigned gender at puberty, particularly around bodily changes. They conceptualized their discomfort with their gender as internalized misogyny, until later recognizing that they do not identify as a woman. Mercury was thin as a youth but wanted to be thinner. They felt fear of developing breasts, having an awareness that a woman’s body was a body to be harmed. They described struggling to identify as a nonbinary person until the last few years, due to their femininity, androgynous stereotypes, and connection with issues that face those with similar body parts. They noted drag was an outlet to embrace and express that femininity.

They were the first person I interviewed, and we completed the interview using video and audio. They had a shaved head, and vibrant way of speaking, using hands to gesture and make their points. They were thorough, thoughtful, and prepared for the questions—it felt as if they had discussed these topics in depth with others. I remember feeling appreciative of their humor and warmth, and their use of creative metaphors to describe their experiences. I felt self-conscious in feeling seen by them—reading the interview, and remembering my experiences, my shame and imposter syndrome as a researcher came through. To these emotions, I could feel

their responsiveness and assurances. They were also very knowledgeable regarding social justice and terminology, which I think made it easier for us to connect—perhaps an extended trust. I also felt it brought out a part of me that wanted to prove I was in the “in-crowd”—knowing the right words and right ways to talk about identity. I remember asking follow-up questions, rephrasing, and feeling a fear that I was being a “bad” interviewer by interjecting (looking back, I now realize that is part of qualitative research). I remember feeling we were both trying to connect to one another, especially regarding race. It made me curious what it was like for them as a Biracial person to be speaking with me, a darker skin, monoracial Asian person. They were direct in their questions and suggestions and had a sharp tongue in describing their own experiences.

Venus

Venus was a 23-year-old Black pansexual nonbinary person who was assigned female and used they/them pronouns. They described themselves as living in a queer city. At the time of the interview, they were middle class, which for them meant they were working, able to pay their bills, but they were unable to save money. Growing up, they were also middle class, although for part of their youth, their family lived solely on their father’s income, although they came from a two-parent home. They were able to afford extracurricular activities and never went without food. With that said, they were surprised to later learn as an adult their family at times struggled financially.

Venus’s disordered eating ebbed-and-flowed throughout their life. Starting in high school, they were experiencing depressive symptoms, where they felt out-of-control of everything. A precipitant to their disordered eating was an experience of criticism from their mom regarding their body. From there, they began restricting their food, learning methods from

the Pro-Ana (pro-anorexic) community on Tumblr. Restriction led to passing out during a sports competition, and entering treatment for anorexia. Once entering college, they continued treatment with a therapist, and disordered eating behaviors reduced. However, their depression returned, leading to unintentional weight loss, and food anxiety (fear of eating in front of others). Venus noted that the time of their interview, they were fasting, and unsure whether they needed to be losing weight. Regarding managing their disordered eating, they described attending therapy and engaging with online platforms about eating a limited amount of calories.

Venus described never connecting with binary genders. As a youth, they were aware of trans men and women, and they recognized they did not want to be a man. Feeling that being a man was their only other option, they did not identify as a gender outside of woman. In the last few years, they were introduced to the language of femme, through a Black queer femme person. This term resonated with them. But they experienced gatekeeping, with their lesbian peers denying their use of this label. Over time, Venus began to use just nonbinary, but appeared to feel a sense of loss, anger, and hurt from the queer community for this gatekeeping. They experienced consistent misgendering—at work, in queer spaces, and in dating. They described intersections between their gender presentation and body ideals, wanting a flat chest, and feminine curvy body. With that said, they noted that they experienced social dysphoria, but not body gender dysphoria.

The interview was completed via video call. During the interview, Venus was reflective, humorous, and transparent. There were several moments where, after speaking, they realized their actual feelings about the topic or would react to the words they shared. For example, they described repeatedly that because gender has become a less central part of their life, it affects them less to be misgendered. However, after saying that, they shared, “Yeah, I can’t even say

that. ..I'm still fucking like mad.” They would frequently laugh, and at times, I found myself noticing that perhaps they were feeling sad. The experiences they shared were funny in sort of a professional comedian sort of way—I’d laugh with the awareness that this was also their life, and when that clicked, I could then feel their sadness. I appreciated what I perceived as their commitment to the study and to ensuring they were answering the questions.

Earth

Earth was a 23-year-old Chinese biromantic asexual disabled nonbinary person. Culturally, they identified as part of a Chinese ethnic diaspora from a Southeast Asian country. They identified their specific gender as related to their neurodivergence, and they noted that they experience gender fluidly. They were raised and currently identify as between middle and upper middle class.

Earth described their body image and relationship as tied to their gendered journey. They felt dissociative, i.e., feeling detached from their body, from a young age. When they experienced puberty as an adolescent, they felt further disconnected from their body. They coped with recognition of this discomfort and their non-cis identity through efforts to achieve stereotypical ideals for female proportions and measurements, such as the hour-glass ratio. From a young age, they perceived the default gender as female, and understood themselves as not-male. In their early teens, they identified themselves as not cis, and began to identify as not-female. They discovered terminology of nonbinary, and, although there were many terms they tried, nonbinary felt most congruent. During the interview, Earth reflected on their fear in coming out, and feeling that was a barrier between self-identifying and sharing that with others. When they began to come out to close friends, they described the pain of the contrast of being seen vs. unseen. This form of social dysphoria, being seen and unseen by others, was not

something they experienced when they were out to no one. They noted that this the pain of being unseen versus seen directly influenced their eating.

Earth described how from a young age that eating was shaped by their cultural upbringing, expectations, and influences of choice. They were given specific food portions they felt did not fit their smaller body, and they felt a lack of power in their food-decision-making. They described habits of forgetting to eat, which, over time, they used to intentionally restrict their intake. They described that once hitting puberty, food restriction gave a sense of being able to stop these gendered changes. Their relationship to food ebb-and-flowed, and it was not until around age 21, did they feel their disordered eating became more intense. They left school for medical concerns (including trans-related concerns), feeling dysphoric and “gross.” They described having an awareness that their restriction was leading to being underweight, though their family did not notice.

At the time of the interview, Earth described sometimes falling into similar behaviors, and having insight of when they are engaging in restriction again, where they then may choose to stop. They also noted they were on low dose testosterone, and they had undergone top surgery and a hysterectomy. They described continuing to experience dysphoria at times surrounding some of the changes, recognizing nuances of their relationship to their body and gendered characteristics. With that said, they also felt general satisfaction with changes.

Earth and I completed the interview through audio-only. They were reflective, often describing how they and others spoke, and then commenting on these disclosures based on how they viewed things now. They would often talk with a slight laugh or chuckle in their voice, which would often influence me to laugh along with them. I noticed in myself reactions to what I perceived as judgment of their past self, around things like identifying as trans-masc for a period,

due to pressures surrounding stereotypical nonbinary presentation. With Earth's background, and experiences, I felt I heard bits of my own story in theirs—a small, Asian, AFAB (assigned female at birth) person. I found myself reflective of similar trans-masc pressures. With this and other interviews, I began to question my own relationship to eating and my body as well.

Mars

Mars was a 31-year-old Black and Native American Wiccan fat nonbinary/agender person who used they/them pronouns. They described culturally connecting more with African American culture, than their diasporic roots and indigenous heritage. They were assigned female, and identified as gray asexual and panromantic. They were raised middle class, since both their parents worked. For them, part of middle class was that they never experienced food insecurity growing up. At the time of the interview, they described their class as lower, given student loan debt and student status. Mars and their spouse lived paycheck-to-paycheck. Later in the interview, they shared they recently separated from their spouse and moved in with their parents.

Mars described their gender as how they see themselves in the world. Their gender was influenced by queer-coded villains growing up. For a period, Mars questioned if they identified as a boy. They did not feel like they performed being a girl well, having the sense that their assigned gender felt like drag. As they aged, they also discovered language of nonbinary, and they felt this discovery helped them make sense of who they were. The more specific term they used was agender, feeling that they were without gender.

Various factors of identity shaped their relationship with their body and gender. As a fat person, they described barriers to presenting how they wished due to their chest size, and institutional barriers that prevented their access to gender-affirming procedures. This tied directly to their disordered eating of eating to cope with emotions, describing food as a reward, friend,

and an area where they felt out-of-control. From a young age, Mars described weight discrimination and criticism around their body size. They noted receiving this feedback impacted their feelings toward their body and gender, feeling an incongruence surrounding body and gender. Feelings of dysphoria were intensified by the consistent misgendering they experienced in public, and when they moved home. While they recognized incongruence and difficulty with their gender, eating, and body, they also described identifying as fat-positive, and viewing food as fuel. They noted efforts to be visible as a fat, Black, and femme nonbinary person.

Mars and I completed the interview via video. We had occasional freezing during the interview, which may have impacted our rapport at points. At the time of the interview, Mars appeared to be undergoing major life changes and stressors, such as separation from a spouse, moving into an environment where they would be misgendered more often, and stressors as a student. I experienced them as humorous, confident, and perhaps concerned around being judged. I perceived the fear of being judged related to their explanations of their eating concerns. I think I felt my own anxiety enter the interview surrounding my straight size privilege and fearful they might feel judged by me. I think this led me to try to show in my body language openness and empathy toward their experiences. I enjoyed what I felt like moments of their showing their personality, such as the fact that they “curse like a sailor” or hobbies they partook in.

Jupiter

Jupiter was a 25-year-old Black fat bisexual nonbinary/gender-free person that used they/them pronouns and was assigned female at birth. They noted identifying with African diaspora, with their family connected to culture from an African country. They were raised upper class, but this was shifted to middle class due to their status as a graduate student.

At the time of the interview, they described identifying as nonbinary, and periodically struggling with this identity. They noted difficulties with being seen as nonbinary, due to the mismatch between their appearance as fat and the stereotype of nonbinary people being masculine or androgynous. They noted coming to identify as nonbinary through exploring and reflecting about what felt right to them without outside pressures; they identified process of fluctuation historically and at the time of the interview regarding their gender. Through hearing about a friend's processes and accessing resources themselves, they connected with nonbinary identity.

Jupiter described their disordered eating as relating to overeating and bingeing to cope with emotions they did not want to feel. They were raised in an Evangelical Christian background that, paired with misogynoir, encouraged them to suppress their emotions; Black women's emotions were deemed essentially too much, so they learned to pack them away with eating. As they got older, they identified they used food to cope with gender-related distress. They noted fears and pressures as a Black person of being gendered as either a man or a woman—the racist gender stereotypes tied to either were not appealing. With that said, being nonbinary or genderless was also a challenge, and sometimes something they struggled to accept within themselves.

Jupiter described coping with disordered eating through a binge eating support group, which helped them to identify that their relationship to eating was connected to their relationship to emotions. They described support from their girlfriend around meal planning, as well as learning about their cultural history of gender diversity.

I experienced Jupiter as intellectual, direct, and social-justice-oriented. They were aware of the research process and made efforts to speak to this in support of the interview. The

interview was audio-only, so it was at times difficult to read their emotions. I noticed myself having more questions, particularly because the interview was briefer. They were knowledgeable and reflective, and I was surprised when they noted they had not considered the connection between nonbinary experience and disordered eating prior the interview. I initially wondered if some of the brevity in their responses was due to protectiveness, having just met me, and I wondered how much they trusted me.

Saturn

Saturn was a 20-year-old ethnically Chinese nonbinary queer person who was assigned female at birth and used they/them and he/him pronouns. They were from a Southeast Asian country; they had immigrated to the US a few years prior. Their class background was shaped by their immigrant identity. They noted that depending on the country they were considering, the currency in the respective country, their class would be different. They ultimately described themselves as middle class due to their dependence on their family. However, in their country of origin, they would be more financially secure.

Regarding their gender, they described recognizing incongruence in their gender around puberty. They noted they felt pressure to be feminine in their youth, and they noticed discomfort from this. When their body began to change, such as experiencing chest volume, they described beginning to engage in restriction to attempt to stop gendered physical development. They attended an all girls' school, where there were pressures to be thin as well. They shared about their family eating habits, which influenced their relationship to eating.

At the time of the interview, Saturn was tired from trying to resolve the pressure regarding their gender. They noted that they experienced pressure to be a trans man vs. nonbinary, and ultimately hoping to they could choose an identity that led to less dysphoria.

They would usually be misgendered, unless they were in queer-friendly spaces. They noted by that point in their life, they felt their disordered eating had resolved. They found methods that supported their recovery such as exercising to increase hunger and to feel good, rather than restrict.

The interview with Saturn was also audio-only. We discussed how to communicate regarding the flow of the interview, since we could not see visual cues. Compared to other participants, they felt their disordered eating was resolved. I wondered if that influenced their responses to be more brief. They also did not have a response for some items. At times, I felt like I was pushing or needing to clarify more often. I also recognized that they were in college, and in the midst of midterms, which could have influenced the interview, perhaps a push to complete the interview quicker. I appreciated their candidness with their reflections, for example naming how skinny their peers were in high school.

Uranus

Uranus was a 30-year-old White-passing Pagan multiracial (White and Latinx) bisexual disabled fat nonbinary person who used she/her pronouns and was assigned female. She was middle class growing up, which shifted to what she described as impoverished by the time she reached college. At the time of the interview, she described herself as working class and felt more financially stable, in large part because of her spouse. She described her gender as feeling like a bubble in gender space.

Growing up, family, trauma, and social influences shaped her relationship with food. Her parents both struggled with disordered eating, which impacted how she related to food. Within her family context, she learned that to be a good woman was to be a thin woman. Uranus also noted that she experienced religious abuse, e.g., she learned to believe that her disability was

God punishing her, as well as physical/emotional abuse in her home. When she hit her late teens/early 20s, she experienced a psychotic break. She felt these mental health concerns led to disordered eating as self-harm/suicidality. These experiences of trauma also caused comorbid trauma-related mental health disorders. She described that when she first began to have anorexia, restriction meant relieving the world of her existence. Over time, she noted her experiences shifted when she began to experience size discrimination as a fat person. She described feeling a loss of control as she became more curvy. At the time of the interview, she felt proud of caring about her eating disorder for the first time. She was under the care of a nutritionist.

Uranus noted she felt overwhelmed and confused when she learned about nonbinary identity. She was introduced to the nonbinary concept through a friend and interacting with others in queer communities, and found that over time, she recognized and acknowledged her own feelings of being nonbinary. At the time of the interview, she described exploring nonbinary masculine identity, which was distressing for her. She identified trauma from masculine-presenting people, so to feel her body wanting to present in line with those who caused her trauma felt scary. She also shared that she never felt before that her body was incongruent with her gender. She described feeling an urge to restrict again but stated knowing restriction would not actually lead her body to change in the ways she wanted.

Uranus was open, warm, and direct regarding her experiences and needs during the interview. The interview was done via Zoom video call. I appreciated her transparency regarding her experiences, and perhaps due to my countertransference with age, felt a reverence for her experience. It felt as if she had been considering aspects of nonbinary identity and disordered eating prior to the interview. More deeply, it was after this interview that I began to identify themes of choice and shame, as well as the impact of things like trauma on disordered eating.

She disclosed her diagnoses to me, despite the possible related stigmatization, and I appreciated the trust she extended to me. I think this initial rapport led to deeper discussion of the dynamics surrounding disordered eating.

Neptune

Neptune was a 23-year-old White neurodivergent pansexual nonbinary person who uses they/them pronouns and was assigned female at birth. They had recently graduated from college, and they described their class background as complicated. They were never fearful of being homeless or running out of food, and they were financially reliant on their partner.

Neptune's history and relationship with food was shaped by familial and social contexts. Their parents separated when they were a child. Food in their dad's home was often spoiled, or they had to cook for themselves. They noted experiencing textural and taste difficulties, and fears of expiration dates/food spoiling in part because of this history and due to learning more about food safety in high school. They were also influenced by their grandma's experience in the Great Depression, in that their grandma would often keep foods past expiration dates. As they got older, they would consume a restricted range of foods because only those felt appetizing/safe. In college, they would eat irregularly because of this relationship with food and because of the time demands of their major. At the time of the interview, they described they may sometimes forget or choose not to eat, which would sometimes lead into intentional food restriction. They described efforts to cope by cooking and making foods they would be open to eating.

Neptune identified as agender, describing it as perhaps a black orb. As a youth, they felt pressure to be a girl. They were aware of trans women and men in their high school but did not identify as such. They learned about nonbinary gender identity through the internet and their social circles. Once they reached college, they noted that they found support and community

surrounding being nonbinary. They noted that they did not experience physical dysphoria, but more so felt a disconnect between their brain and body. They expressed pain in feeling unseen as a nonbinary person, due to their body not fitting nonbinary stereotypes of an androgynous thin person. Although they did not experience dysphoria, they identified that the disconnect between their body and brain would lead to difficulty acknowledging hunger signals.

The interview with Neptune was audio-only. At times, I had difficulty hearing them, which may have led to feelings of frustration on my end. In general, I found them to be light-hearted, speaking with a light chuckle in their voice. They cried and expressed vulnerability surrounding being unseen, which helped me to solidify various thoughts around the impact of being unseen on one's emotions.

Pluto

Pluto was a 21-year-old White-passing South American Mestizo/Spanish bisexual agender person who used they/them pronouns and was on the asexual spectrum who was assigned female at birth. They had lived in several countries throughout their life, and they felt their upbringing was financially stable. They were more independent from their parents financially at the time of the interview, and they were budgeting more. They noted they were usually misgendered (e.g., in public or with family) unless with close friends or with support groups.

Pluto described that while growing up, gender nonconformity was acceptable, but identifying as trans was not. Within the last few years, they experienced dysphoria but had not considered being trans, until their boyfriend noted they did not have to identify as a woman. They expressed this brought a realization they had options and led to researching and finding nonbinary identity. Coming to identify as nonbinary brought them peace and relief related to

disordered eating.

In their teen years, they restricted their food intake and used compulsive exercising. They described pervasiveness of diet culture and reinforcement from their family surrounding weight loss. Over time, anorexia blogs were a place where they found community and connected with others. Because they moved so frequently to different countries, they often felt: (a) like an other, and (b) that one of the consistent themes across cultures was diet culture.

With learning language to label their dysphoria, they began to reframe their emotions and disordered eating. They noted how they recognized that their efforts to change their body through anorexia were actually rooted in gender dysphoria. Thus, when they began to pursue gender-affirming methods, like changing their dress, performing drag, etc., they began to feel greater acceptance, and their anorexia reduced.

My experience of Pluto was that they were very optimistic. Although they voiced some hardship surrounding their boyfriend's parents rejecting them for their gender expression, they seemed encouraged by knowing their gender. Their experience with gender and disordered eating felt very clear cut, whereas other participants seemed to see more broad connections or none at all prior to their interviews.

Ceres

Ceres was a 23-year-old Chinese American demi panromantic asexual nonbinary person who was assigned female and used they/them pronouns. They described that they were raised upper middle class, given their parents' involvement in technology sectors, and their access to good health insurance growing up. They noted now, they were lower class, but still middle class living away from their parents. They felt secure given their parents' financial support and in having a job with benefits.

Ceres was raised as a girl, and thus, in their understanding, assumed they were. They described, toward the end of high school, coming to identify as nonbinary following meeting nonbinary peers. They talked about exploring terminology online, and finding that nonbinary fit for them. Since then, they felt their gender identity has remained relatively constant. At the time of the interview, they described struggling with social dysphoria, and self-blame of their body for being misgendered. They described often being perceived as a masculine woman and being misgendered. Ceres noted a lack of support from parents around their hormone therapy, with Ceres' parents blaming themselves for Ceres's transness and depression.

Regarding food, Ceres noted struggling with self-hatred surrounding their body, and different aspects of it such as height and weight. They noted that since they were young, they experienced shame around food and their body. They talked about how their nuclear and extended family experienced health anxiety, and their dad had colon cancer when they were a child. They had PCOS (Polycystic Ovary Syndrome) and hit puberty at a young age; they recounted feeling self-conscious with their bodily changes. In their youth, Ceres was also bullied. As they got older, they experienced criticism from their family surrounding eating, their body size, and consuming "good vs. bad" foods. Since they were young, they engaged in eating to cope with stress, particularly foods that were labeled "junk foods." As an adult, they noted efforts to reduce stress eating through distraction. Ceres described that their experiences surrounding gender did not seem to impact their eating until they gained weight in recent years. They noted concern about their chest being more visible and that weight gain led to more misgendering and coping through stress eating.

Ceres was open, thoughtful, and worked to respond to every question. I was surprised when they shared that they had not considered the overlap between gender and disordered eating

prior. I experienced them as ashamed and could feel their self-anger. I found them intelligent, anxious, and in pain. They were very supportive of this research and made efforts to advertise the study. I was struck by their reflections regarding self-hatred, and the interview made me reflective of how shame could play a role in experiences of disordered eating.

Makemake

Makemake was a 33-year-old White queer genderflux/agender person who used they/them pronouns and was assigned female at birth. They described themselves as middle class growing up and upper middle class at the time of the interview.

Makemake described themselves as masculine-leaning. When they came to California a few years ago, they began to see others use pronouns outside of he/him and she/her and identify with genders outside of the gender binary. Seeing this gender diversity led to their personal exploration and eventual identification with their gender. They noted that they generally feel most comfortable masculine-presenting, and they use exercise to support their gender presentation. They were often misgendered, except within close friend circles. In the workplace, coworkers continued to use the wrong pronouns, despite their request that coworkers use they/them. They struggled in gendered spaces like locker rooms and bathrooms, feeling unwelcome in the women's and men's sections. At times, they considered identifying as a trans man, pursuing gender-affirming medical procedures, but they expressed uncertainty about that.

Regarding food, Makemake identified that they would binge and restrict in their youth. Their parents were focused on body image, in a generation where dieting was the norm. This led to childhood invitations to Makemake to diet. When they reached college, their disordered eating changed to primarily bingeing, and they experienced food anxiety and shame around bingeing. Several years ago, they lost a significant amount of weight, and they began to restrict and purge

through exercise. Several months ago, during a period after a break-up, their restriction and exercise led to a seizure. From there, they pursued a recovery program for food addicts, where they measured their food to ensure accurate amount of calories. They felt proud of their recovery, and also fearful that their behaviors may lead to an eventual binge.

Makemake noted that for them, there was an aspect of restricting that gave them feelings of control. This aspect of control felt good, though they did not understand why. They noted that because their ideal body was masculine and slim, they felt pulled to engage in eating and exercise to meet this goal. They struggled with separating dysphoria and dysmorphia in this way, having a feeling they likely had dysmorphia in addition to dysphoria.

The interview with Makemake was audio-only. They were direct and comparatively brief in their responses. They seemed perhaps self-monitoring or introverted and at the end expressed concern that they had not answered the questions correctly or fully. I think their sharing that they were going to think about the questions following the interview gave some insight to their thoughtful presentation. There were also spaces where I wondered if they felt guilt or shame for sharing, at some points commenting that it may be difficult for me to listen to someone share deeply as they were. Thus, I found myself wanting to be encouraging and hold space for them to express themselves.

Haumea

Haumea was a 22-year-old White, French American queer, trans-masculine nonbinary person who was assigned female and used they/them pronouns. They were raised in what they called a financially secure family that did not struggle to access food. At the time of the interview, they were a graduate student who was dependent on their parents to pay tuition and rent.

Regarding their gender, they saw their gender as fluid. They did not experience incongruence around their gender until puberty, where they began to feel uncomfortable with their body. During these earlier years, they did not have language for this discomfort, and would subconsciously try to change their gender presentation (e.g., binding by wearing multiple sports bras). In high school, they learned about nonbinary terminology through community. They then began to test they/them pronouns, and in college found supportive community. Most recently, they noted starting hormone therapy in efforts to match their physicality with their self-image. They described a pressure to identify as a trans man, pursue top surgery, and use he/him pronouns. They wanted to be taken seriously, to be seen, led to self-criticism regarding their feminine aspects they otherwise enjoyed. They shared fearing these feminine aspects prevented them from being gendered correctly. They noted generally being perceived as an androgynous man, unless someone heard their name or was a classmate, and they would then be gendered as a woman.

At age 13, they developed anorexia, and tied their self-worth with being thin. In the interview, they reflected that their anorexia was related to their increasing discomfort with the gendered aspects of their body from puberty, but they were not aware of that dynamic in these early years. For example, they restricted in hopes of making their chest smaller and to stop their menstrual cycle. At age 19, they were hospitalized and placed on an eating and weight gain plan. They began therapy to address eating concerns and depression, and they sought to find self-worth outside of their relationship with food. They found that finding alternative methods to addressing their dysphoria reduced the urges to restrict and control their shape and size.

Haumea and I completed the interview through video call. They were thoughtful, and reflective about things like Whiteness and colonization, which I had not expected because of my

countertransference to their Whiteness. I found myself trying to ask follow-up questions, noticing at times they were perhaps more broad with their responses. I was curious what about their environment led to consciousness of and reflection on impact of Whiteness.

Aidan

Aidan was a 30-year-old White asexual agender person who was assigned female and does not use pronouns. Aidan was middle class growing up, and described being less financially secure at the time of the interview due to Aidan's graduate student identity. Aidan noted being perceived as female majority of the time.

Aidan shared feeling uncomfortable with puberty, although Aidan was not conscious this discomfort was tied to gender. Upon reflection, Aidan named restriction was a way to slow puberty. Five years ago, Aidan began to read and learn about people identifying outside the binary. Aidan saw that no gender felt present, identifying as agender. Gender was tied to experiences of depression and anxiety, where when depressed, gender did not seem to matter. Aidan felt pressure to be androgynous as a nonbinary person, and generally did not feel connected to Aidan's body. Aidan voiced generally not sharing pronouns, to avoid attention.

In middle school, Aidan started to restrict calorie intake, which lasted through high school and for a few years after. Calorie-restrictive periods occurred on occasion since then. To cope with disordered eating, Aidan monitored eating to ensure sufficient food intake. Aidan identified wanting a sense of control over eating behavior, largely to reduce anxiety. Therefore, managing anxiety also helped to reduce disordered eating. Aidan found that remembering that Aidan's body did not have to look androgynous to be valid helped anxiety management.

Aidan and I completed the interview through video call. I found that perhaps Aidan did not want to take up much space, sharing more brief responses. When we built some rapport, I

found Aidan was more open, sharing, for example, that Aidan preferred no pronouns and shared a preferred pseudonym. Similar to other participants, there seemed to be a parallel process with the tension between sharing oneself, vulnerability, being seen, and discomfort/anxiety within this possibility of vulnerability. I found myself pushing more in this interview, wanting to connect and understand. Following reflection and feedback, I chose to maintain Aidan's pseudonym throughout this document.

IB

IB was a 29-year-old Asian queer nonbinary person that used they/them pronouns and was assigned male. They immigrated to the United States from a Asian country. They were the only participant assigned male. IB described their class as middle class. They found they were typically gendered as male, unless they were in a safe space, usually queer spaces.

Growing up, IB saw representations within their home country of transgender people, but not nonbinary individuals. They experienced cultural expectations around their assigned gender, such as the amount of food to eat, body size, and body hair. They described feelings of inadequacy surrounding being chubby as a child. They also described feelings of rejection in gay male dating spaces due to the privileging of masculinity and exclusion of nonbinary individuals.

IB shared that they learned to view binging as reward and distraction from stress and difficult emotions. For example, they noted binging and weight gain when they experienced difficulties with immigration. To address binging, they described efforts to avoid certain foods that might trigger binging.

IB and I completed the interview through audio-only Zoom call. I believe we had different expectations for the interview. They seemed to want to learn from me about the connections between disordered eating and nonbinary identity, whereas I sought to learn from

their experiences. I think this mismatch of task sometimes led to miscommunication and frustration on my part. Their responses felt brief, and I at times wondered if they did not want to complete the interview. This may have shaped their responses and the data collected.

Bennu

Bennu was a 26-year-old White spiritual nonbinary person who was assigned female and used they/them pronouns. They described increased usage of he/him which also felt good to them. They noted reconsideration of boundaries between platonic and romantic relationships, and they described their sexual orientation as pansexual/fluid.

Bennu was aware of discomfort with their female body as a youth. They described becoming very femme as a reaction to their dysphoria as a teen, which they later described as their drag. Over time, they were exposed to more resources and learned history of the gender binary, and they began to identify as nonbinary and use they/them pronouns. This fluctuated, and for a period, they grew afraid the world would not accept them, so they rescinded this change of pronouns. By the time of the interview, they noted growing tired of people who did not accept them. They described a comfort with their body, presentation, and finding the support around their gender identity. They described at times feeling dysphoria, particularly in reaction to their perceived stereotype of nonbinary individuals: White, thin, masculine-presenting with top surgery. They noted misgendering sometimes led to wanting to adapt their body to this image to reduce misgendering, and to feel seen by others.

Bennu described they were a thin youth. In their teen years, thinness became tied to their sense of self-worth, tying it to self-discipline. This led to disordered eating in the form of orthorexia (limits on eating based on foods being “healthy” vs. “unhealthy”). They described engaging in binge-restrict cycles. Within these experiences, they noted disordered eating was

also driven by fears of losing thin privilege/self-worth, urges to control, and anxiety. Disordered eating helped them feel in control and cope with anxiety they felt since they were young. Over time, they began a form of recovery they described as “pseudo recovery.” They described this recovery as still rooted in fatphobia, since they continued to limit themselves to what they felt were healthy foods, though they allowed themselves to eat whatever amounts of food they wanted. It was when they found Christie Harrison’s Food Psych podcast on intuitive eating, podcasts by people of size, and began therapy did they feel they found the recovery that fit for them. They noted at the time of the interview being in a good place with their body and eating, although they continued to experience periods of wanting to alter their body due to experiences of misgendering.

It felt opportune that my last interview was with Bennu. They spoke about similar themes others mentioned and tied together themes of healing and recovery that were bubbling in my mind. They were open, expressive, and vulnerable. I appreciated their willingness to speak about their experiences, and I found myself leaning and rethinking influence of oppression on expectations of body and thus eating. They seemed to live and breathe their recovery, and also seemed to struggle with the fact that they still sometimes struggled with being misgendered. There seemed to be a part of them that wanted to present that, because they had the resources they needed to no longer be hurt by things like misgendering, which I related to.

Axial-Level Categories

Food is the Band-Aid

Food is the Band-Aid is comprised of various contributors to disordered eating (DE), including cultural influences, trauma, social/body dysphoria, and family of origin experiences/relationships. Several participants conceptualized their distressing relationships with

eating as a manifestation of other concerns. They noted that any focus on just their eating invalidated and erased these contributors to these experiences.

Nonbinary-Disordered-Eating Connection. One of contributors to disordered eating reflected the primary research questions for this project: How may nonbinary experiences be connected to disordered eating? Under the sub-category of *Nonbinary-Disordered-Eating Connection*, open-coding categories included social dysphoria, minority stress, and cissexism influenced eating. Participants conceptualized their own disordered eating and emphasized the importance of addressing the underlying concerns that drive disordered eating. These participants named wanting a sense of control (to relieve anxiety, to cope with feeling disempowered), anxiety, history of health concerns in their family leading to health anxiety, rejecting families, gender dysphoria, shame, trauma/generational trauma, self-hatred, lack of access to gender-affirming methods, marginalization, and other factors. An example of this experience was Jupiter's reflections around eating. They shared that socialization through Black womanhood in an evangelical Christian faith set up the conditions to cope with emotions through eating. They noted that in particular, because of misogynoir, their anger was labeled unacceptable. Thus, eating helped them to regulate these emotions, to be acceptable to others.

Like corral in your feelings. If you're angry, or sad, or emotional about whatever—you're not supposed to be. And so I think food goes a long way. Oh, this feeling you're not supposed to have? Don't have it; stuff it away with food.

For Pluto, their anorexia was directly tied to their social dysphoria; their discomfort in their body was rooted in experiences of misgendering or, as Jupiter called, gender tension: "a tension of how you see yourself against other people, how you want to be seen, and how you understand yourself." Thus, when Pluto's view of their body did not match the views others had

of them, this created distress which they coped with through restricting eating and purging through exercise. When Pluto was able name their dysphoria, they were able to then address this dysphoria through gender-affirming methods (changing dress, make-up, using pronouns that fit, connecting with supportive spaces). This increased congruence for them in their presentation and others' perception of them. They also found community and support that validated their sense of identity. Restriction and purging through exercise were no longer their go-to outlets for this sense of control.

The changes we push ourselves to, via the eating disorders, aren't necessarily the changes we want as trans people. So maybe we think we want to lose weight, but actually we want to have broader shoulders.... Or stuff like that. So, and, in that case, if that's the reason behind the eating disorder, all the therapy, I personally knew does not help at all. Because it's just not centered around those underlying issues....And how there's more than only one way to help you.

Within Plutos's reflection, they refer to a singular way providers approach eating disorder treatment. This singular way, I believe, is the White supremacy commonly found in eating disorder conceptualization and, subsequently, treatment. Looking across participant experiences, they described the focus on thinness, Whiteness, cisgender womanhood, wealth, and ablebodiedness that pervade treatment and understandings of eating disorders (captured in open-level categories: The Nonbinary Body, intersectional validity, and nonbinary masc). These experiences regarding Whiteness, cisgender womanhood, and other privileged domains are valid and important to address. With that said, when these experiences are not located as part of dominant narratives, experiences of trans/nonbinary people, people of color, disabled people, people of size, poor people, and the intersectional experiences among these are relegated to the

margins.

Although all people experience rejection, marginalization creates this experience at a macro, repeated scale, surrounding an identity. Over time, marginalized people can internalize these messages that their identities, their sense of self, are a cause for their rejection. In combination with the stigmatization associated with disordered eating/eating disorders, experiences of rejection can lead an individual to believe that they are wrong, bad, and will lead to disconnection if truly known. This may then manifest as self-minimizing, hiding who one is, performing, and other actions to prevent disconnection. These acts of hiding may support survival, to be connected to others. For example, I recall when I started using he/him pronouns in addition to they/them. Looking back, part of this choice was informed by wanting to be more palatable to others. My transness already felt burdensome—people had to shift their lives in order to accommodate me. While nonbinary identity and the diversity of these experiences are becoming increasingly familiar, pronouns like they/them were still generally uncommon. I hoped, then, to make my medical transition easier. As time passed, I noticed most, if not all people who met me and learned my pronouns opted to use he/him. I began to notice that hurt. It reiterated this narrative I have had for much of my life, that many participants also had: that people would not want to make space for who we are. Perhaps my identity is the problem; therefore, perhaps I am the problem. Thus, while my goal was to try to belong, if belonging includes hiding parts of oneself, that is not truly belonging. Several participants spoke about similar experiences. As noted, reliance on dominant experiences as the baseline led to erasure. Nonbinary identity and the assumptions of what nonbinary looks like (which often excluded participants who were femme, of size, and people of color) hindered belonging, and prevented opportunities to be seen. In addition to other disempowerment, the experiences of erasure led to

pain and coping through disordered eating. In Uranus's experience, for example, losing weight became a manifestation of coping with shame. Because they had internalized generational trauma, rooted in marginalization (racism), and their own traumas, they learned to believe their existence was wrong. Thus, Uranus described relief, or self-love, as losing weight—to, in other words, exist less.

...My eating disorder was akin to suicidality or self-harm for me... It's really sad looking back because I cared so much my whole life about being a good person that even when I thought I was utterly, morally bankrupt, I cared enough that I was like, well, the last best thing I can do for the world is not exist in it anymore.

Manifestations of shame appeared in all of the participants' narratives, albeit sometimes in different forms. Ceres described comparison to an ex who experienced anorexia prior to seeking medical transitioning. They noted once their ex had access to gender-affirming experiences and affirming community, their ex's anorexia dissipated. Ceres reflected a sense of what felt like envy and sadness regarding their own lack of support. Their shame seemed to appear throughout their interview—tied to their sense of identity, to the point that they expressed shame surrounding coping and recovery. This internalized sense of shame seemed to lead to: (a) coping through binging/restricting, and (b) seeking that piece of their life or themselves they could change, that would alleviate this shame.

If I felt like if I had actually power to leave this world a little bit better than I came into it, I think that also would make me—I'd be able to feel good about myself. And I think I would be better than at just listening to my body. Just eating only when I'm hungry, being able to stop and feel satisfied.

In consideration of shame, I found myself wondering—how did we get here? What

causes non-binary people to feel this level of shame? I think as a clinician, someone who also struggles with similar concerns as the participants, and a human being, hearing stories like Ceres' hit me hard. I was forced to look beyond my intellectualization of disordered eating and nonbinary identity, along with my own biases. What drew me to this project was an effort to fix and relieve my pain, and seeing someone close to me experience an eating disorder increased my distress. I coped with my own anxiety and shame through attempts to control, through seeking ways to know (i.e., a dissertation). Coming into this project, I believed marginalization caused disordered eating, which is in part true. But this study reveals that it is not the identity or the oppression itself, so much as the impact of marginalization. When a person hears repeatedly that this part of who they are is not normal, is bad, they start to believe it. Belief in this marginalization can be explained as a manifestation of trans minority stress and internalized transphobia (Hendricks & Testa, 2012). When experiencing distal factors of oppression, such as rejection from others, and misgendering, participants began to experience proximal factors, self-blame, and shame.

One way to cope with this experience is to hide that part that feels unacceptable, minimize its pain, in hopes of increasing connection. As noted before, if hiding/avoidance is the only way shame is addressed, the same efforts that once supported connection may lead to isolation and disconnection.

Developmental Contributors to Disordered Eating. *Developmental Contributors to Disordered Eating*, a subcategory of Food is the Band-Aid, encapsulated the experiences in development that created conditions for a shame-based relationship with self, as well as beginnings of feeling out-of-control. Within these greater systems of marginalization, participants experienced trauma, puberty, and family of origin dynamics. Participants spoke to

hardships within their families that they felt contributed to the development of disordered eating, as well as familial culture influences on relationship to food. Participants also showed some predispositions to disordered eating such as anxiety and being “picky eaters.” These facets laid the ground work for development of disordered eating.

Family of Origin. Family included relationships of both support and hardship. Within these relationships, participants learned what would be considered normative in eating, body, shape, size, and gender. For example, participants spoke about body ideals learned from family. For fat participants, families were often common sources of criticism. In these situations, eating became an arena of lack of self-control, if the participant was considered fat. Mars described being called fat by their father, leading to feelings of shame, and hopelessness regarding feeling acceptable in their body. This, tied with feeling discomfort through gender dysphoria, led to binge eating. During the interview, Mars appeared to feel pulled to explain their binge eating and their fatness. In reflection, I perceived this was rooted in internalized shame about themselves, their size, and their binging behaviors. Although I did not communicate that I felt that eating was tied to size, this seemed to be something they had also internalized and automatically attributed to me. Their connection of eating to size may also be in part due to their cultural transference of me and my presentation and privilege as a thin nonbinary person.

And I basically just ate myself to a larger size because of the fact that I was told that I was fat. So, being dissatisfied with the way I look ‘cuz I was told I was fat, I kept eating ‘cuz it didn’t matter, I’m already fat. I can just keep eating.

Participants also described gendered narratives that led to feeling like an imposter. Several participants spoke to feeling like they were in drag for much of their youth, as their internal sense of gender did not fit the expectations surrounding gender performance. Saturn

described, for example, the ways they were expected to perform duties for their family based on gender—that is, to be a “good child” meant being a good son or daughter. Pluto noted they were taught being a masculine woman or feminine man was acceptable, but to be trans was not. Pressures to conform to gender expectations in this manner can strengthen that pressure to “wear a mask” in a sense. If they portrayed themselves aligning to others’ expectations, perhaps that would provide more acceptability.

Some participants also identified ways their relationship with food was shaped by familial culture. For example, Ceres described their family history of food insecurity that led to fear of not having enough food, despite their current access to resources.

My mom also said her father, he was a really fast eater because he grew up in situations such that people had rationed food. But if you ate fast enough, you would beat the other people, and be able to get seconds. And so even when he wasn’t in that environment of scarcity anymore, he would still be eating fast out of this kind of muscle memory or habit. I think it sort of just carried over, and I sort of just learned it.

Neptune also described their family’s histories of poverty that led to fears of wasting food, even when their families were no longer experiencing poverty. Some participants also described disordered eating within their families. Several participants shared that dieting was common as well as their family members’ own body image concerns. For example, Mercury discussed how their mom’s enforcement of family rules around food led to difficulties in saying no. They learned restriction from their father, who also demonstrated disordered eating behaviors. They shared learning that their father was raised in an abusive home, where he also developed disordered eating behaviors he came to view as normal.

She has this mentality that you do not leave until you finish your food. And I was a small

child, and I was having hard time eating my food, and my White dad told me, "...Well another thing I used to do was, I would just eat it all and throw up later." My dad came from a really abusive household, so I don't think he necessarily understood that this was really problematic and damaging advice to give to a young, AFAB person. So like I really internalized that. I didn't have a lot of control over being allowed to say no.

Thus, to understand disordered eating for each participant, it was important to understand the context they came from. Relationship with self was shaped by these contexts. And these contexts also gave individuals the tools of disordered eating to cope with emotional reactions to the challenges they faced in life, whether those challenges were marginalization, anxiety, trauma, and beyond.

Puberty. For participants who experienced gender dysphoria within their bodies, puberty was often part of the precipitant, stirring feelings of lack of control, which led to the use of disordered eating behaviors to cope. Puberty was a salient factor for nearly half the participants. The biological impact of puberty and subsequent change in how participants understood themselves as gendered beings led to feelings of disempowerment, confusion, and/or distress. Haumea described how once they hit puberty, they developed anorexia.

I feel like early on, like in like when I was experiencing puberty and like kind of like that middle school phase. ...When I was 13, I developed like an eating disorder, like anorexia nervosa and like I wasn't aware of the, the gender connection at the time. I mostly, like, I had no idea, like when I was hospitalized, like why. Why I was doing any of this or like the background reason that this was happening. But like later on through like therapy and like a lot of self-reflection, like recently I think...the discomfort I felt like with my body when I was experiencing a lot of changes that I didn't really want.

Although restriction also did not bring about the changes they sought gender-wise, it was a reaction to losing control surrounding body. As illustrated in the *Healing* axial-level code, community support and gaining choice in other ways facilitated recovery—identifying that their distress was gender dysphoria. Thus, having language for one’s experience, being able to name and identify gender dysphoria, served as a form of healing.

As previously noted, several participants described feeling like their genders were given to them, or feeling like they were faking or in drag/a costume, before they identified or knew the language of nonbinary identities. It appears from these data that puberty is perhaps the start of body image concerns, gender dysphoria for some. Aidan (who does not use pronouns) talked about how puberty led to being more gendered, and restrictive eating was an effort to slow this. Aidan described experiencing a disconnection with body and discomfort with the projection of gender on the body from others. Within Aidan’s experience, the relationship with food served as a form of control and managing anxiety, which in part stemmed from societal pressures to match the expectations of Aidan’s assigned gender, roles, and appearances. This interplay of body image concerns, gender dysphoria, and mismatch between societal pressures and identity serve as part of a phenomenon that Aidan and most other participants grappled and struggled with—the pain of being unseen by others.

A key theme among these participants was the experience of not being seen as who they are, specifically their gender, which brought about pain. Puberty increased this, as the world started seeing them incorrectly more frequently, and the world began to impose stronger gendered expectations. Mercury described neutral acceptance of the gender they were assigned prior to puberty. However, when puberty hit, expectations and gender became more prominent. For Mercury, this was the beginning of dysphoria, although they did not have the language for it.

Yeah! At least for like the first 10-12 years of my life, I can solidly say I didn't really identify with a gender... And then, as like puberty started to happen, I felt uncomfortable with the changes in my body, specifically, because of the way they were so gendered... So, I really hated that. I didn't know that was dysphoria at the time. I just thought that I had internalized misogyny, about the way I felt about women.

A unique experience that appeared from nonbinary individuals was the lack of awareness of the existence of gender outside of man or woman. Several participants spoke of awareness of trans men and trans women, but not other genders. When there was not language for their experience, participants described hiding from themselves that they were not cis. Experiencing this confusion and distress surrounding one's body, perceptions from others, feelings of rejection in family, and internalization of diet culture, were present in several participant experiences.

Dysmorphia or Dysphoria? Body Dysmorphia (i.e., a disconnection between how participants view their bodies, a feeling of inadequacy rooted in one's body) emerged as separate from gender dysphoria (i.e., feelings of distress/unease from incongruence of one's body with their gender identity, other people's perceptions of one's gender). However, as noted before, participants at times did not and sometimes could not differentiate the two. For several participants, feelings of dysmorphia stemmed from feeling inadequate in their assigned gender at younger ages, rather than their gender identities now. IB, who was assigned male at birth, described that as they were growing up, their "chubbiness and softness" led them to feeling "less than" male peers. Mars had a similar experience where they experienced shaming from their family around size—their dad would call them "fat" in a negative way. Ceres expressed a sense of inadequacy from young age, feeling shame around multiple aspects of their body; they described feeling "fat," "too short," and "ugly."

“I don’t like this, I feel like I look ugly. I look fat. I look too short. I look like I don’t have the right proportions.” Even though—I guess there are just times when it comes up nowadays. I remember someone told me one time, referring to my chest, “Oh you’re so big.” And that was pretty jarring and didn’t feel good because that was something that was pointed out to me, even when I was 9, and I hit puberty earlier than other people. Having that pointed out about my chest made me feel really bad about myself. I guess even now, some people would gladly trade with me. But somehow it feels wrong. It feels like I’m too much of certain things, and too little of other.

Ceres’s assessments of their body were global, though they also included gendered aspects. Dismorphia and dysphoria were closely tied, particularly as the participants recognized that they were experiencing gender dysphoria. Uranus shared that “in terms of body hatred, when you hate your body for one reason, it’s sort of easy for that to transfer to hating it for other reasons.” In other words, experiencing body hatred may manifest as dismorphia or gender dysphoria, and those experiences can co-occur.

Bennu provided a clue to the experience of overlap between dismorphia and dysphoria, in ways they recognize their dismorphia. They shared that their dismorphia/dysphoria fluctuates. A key factor that increased this dismorphia/dysphoria were experiences of misgendering, and internalization of the blame for this misgendering in their body:

And at the same time, like I have, a dysmorphic sense of my body a lot of the time. So, I’ll be very conscious of like where fat is on my body and the fact that like the fact that like I have like a visible chest and all these things. So, some days I’ll be comfortable with this. Other days, it’s really hard. And my brain goes to that place of like, “Oh, like, these are the reasons like you’re being misgendered.”

Participants seemed to have internalized a sense of shame regarding their bodies, leading to feelings of dissatisfaction. The category *Height* was similar—a feeling of dissatisfaction associated with another aspect of body. Height was a salient characteristic for Ceres and followed a similar pattern to other areas of themselves that feel inadequate—such as body size, gender presentation, racialized gender, and gender identity. While height was related to gender, the feeling of dissatisfaction, of body hatred, was present prior to identifying as trans. Thus, dysmorphia and dysphoria are closely related, and can be similarly addressed.

Make the Feelings Go Away

Participants used various methods to cope with their emotions. Such coping methods consisted of behaviors and thoughts that these participants used to self-soothe emotions, which stemmed from various sources such as dysphoria, trauma, etc. These individuals developed disordered eating in the context of various distressing experiences (e.g., marginalization, trauma, gender dysphoria) where disordered eating served as coping with these situations. As emerged in the *Food is the Band-Aid* axial level category/theme, what triggered the start of disordered eating for many participants often was related to family and early childhood experiences. Once a relationship with food was established that was tied to emotion management, it became a proverbial tool in an individual's coping toolbox. For example, when IB experienced challenges with their visa, they binge ate to cope with the stress. Although the specific disordered eating behavior may vary, the individual's relationship to the behavior tended to have themes of coping, control, and self-soothing.

The participants in this study talked about a range of food/eating-related behaviors, such as restricting food intake, bingeing, avoidance of certain foods, purging through exercise, laxatives, and other behaviors. Some participants exhibited a predisposition to concerns with

food, such as being picky-eaters as children. Neptune described avoidance of certain foods and sticking to consistent foods that felt safe for them, which ultimately became a root of their disordered eating. Other participants noticed difficulties with types of food, or restrictions of certain types of food. Although not every participant spoke to difficulty with some foods, there seemed to be an underlying predisposition to discomfort or anxiety surrounding food.

Shame-based relationships with food were normalized in many participant narratives. In consideration of shame, an important aspect of shame comes with comparison—feeling one is simultaneously below and above others. If one feels a sense of inadequacy, they are driven to do things that allow them to feel above others to mend that feeling. Within a culture focused on productivity, fitness aspects of disordered eating were reinforced and became character traits to be respected, particularly for straight size people, i.e., individuals that experience social advantage for their size, that do not experience marginalization due to their body size. For example, Bennu described in high school, learning to view their thinness as a point of pride, given that others reinforced this quality. This led to restriction for them, fearing losing this positive quality. For participants of size, the experience of negative feedback, and that their size represented a lack of control, was a source of ailment and pain. Self-described fat participants shared regarding discrimination, especially from medical providers, who assumed all their health concerns were because of their size.

Disordered eating behaviors can ebb-and-flow in a person's life. Makemake described how their disordered eating fluctuated, and changed from bingeing to restricting and purging, following significant weight loss. In Makemake's case, they gained a sense of control from restricting and controlling their food intake. In consideration of these factors, the disordered eating appeared to serve a similar purpose (i.e., coping with emotions), despite the change in the

specific behavior. Makemake may have experienced straight size privilege following their weight loss. Having experienced possible marginalization prior to the weight loss, they may have been acutely aware of both social advantage and disadvantage that can come with size. Awareness of advantage and disadvantage may have reinforced behaviors to control their restriction and prevent experiencing marginalization again.

I reflect on my own experiences of thinness throughout my life, and the automatic praise I received. People assumed that because I was thin, I was “fit” and therefore “hardworking” to maintain my size. A double standard existed when I would eat large amounts of food in front of others—it made me more interesting, surprising, whereas a person of size in a similar situation would be called negative slurs and called out as fitting a stereotype. Thus, disordered eating can be used to cope and manage the fear of losing size privilege, or fears of rejection due to having a marginalized identity.

Venus observed that their restricting behavior fluctuated, based on their environment, relationships, and weight. Whereas their specific disordered eating behaviors varied, there appeared to be an underlying negative evaluation of self. Earlier in the interview, Venus described experiences of depression. They seem to also exhibit self-deprecating humor (e.g., blaming themselves for weight gain, negatively evaluating that weight gain, and feeling a lack of control surrounding their behaviors). They also spoke to fears of being fat, or, in other words, fears of being rejected due to stigmatization.

Now, I’m like, back where I was in high school. I graduated, gained so much weight. Because I had money. Was buying my own food. I was, drinking a lot. Just because I could. I was like, “Oh my god, I can go to the store; I can buy alcohol.” I was living on my own, I still am. I was drinking, just excessive amount of alcohol. Which is just

straight calories. So, I gained weight, and I was like—shocked face. Pikachu. What?

Eating whatever I want and drinking all the time, wait what? I was like, “Uh uh, fam. I gotta lose it.” So, I lost a shit-ton.

Body ideals ranged according to salient identities and internalized messages. At their core, body ideals reinforce the politics of acceptability. People are driven to be accepted, to find connection, to be seen. Thus, when one feels disconnected, they may feel a sense of shame tied to who they are. When people experience shame tied to identity, they may pursue changes to alter who they are. Change can manifest as fitting certain internalized ideals, which can vary based on salient identities. For example, Venus voiced that they feel distress with fat on their body, leading to restriction. Although Venus’s motivation connects to the “thin ideal,” their ideal for their body was related to phenomena beyond thinness—namely a flat tummy and large butt, tied to their experience of Blackness as a feminine person. Or shame can be internalized and contribute to feelings of rejection. For IB, this appeared as being rejected for their nonbinary identity. Within the gay male community, masculinity was seen as attractive, and thus, for them, a source of their rejection.

When experiencing these messages of acceptability or rejection around identity, participants described a focus on controlling body, shape, and size to fit into specific gender constructs. However, for some participants, access to acceptability may have been more limited. For example, some participants described what I deemed the Nonbinary Body—White, thin, masculine-leaning. For POC, people of size, and/or femme folks, these ideals may not be attainable or wanted. When their body did not meet these ideals, participants described feeling a lack of control, and shame regarding their bodies, even body hatred. Mars noted in the previous excerpt how their gender presentation felt unattainable, they felt a lack of control of their body.

Ceres described that when they gained weight, they felt fearful that their weight would lead to their being misgendered more often.

Also, this other layer of feeling like, “I’m probably also being read as female more because of this weight gain. Making my body more curvier to people.” I guess there’s also this level of jealous or resentment toward other people. Because knowing a lot of people who have a flatter chest or who are taller or thinner, and I always kind of envied them. Maybe that’s why these people seem to pass or not be read as female at a higher rate than I am.

In reflection of Ceres experience, I considered, what is the function of blaming one’s body? Ceres described being less than others. If they were thinner or taller or had a flatter chest, they would be seen as who they are. This seemed to communicate perhaps two things: (a) the problem is perceived to be located in the self; and (b) they need to change themselves. I believe this need to change oneself is the careful and difficult quandary I face as a trans person as well: I believe there is a large amount of truth in finding acceptance and power in a gender-affirming presentation, congruence with myself. Similar to some participants, I possess qualities that may lead the general populace to perceive and misgender me as a woman—I’m short, I’m not particularly masculine, I’m Asian and thus, due to anti-Asian racism, perhaps seen as more feminine. When I am misgendered, I can go into self-questioning and self-blame. If I reflect on my experiences, I think self-criticism helps to give me a sense of control—that maybe if x is what is wrong with me, I can change x part of me, then I can control others’ perceptions, and then reduce this discomfort/misgendering. Over time, I have come to admit I may not be in my control. I have learned that if trying to change my gender-related presentation is my only response to being misgendered, I am also reinforcing the message that *I am the problem* because

of others' misperceptions. I think efforts to control through locating the problem in myself is rooted in shame. Brown (2020) defined shame as a painful feeling or experience where one believes they are flawed, and, therefore, undeserving of being loved. In this situation, the flaw is located within the body that leads to disconnection—being misgendered, not seen. If I continue to see my body as the problem, I am, in a way, furthering my own marginalization.

What I garnered from these experiences and accounts of gender identity and disordered eating is that, when seeking to understand disordered eating, it is necessary to look beyond the individual. It is important to attend to the interaction with the internalized shame and with society. Shame appeared in the data as participants feeling inadequate and unacceptable, and behaviorally as hiding parts of themselves. For example, several participants described feelings of anxiety around others seeing them eat. Participants differed in what led to the anxiety (e.g., fears others would see them binge, that others gave them feedback about how much food they would eat, fears of rejection due to size), but what seemed to underly the anxiety was rooted in relationships; that others possibly seeing them eat would negatively impact their relationships with others, judged as unacceptable, or unworthy of connection.

Fears of this unworthiness of connection can appear then in non-binary individuals' relationships to food. Moralistic Eating was an open-coding level category in which food was conceptualized in binary terms—good vs. bad, healthy vs. unhealthy. Thus, when one would eat foods labeled healthy, they would feel good, and when they ate foods labeled unhealthy, they would feel bad (i.e., ashamed). This moralistic approach to food was prominent for Bennu in their experience of disordered eating. When one fixates on behaviors/foods in binary terms, they hold conditional regard for themselves, such that when they eat foods labeled unhealthy, positive self-regard is lost. And shame sets in.

But like orthorexia was really like the base of it all, because my perspective was that I was just wanting to be like the healthiest I could be and eat the cleanest foods and all these things...And just go through, obviously these binge-restrict cycles and with that was all of the moral judgments on what that meant to me, what that meant about me as a person with, you know, like self-discipline with my goals of like being healthy.

Several participants identified how they were in situations where they lacked a sense of control, feeling disempowered. Thus, disordered eating behaviors, as noted before, served as providing feelings of control in contexts where they lacked control. For example, Makemake fainted following intensified restriction and exercise, following a break-up of a long-term relationship. They reflected that the pull to control was likely influenced by external stressors like the break-up; control helped them to cope. Because controlling food intake was a part of their disordered eating, they shared that as they engaged in recovery, they were intentional in attending to the urge to control.

There's something about the control aspect of it that I like. So, I still feel it there, even though, like I said, I haven't engaged in disordered eating in a while and like the last few months I sometimes still feel myself get triggered. I'm like, Oh, I, I don't have to eat lunch today. Like, I'm not that hungry.

These feelings of being out-of-control, being disempowered, seemed to be an inherent part of these participants' experiences when they were chronically misgendered. To cope with these chronic experiences of marginalization, these participants exhibited phenomena that I labeled gender noise (cf. Olson-Kennedy, 2016). Gender noise refers to multiple thoughts regarding gender, body, physical safety. Or, said in another way, gender noise was a manifestation of social anxiety surrounding gender, similar to food anxiety. This psychological

form of control also appeared to serve as a coping mechanism, i.e., if the issue lies within me, I can change it. However, this internalization of marginalization also reinforced feelings of shame. For participants who did not fit the Nonbinary Body (i.e., White, masculine-leaning, tall, thin, AFAB, able-bodied, androgynous), this self-questioning seemed intensified. Jupiter discussed how their fatness may lead to misgendering and not being seen as nonbinary.

So I think part of why I am I assumed to be woman is because I'm fat and at least in my mind it's harder to pass as, you know, a man or kind of look androgynous or anything else because I'm fat.

For Jupiter, experiences of misgendering and gender noise would lead to a "Gender Crisis" every couple of months, where they wonder if being a cis woman or trans man would be easier. The pain in being misgendered, not seen, was chronic and tied to their body.

Misgendering led to an internalization and eventual gender noise in the form of questioning their identity, despite identifying in that moment, knowing who they are (i.e., nonbinary). These experiences of distress contributed to coping through binge eating.

Once disordered eating develops, it can also perpetuate what it was intended to address. In other words, disordered eating can also provoke feelings of shame. Jupiter described binge eating that they hid from their girlfriend. The fear of being seen, of their girlfriend knowing they binged, a stigmatized action, provoked a feeling of shame and subsequent hiding of binging. Similarly, Mercury described when they would eventually eat, they felt they had to punish themselves, as if they had done something wrong for eating/breaking their restriction.

Participants described other methods of coping, such as distraction, dressing congruently with their gender, or finding ways to feel in control. For example, Bennu described feelings of gender dysphoria were triggered from a build-up of chronic misgendering. They described pain

of chronically feeling disempowered through being misgendered. Feelings of disempowerment and dysphoria led to coping through adjusting their gender presentation.

I just really got super dysphoric and all these emotions just bubbled up about like all of the, it's just like the hurt that I carry and that we all carry, like when we are constantly misgendered and constantly not seen as we want to be seen because that's our autonomy being taken away from us. And it's a lot to deal with every day... So, like my response to that was like, I basically ran out to a thrift store to like find men's jeans and a hoodie [laughs] and I felt so much better when I put them on, 'cause I was just like, okay, like now I'm being read as more masc. Which for myself, I don't feel I need to do, but like it made me feel more protected to be like hiding under these clothes these men's clothes.

Thus, actions to provide a sense of control were important for participants. A variety of control responses were revealed, such as choosing social bubbles very carefully (e.g., Venus), gender-noise responses (social anxiety surrounding gender), and also disordered eating. These choices and behaviors allowed these nonbinary individuals to feel in control, and sometimes even empowered. For example, Mercury described cutting their hair, and presenting in a manner that led to others questioning their gender more often.

Yeah, I just shaved my head recently. I used to have long hair on top, and sides shaved. And I think people perceived me more easily as a femme or a woman person that way. That like, now people are more like, "Yeah you're so pretty," and there's like no hair. And I can see them trying to reconcile within themselves, and I really appreciate that. [M: That process of being like "You should question, or you don't know."] Yeah, like you don't need to know. What you need to know is what are my pronouns and what's my name. That's the only thing you honestly need to know about me.

They described appreciating the reconsideration of their gender, people grappling with a lack of hair and their prettiness. It appeared that they were able to put a wall between themselves and others' assumptions of their gender, that is, "you don't need to know." This was within the context of their reflection of how they are gendered. They shared that they were typically gendered as a woman, but this changed in different contexts. Shaving their head seemed to empower them to feel they had an influence on whether others easily gendered them, and that felt good to them.

The differentiation between control and empowerment may be an important differentiation: not all experiences that increase feelings of control lead to empowerment. Overuse can lead to feeling out-of-control and harm. In consideration of the category labeled as *Healing*, methods that provide choice and acceptance may be a way to address disempowerment rather than relying solely on disordered eating. *Make the Feelings Go Away* captures the fluctuations and development of disordered eating, as a coping skill, and manifestation of relationship with self. Participants differed in the specific precipitants of disordered eating, types of disordered eating, the ways their disordered eating changed over time, severity of disordered eating, and current relationships with eating. They also shared similarities in the underlying relationships with themselves that were shaped by shame.

Intersectionality

When designing this study, my goal was to develop a grounded theory about disordered eating symptoms among nonbinary populations. I wanted to know if masculinity/femininity, oppression/privilege, and gender dysphoria played a part. Simple answer: yes, yes they do. Prior to doing this project, I often would separate identity from experience, viewing identity as an important but additional factor. I now understand that it is not different nor complicated. I think

my previous thinking speaks to the way I was trained, to see identity as separate. However, I have come to understand identity factors are domains where we experienced shared experiences of emotions like shame, anger, sadness, joy, grief, and more. Identities are also domains for connection and healing. For example, through privilege I may experience a sense of self-worth, acceptance, and self-esteem. The aspects of my identity that are privileged involve characteristics and validated by others. Thus, the prospect of losing privilege can lead to fear of losing acceptance and self-esteem. Thinking of my own relationship with food and identity, I see how striving to be muscular and to stay thin, I seek acceptance aligning with privileged existences. There is a hope that if I embody these qualities, for example, I will feel connected to others. Similar to other straight size participants, I was given assumptions of attractiveness, diligence, fitness, and other positive qualities due to the dominant culture around my size. On the other side of the same coin, marginalization is a representation of rejection that is chronic, repeated, and embedded in cultures and histories. Marginalization can lead to feelings of shame, isolation, sadness, anger, anxiety, and others. Disordered eating then can be a way to numb these feelings and improve themselves (i.e., align more with privilege), to be more connected and seen. Thus, throughout my results, identity were interwoven throughout.

In this study, the axial-level category of *Intersectionality* emerged as experiences surrounding identity that can lead to healing, rejection, and overlap between the two. I observed the same human experiences appearing in different domains—gender, size, ability, class, race, and gender expression. I will speak to some perhaps unique aspects of nonbinary identity and intersecting identities that stoked the fire of shame, disempowerment, and disconnection that created the groundwork and reinforcement of disordered eating for these individuals. Similarly, in the healing section, themes emerged related to how nonbinary identity also supported

healing—choice, connection, and congruence of self.

Participants described various identities where they experienced shame in the context of disordered eating and recovery. For example, several participants shared about negative internalized messages around size and morality around eating. Ceres described how they began to see their weight negatively when their Wii Fit labeled their BMI in bright red letters as “overweight.” Neptune described, on school vending machines, stickers labeling what was healthy and unhealthy, leading to feelings of shame. The similarities across these experiences were messages around body, eating, and size, in seemingly benign places. Certain bodies (i.e., thin bodies) and foods were acceptable, and others were not (i.e., bodies of size). The pervasiveness of these messages created an insidious feeling of messages being everywhere and nowhere at once.

Disordered eating and related behaviors are both stigmatized and normalized, depending on the bodies they appear in. When participants did not meet the stereotypical image of an eating disorder patient (i.e., a thin, White, cisgender, middle class, U.S. American woman), they described experiencing invalidation from others around the validity of their disordered eating. They talked about the pain they experienced when their concerns were not taken seriously by medical providers. For example, Uranus described doctors recommending she diet, without any attention to the danger of this recommendation to someone with anorexia. Experiences of size discrimination like this led to anxiety and worry when she goes to doctors’ offices, in preparation for unsolicited and harmful feedback about her eating. Notably, straight size participants did not describe this similar feedback from their providers.

Like, being told constantly that I need to lose weight, and that I eat too much. Bad things to hear as a person with anorexia [chuckles]. You know, gosh, just like constantly,

constantly, I start breathing sighs of relief when I'm exiting a doctor's office and they haven't talked to me about weight or food. That's because most of the time, they do, without actually doing any research how I eat.

Participants also described shame related to disordered eating. It makes me think of the many clients I have had who when I assess for eating concerns, immediately note they do not have an eating disorder. Why distance themselves from this concern? I think there is an implicit understanding that to be labeled with an eating disorder indicates a severity beyond the normalized disordered eating. I think, for some, there is an underlying fear of being labeled with a mental illness, and an implicit awareness that having this label is negative and represents a place where one can experience judgment and further shame. For example, Venus described the embarrassment they felt when their friend discovered their fasting application on their phone. If someone hides parts of who they are, there will always remain a part of them that is unseen, that does not get to experience being seen, accepted, and loved. The hidden part also does not risk being rejected either, if the person continues to choose to hide it. Therefore, hiding is both protective and reinforcing of secrecy and shame.

I don't really talk to my friends that much about my disordered eating. Just because it's kind of embarrassing. Like one of my friends saw my fasting app, and was like, "What is that?" I was changing my fast mid-day. I was like, "Oh, it's my..fasting..app." And he was like, "You fast? For what?" And I was just like, "?" It was just kind of embarrassing, I don't know.

A unique experience for nonbinary folks in their experiences of shame surrounded: (a) a lack of visibility/awareness of this identity existing, and (b) legitimacy of one's nonbinary identity. Within this domain of nonbinary identity, participants spoke about experiences of

chronic rejection and disconnection. They experienced misgendering, and sometimes gatekeeping, within their own communities. Misgendering and gatekeeping (i.e., determining who is acceptable vs. not; preventing access to) led to feelings of shame, self-questioning, and gender noise. In other words, it is hard to be who you are when who you are is a constant topic of debate, even among your own communities. Participants exhibited worry surrounding their own actions and expression that could lead to misgendering.

In this study, it was revealed that disordered eating develops as a form of coping with emotions through muting them and disconnecting from the body. Over time, such efforts to mute emotions creates further sensitivity to emotions, which are then repeatedly provoked by experiences of marginalization. Behaviors of disordered eating are then reinforced. Worry serves as a form of control, although, like disordered eating, can lead to its own challenges over time. For example, Earth and Jupiter spoke to experiences of self-questioning and change in performance regarding their genders as nonbinary. Earth noted first identifying as trans masculine, despite this label not being 100% accurate. They described identifying that way in an effort to seek legitimacy and acceptance from others.

So, when I first started medically transitioning, I felt a lot of pressure, which I kind of gave into [laughs]. To identify as masculine, even though I don't generally identify in that way. To the extent where I did openly identified as trans-masc, even though I'm not. It's because it's very, I guess, to do with a typical narrative of what a trans person is and does. Oh, so a trans person that's assigned female, transitions into a quote-unquote man. Even in nonbinary spaces at the time.

As Earth described, when there is a typical narrative in an already invisibilized identity, there is a draw to inhabit this narrative, even if it feels incongruent. Inhabiting a legitimized

narrative, even if incongruent, strengthens feelings of control over one's legitimacy. Jupiter described at times experiencing a Gender Crisis, where they question their nonbinary identity. They considered perhaps identifying as a trans man or cis woman could be easier, since society appeared to have a conceptualization for men and women. However, they also considered the repercussions of being perceived as a Black man or fat Black woman. They voiced aloud their thoughts and worries of harm and pressures if perceived as either.

If I was to medically transition, and like look more like a Black man, like society's ideas of who Black men are terrifying and pretty gross... I spend a lot of time worrying if I was going to transition in that way, like I wouldn't..adopt what society puts on Black men. Like I would be really uncomfortable, but then if you don't accept the way society accepts Black men to be, then you run the risk of not passing, and people will see you as...[pauses]...A man who doesn't fit into their conception and that puts you at risk for additional violence. And then there's like police violence, which is a whole 'nother thing. ...I'm perceived as a Black woman, the same things kind of happen, just in different ways. Again, people violating your space...But then there's pressures to, you know, look really feminine. Especially...if you're perceived as a Black woman, then especially in professional spaces...And I think that goes once for being a woman and twice for being a fat Black woman because you don't want to look sloppy...So do the hair, do the make-up, do the dress, skirt, whatever.

In this quote, they weighed their options in managing others' perceptions, in seeking to be seen. However, the intersecting oppressions of being Black, angry gender, and fat all had possible dangers in a racist, cissexist, sizeist society. Other participants spoke about a similar effort to manage others' perceptions. Aidan noted often navigating introductions and choosing to

withhold Aidan's identity or preference for no pronouns, due to the lack of legibility (i.e., general awareness of) of nonbinary identity. Having to explain oneself, and still risk being misunderstood at a basic and often taken for granted level (gender), can be taxing and a source of minority stress. It can contribute to disordered eating to again attempt to be more legible or seen; "if I eat less, I can have a flatter chest, less wide hips, and maybe then I will not be misgendered." The distress that can accompany these marginalizing experiences can also be overwhelming, and disordered eating can be used to cope with these emotions. Venus described this experience of emotional labor well: they felt they had to give an entire Gender Studies lesson whenever they come out as nonbinary. Thus, nonbinary individuals have to manage and decide, whether this effort is worth their energy, their vulnerability. When making this choice, there is a possible benefit—being understood. There is also a risk of rejection, or more labor. In other words, nonbinary people have to consider what is and is not in one's control. At the same time, when the environment continues to not see a person, that can also lead to pain, self-blame of one's body, worry, and a loss of sense of control.

Emotions associated with not being seen, and in this context, around gender, can be deeply painful. Neptune described this process in recognizing, during the interview, that others may never see them as nonbinary.

So it's, 'cuz then it's a small picture that the general populace has of an androgynous form. That it's...short-haired, tiny model, fashion, I think...something stupid. But it's not my fate. Nor will it ever be. It's mostly aggravating. And upsetting. [M: You said, there's a small piece of you, regarding, if you were a certain way, you'd feel, perhaps valid? May I ask valid in what specifically? I think I have a guess, but I want to make sure I understand what you're saying.] Valid, validated as what I am. By a stranger. [tearfully] I

will never be seen what I am, by a stranger.

Whenever I think back to this moment, or read their words, I feel their vulnerability.

Humans are social beings that want connection. From my own experiences as a clinician and as a person, I have seen this pain repeatedly. I can attest that marginalization rubs on this wound of not being seen, suggesting to a person that they caused their identity erasure. If they were only more x, or y, or both, they may be finally belong. In the case of nonbinary identity, Neptune spoke to this x and y as what emerged as the Nonbinary Body—that legible nonbinary people are White, thin, masculine-leaning/androgynous, able bodied, flat-chested, AFAB. Participants at times spoke of attempts to change themselves to this image, to question the legitimacy of their own identities when they did not fit this presentation. Options appeared limited—"do I adapt to be seen, at risk of not being authentic? Do I try to determine and express who I truly am and risk others rejecting and/or accepting me?" Participants grappled with these questions and named the confusion and anxiety within navigating this gender tension. This gender tension led several participants to question whether they wanted medical procedures or hormones, or to present more in a fashion they hoped would be more legible to others. This strengthened emotions of anxiety, fear, uncertainty, and for several, self-criticism and shame.

Jupiter recounted their intermittent Gender Crisis, which they described as their "lack of ability to accept themselves." Placing this blame on themselves, I think is misplaced—if one exists in a world that does not see them, they would feel pulled to be something that allows them to feel seen. I viewed this Gender Crisis as a form of worry combined with efforts to control—"if they blame themselves, maybe they can be in control of this emotion. If they can finally accept myself and this anxiety, these emotions will end." However, I do not believe this is as simple as a one-step resolution; given that society and our circumstances are slow to change, this process

of self-acceptance will be ongoing and challenged.

Gender-affirming medical procedures were also seen as a valid choice, if it is truly a choice to a person, no matter the reason. Whether such procedures allow one to present in a way that allows increased safety and connection, and/or to feel more congruent in one's body, and/or to try explore whether that is something one wants. At the same time, pressure from hegemonic depictions of an identity can make gender affirming medical procedures feel less like a choice. For example, Earth described what they termed Binary Lite. It was not until culture shifted that Earth felt more comfortable to explore more what felt congruent for them.

Like the vast majority of nonbinary people were just like, I don't mean this in a demeaning way, just like their identity is binary-lite. In which case, they identify with "I'm very masculine, but I'm not necessarily a man." Yeah. Like a lot of them is, "you can call me man dude, bro, I'm not binary. But that's it." There's not really a significant distinction. Obviously your nonbinary identity is valid, it just very close to the existing narrative. And then there's a lot of other narratives. Like, it's not a 100% but you're still like 90-80. That was just the narrative. Now it's a lot more open. And part of that is why I feel more comfortable not putting myself in that box. I think another part of that was like "Hm, this isn't me."

I also do not want these data to be used as evidence that gender-affirming medical procedures are wrong, and only seem like viable options because of oppression. I think that idea in and of itself is oppressive. Nonbinary people should be allowed to be unsure, to experiment, to change their minds; there should not be higher stakes around the bodily choices of nonbinary and trans people because of their identities.

Expectations around gender presentation were reported not only in cisgender and

heterosexual spaces, but they were also found within queer and trans communities. Participants described instances of being questioned for their femme identity, intersections between race and gender identity, and gender-disability identities. These expectations, or Nonbinary Body, appeared to have social capital both outside and inside nonbinary communities. When these experiences of rejection came from places where participants expected more safety, inclusion, and support, the resulting pain appeared deeper. An example of those arose in my interview with Earth. They shared how their gender connected with their neurodivergence, and to a lesser extent, their disability. However, when they would share their intersectional identity with others in their queer communities, they were met with judgment. When I asked what this gender was, they said they preferred not to share it. Within this example, I can see the protectiveness Earth developed around their gender—having experienced mocking from others, they understandably did not share their gender during our interview. There is power in having this choice for oneself—deciding who is allowed in. At the same time, these choices occurred in a sociocultural context that makes it all the more difficult and risky to make the choice of authenticity around identity.

Forms of this identity erasure also appeared in treatment for disordered eating. As a clinician, I was particularly curious to hear about participant experiences in the medical and mental health fields. Participants spoke to the importance of affirming spaces that allowed them to name their identities, explore who they are, and also question their providers. Negative experiences arose when providers did not have training or time to put in diligence to learn. For example, Earth described their experience in a psychiatry ward and their provider assumed nonbinary meant bisexual:

I think a very obvious first start, which is unfortunately not very obvious, is know what

nonbinary is. Because one time, I was in a psych ward. This is so terrible, but funny in retrospect. I told the psychiatrist—I came out to them. It was the first time I came out to any medical professional and they were like, “Ok, what’s that mean?” And I kind of explained it a little bit. And then later, I guess, the social services/counselor person brought me to her office. And she basically thought—she showed me the website of a local career center which I already knew, because she literally just Googled it. She basically thought being nonbinary meant being bisexual. I was like, you’re on Google right now; like you didn’t look it up? [laughs]

Moments like this might be attributed to burnout and the demands providers face. Well intentioned, this counselor may have felt that she had to provide resources. At the same time, providers exist in a system that continues to reinforce messages that anything outside of dominant experiences are extra or even burdensome. Until systems change to create space and prioritize marginalized experiences, those we seek to serve will continue to carry the burden of emotional labor and messages of shame. Thus, themes regarding what perpetuates and instills shame, disconnection, and disempowerment can also shed light on how to heal and prevent these experiences: (a) being seen (through interaction, embracing of diversity, representation), (b) connection, and (c) choice/empowerment.

Healing

Healing as a theme emerged throughout these participants’ narratives. It included empowerment through *choice* and *being seen*, externally and internally. Choice and being seen were often intertwined, for example making choices surrounding their gender expressions, and experiencing their identities being affirmed and accepted by others. Participants spoke to experiences of being seen and its impact in various ways and areas. As noted in Intersectionality,

participants spoke of the pain of being unseen in various domains, and how this pain was internalized within the self as shame. Over time, participants described a process of experiencing this pain from others even when they were alone. They then coped through avoidance of these emotions via worry (e.g., gender noise), disordered eating, and other coping skills, and avoidance of situations that could evoke this. At the same time, some participants also spoke to ways they have engaged and experienced healing.

Inherent in shame is secrecy—if I am seen for who I am, then I will not be loved, so I must hide. Thus, healing comes in exposure to shame, and having these parts revealed in the light. Systemic forms of healing arose in participant narratives. For example, several participants thanked me for doing research on nonbinary identity and disordered eating. There was a sense of surprise that gender identity and eating could be connected. An example of this is when Makemake shared their reflections on the interview.

...thank you for kind of, you know, choosing to do research around it. I feel like there is definitely a lack of research when it concerns nonbinary or trans people and anything, not just eating disorders, but basically everything that, that you might want to study. So, thank you for taking on a portion of it. I hope you're going to get something, something valuable out of it.

In a parallel process, hearing positive feedback from participants about the study felt both good and incongruent for me. In moments like this, where participants gave acknowledgement to me, I felt a push against this part of myself that was used to, and even stuck in a negative evaluation of myself. I was not aware of it at the time of the interviews, but I was also struggling with my own experiences of shame. Rereading Makemake's and other participants' words showed that being part of a research study about their lived experiences validated them, and

conducting this study and interacting with them validated me as well.

Experiencing inclusion challenges the implicit messages of eating disorder and disordered eating research and treatment—that disordered eating only applies to White, thin, middle class, American women. For example, Bennu described a key to their recovery was learning about intuitive eating. He noted Christie Harrison’s podcast Food Psych was key to his recovery, with how Christie included nonbinary and trans people in the discussion. He observed that, in other disordered eating recovery spaces, he felt like he was “sneaking in the back or like have like an ear to the door.” This sense of secrecy can add to feelings of shame even when seeking recovery. When Christie Harrison included nonbinary and trans people, Bennu described: “Oh my God, I’m invited into this conversation.” Inclusion in domains of greater society can disrupt the feelings of lying, being an imposter, and reduce the labor of making space for themselves.

These participants also spoke about the importance of having these experiences of *being seen* at the interpersonal level. Several participants described social support experiences that were key to their healing processes, even if that support surrounds engaging in behaviors related to their disordered eating behaviors. For example, Venus discussed being part of an online community geared toward a specific calorie limit. Although limiting calories may be counterintuitive to recommend for someone with anorexia, the community provided harm reduction and challenge to the shame and secrecy within disordered eating.

...This is not an eating disorder sub. It was in that community I was able to find recipes that were just healthy. And just a really supportive group. Like I’m able to find low-calorie ice cream, because that was one of my “no-no” foods. ...But I was able to find super-low-calorie ice cream through them. Things like that. It was that community.

...And the thing I like about these groups is that they're very anti-eating-disorder. So really you should only be in those groups if you absolutely need to fast. Or absolutely need to eat a small amount of calories. Which I don't know if I do. That sounds weird, right? I don't know if I'm, if I should be losing weight or not.

Other identified support spaces were queer and trans spaces where they would be more likely to be gendered correctly. IB described carefully choosing their spaces and what parts of themselves they revealed. Queer and trans spaces were especially important, given that majority of participants described being misgendered most of the time, outside of these spaces. At times, it can be life-changing to have a loved one validate one's pain and communicate their openness to be a support. Pluto described their struggle with disordered eating, body image, and dysphoria, and how they came to identify as nonbinary.

So, I was in college and it was spring, so we, unfortunately, started using less clothes and everything, and it gave me crazy dysphoria. So, for two months, I was obsessed about how I didn't like my body and I hated it, and I wanted all these modifications. And also how I—it actually hurt to see myself as a woman, and my boyfriend saw my distress and told me, “You know, you can not be a woman” [laughs]. “That's a possibility.” And that just blew my mind. And when I started doing more research and everything, I found out nonbinary was actually something I felt I identified to and brought me peace.

In that statement, Pluto's boyfriend acknowledged their pain, and validated that their dysphoria was real. He bore witness to their struggle, and rather than say “don't struggle” or “why are you struggling? I think you're great,” he presented more choice, where Pluto was feeling trapped. This was in contrast to their experience with their therapist.

I went to therapy, and the first was trying to convince me that “No, it's only—you

actually look great. And you're so beautiful and everything." And that didn't work [laughs]. So, basically, my therapy was, I want to be a professor in a university, I have to stay alive for that.

Having support that did not stigmatize participant experiences seemed to serve as an arena for participants to engage in the process of their self-acceptance. This also appeared in Haumea's narrative.

...Later, in college, when I had like the, the community and the like, like resources to be able to understand what was happening, and accepting of what was happening...I was able to like, make my body, well, what I wanted it to me, or like, in a way that made me happy as opposed to like a, with anorexia. It's like very like destructive, very like self-hating. Whereas I feel like I went through the opposite process, like in college where I was like practicing self-love or self-acceptance.

They noted that once they entered college, they found a supportive community and resources to understand the role of dysphoria in their anorexia. This led to acceptance of their gender and disordered eating, beginning the practice in self-love. For Haumea, self-love included changing their body through gender-affirming practices, rather than through "self-hatred" they associated with anorexia. Community and engagement in their own power through choice connected participants to a process of healing.

When shame becomes part of one's identity, change is supported when one is seen and accepted holistically, by others and oneself. In other words, healing comes when people are able to experience and walk through the shame with themselves and others, and experience acceptance. At first glance, this may seem counterintuitive—to combat shame, I have to feel shame? However, it is not about ridding the emotions but practice in experiencing the emotion.

Shame will not reduce through avoidance (i.e., disordered eating), though it will be temporarily withstood. This can be a necessary part of survival, even recovery. Although hiding the parts people may dislike about themselves may provide relief, withholding shameful parts of themselves creates circumstances where they become more sensitive to shame. Further, when others see these good qualities in them, they may not see that in themselves, creating a feeling of being an imposter. Therefore, healing can be found when these shameful parts are shared and accepted by others and themselves.

Through self-acceptance, there is an inherent piece of choice to accept oneself. Several participants spoke to the importance of *choice* in healing. Bennu described that they had a choice about their disordered eating, a choice regarding their pain. And it was when they heard that this action they felt shame about—disordered eating—was understood, ok, and no longer needed, they chose to tell themselves this same message.

I was starving for someone to recognize the pain that I, that was inflicted on me, but that I was also choosing to inflict upon myself and just say like, you don't have to do that.

[becomes tearful] And it's OK to eat and the body you're in is OK.

Within Bennu's words is what I see as a key part of healing: empowerment and ownership of one's experience. I find myself thinking of experiences around marginalization, choice, and healing in all-or-nothing terms. That if a key to healing is empowerment and choice, then perhaps people that struggle with healing are refusing to make the choice to heal. However, I think part of healing is being able to hold the dialectic of both the importance of individual choice and the circumstances that at times make this choice difficult, or limits the types of choices that can be made. And to also acknowledge that it is the process of choice, rather than the content, that is important.

These participants described many choices and ongoing difficulties with disordered eating. These individuals developed disordered eating often within situations where they were disempowered and were not given choice. For example, disempowerment occurred upon going through puberty and one's body becoming gendered in ways they did not understand nor want. These experiences of disempowerment are made chronic when people are marginalized due to oppression, when they experience loss and/or trauma. IB discussed being bullied for their weight; Mercury described White peers harassing them for being one of the few Asian students; Mars described being labeled as fat in a critical manner, etc. Thus, when it comes to recovery, it is important to facilitate participant choices and to validate their efforts, *especially* if they continue to engage in disordered eating. Inherent in disordered eating is shame. To provide feedback or suggestions for change without understanding the development of something can be experienced as criticism or a lack of acceptance. For example, Venus described engaging in fasting, and presented this with self-judgment. With that said, their willingness to share that information with me as an interviewer represented recovery and healing as well, challenging secret-keeping.

I'm trying to do 1200 calories a day. I've been eating a little more. But I have been doing 16-18 hour fasts. That's where I am right now. It's disordered as hell. It's only because I saw my weight. So, this is like just what feels comfortable for me right now. I don't feel. I feel uncomfortable eating. It feels weird to me. So, when I am hungry, when I do eat, I feel gross. Right now, I feel fat. I just feel fat and I feel gross. And, I don't know. My fast is over at 7PM, so I guess I'll eat, but I'm like..[shrugs]. That's where I am right now. It's not great. It's not even good. [laughs slightly] That's what I'm doing.

These participants often presented their disordered eating with shame during the

interview generally. Many participants presented their behaviors via self-deprecation/self-shaming. Mars described an instance where their mom questioned their eating Oreos. In the moment, I experienced that story as frustrating and sad—that their mom would question them and that they expressed this self-disappointment. However, their assessment of the story was that they have a control issue, which is congruent to the self-talk of someone who experiences shame around their disordered eating.

And my mom saw those Oreos, and my mom was like, “Why are you eating those Oreos? You shouldn’t be eating those things.” And I was like, “I only ate a little bit of them.” And she was like, “Let me see how many you ate.” And I was just like, “Fuck off. You can’t..I don’t need you to tell me that I ate too many. I already know. It was just too much.” So I definitely see that I definitely have a control issue. And I definitely like..food is just a reward, is like a friend; it’s just a comfort.

In these participants’ experiences of ongoing healing from disordered eating, aspects of *being seen* and *choice* also appeared. For example, later in the interview, Mars described their efforts to be seen, and serve as representation to others, which supported their management of disordered eating.

...Being nonbinary, I feel like there’s a lot of pressure to be thin, androgynous person. So like, it’s hard to not want to be that. But I try to remember that. Like I try to be more positive and be very visible. ...And on Trans Visibility Day, I’ll post picture of myself. Like, “hey, you know, being nonbinary doesn’t mean you have to be thin, White, and androgynous. You can be fat, Black, and femme. It’s fine. It’s ok. You can look however you want; you’re still nonbinary.” So, things like that. So with that, sometimes it does help me relax about how I’m eating. Take a pause and just go, “I don’t really need to

have that. I'm fine. I'm ok."

I felt Uranus summarized well the key aspect of *choice* as a part of healing. The process of choice is embedded in identity and recovery. When participants did not have the choice of being their identity and having it be acknowledged and validated, this creates an experience of disempowerment. When they were able to choose their identity, presentation, community, recovery, and life choices, this provided further tools and support for healing.

I would say the thing that like is most significant for me in terms of my recovery, that I think applies to both gender and eating, affirming peoples' choices. ...And I don't know exactly how this applies because obviously there are situations where...Emergency interventions are needed. But apart from that,...I feel like as a nonbinary person, the hardest thing I face is not being seen for who I am, and not being allowed to just be who I am. And to decide that for myself. And that's the hardest thing with eating, too. Is finding out that...finding out that your body is your own. Just like your gender is your own. And that your eating belongs to you, and not to some fucked up societal standard, to your parents' problems. But to you. That you belong to you, is the most important thing.

Gender Is a Social Construct—Navigation of Disempowerment and Choice in Identity

Choice, an open-coding category within the axial-level category of *Healing*, manifested in how participants came to recognize their genders, expressed themselves particularly surrounding gender, and engaged in recovery. For example, participants spoke to the lack of choice in puberty, as discussed in *Food Is the Band-Aid*. Their bodies changed, and gendered standards were imposed on them. However, all participants made efforts to see themselves, and inadvertently, combatted feelings of shame.

Participants described how identifying as nonbinary empowered them. Jupiter described

that as a Black person, gender expectations placed on them intersected with racial expectations. As a Black nonbinary person, their self-conceptualization of their gender was outside of society's rules of who they should be. This helped to relieve some gender noise about people's expectations of them.

But I feel like there's maybe a little bit more freedom whenever I set myself as nonbinary, because I conceptualized maybe myself outside of like society's rules about what Black men and Black women should look like or act like or do. I'm like, "Ok, I can be this. Or this, or this." Other options that maybe I'm little bit less worried about what other people are going to think or perceive me.

Similarly, Bennu spoke to the discovery that there were gender rules. Within the process of learning these rules, they also came to recognize they could choose to not follow these rules.

And that really opened my eyes to the world that I had been happening because like gender, like I was participating in this system and I was following these rules, but I did not realize that it was optional. ...And I think just realizing the limiting nature of defining myself within that binary and all the pain that was me and being able to finally name it was like really powerful. I think I just started getting turned onto like more and more like resources, voices yeah, like activists authors and just started expanding my knowledge like on, on this topic...And the fact that like, I can opt out if I want to and how that felt so much more comfortable to me.

Like other participants, Jupiter and Bennu described how their self-conceptualizations of their genders gave them choice as to who they were. These representations of choice in their lives were healing, even as they simultaneously experienced confusion and marginalization around identifying as nonbinary

Many participants described puberty as an onset of noticing incongruence with their bodies and genders and/or gendering from others and their self-identification of gender. When thinking about shame and general emotional avoidance, disordered eating provided a method to cope with emotions. Through exploring their genders and acknowledging dysphoria, whether bodily and/or social, participants engaged in active choice and seeing themselves. Engaging in choice and seeing themselves showed an openness to emotions of incongruence with their assigned genders. For example, Mars described their discovery of being agender (i.e., without gender). They chose to see themselves in this moment and connected their feelings with language.

It's kind of corny, but I found out the word nonbinary through Tumblr. And I was just like, "Oh my god. There's a word for how I feel. It's so cool!" And then I found the word agender, and that's exactly what it is: I don't feel like I have a gender at all. I am completely without it.

Exploring gender through finding community represented another domain of identity in which healing can occur. Although disordered eating can mute feelings, exploring and connecting language with feelings can be a tool for healing. Makemake described their process of their exploring their own gender and pronouns. They shared that being in an environment where there was more gender diversity allowed for their own exploration and eventual openness to requesting being seen by others.

Participants also spoke about openness to the ongoing journey in exploring their genders and how things varied or did not vary over time. This attunement with themselves, and, in a way, self-empowerment to loosen the gender imposed on them, served as a form of healing. For example, IB described recognition that, for them, their gender may change over time.

I think I'm still trying to understand it growing, but a big part of it is for me, I guess, is I'm not necessarily aspiring towards one or the other traditional sort of construct of gender, but participating in multiple different types of it that may even change with time.

Participants also discussed periods of suppression and consideration. Haumea described the lack of representation and knowing they were not ready to consider being trans. The lack of representation and language for their experience made it more difficult for them to acknowledge their trans identity.

And so I feel like I definitely became aware of like, being uncomfortable with my body at like 12 or 13, but I didn't necessarily have the words or like the confidence at all to even, like think about being trans and like the one, I guess the first time I like considered it. I like immediately push it away. And I was like, no, are people, people are trans and it's like, not, not you. And they didn't really know any trans people that were like out or like in my family at all.

Without community and support, it is difficult to feel safe enough to identify in the margins. In the case of Haumea, it may have even been distressing or overwhelming to identify as such before they were ready. Once Haumea and others they found community, similar to Mars and finding terminology and others using nonbinary, could they see being nonbinary as a possibility. Thus, healing often occurred simultaneously through acceptance and exploration of self, through seeing oneself and being seen by others. Through support and seeing examples in their support system, Haumea became open to experimenting to find what felt right for them.

Until maybe like senior year of high school. And like I learned about like nonbinary genders and it was like, I was pretty hesitant to like, identify with that at first the like gradually as I went on and as I met And like befriended nonbinary folks. I started to

realize that that was like an actual possibility for me.

In summary, what is healing, in my findings and experience, is the acceptance of themselves from themselves and others, no matter where they are. If that is acceptance of one's gender identity, that is awesome. If it is acceptance that perhaps they are not cis, but they are not ready to admit that to themselves or others, that is perhaps even more important. There can easily be shame or pushing of oneself to be out and proud, but that is not necessarily a safe reality, and can recreate dynamics of disempowerment and shaming. In other words, that to be accepted, they have to be someone they are not at this moment. For example, Haumea recalled their therapist directly asking them if they were trans.

...He like just point blank asked me is like, whether I was trans not, not specifically using those words, but just like, "Do you identify as a boy? Like, have you ever like, felt like you wanted to be a boy or something like that?" And I like, at that point in time, like I just wasn't ready to, to think about that stuff or like face it...If somebody is going through it, like relatively young I don't know, like maybe [pause]. I don't know. Maybe like maybe just explain that it's like okay. To not know.

To Haumea's point, what they needed was acceptance of the fact that they did not know their gender identity. Pushing outness, pushing knowing before someone is ready, can disempower them, even if the intention is to affirm their identity. Perhaps, what is even more important than affirming one's identity, is to affirm one's *choices* around that identity. Marginalization around gender includes the enforcement of gendered rules (as Bennu and others described). Thus, to create more rules as to what a trans person is (someone who is out, proud, certain, etc.), further marginalizes a person.

I reflected upon the function of coping strategies like disordered eating and worry (e.g.,

gender noise, food anxiety). These skills came into play within contexts where participants did not have control and choice. For instance, coping strategies developed within contexts where participants experienced a lack of choice around how their bodies changed, expectations from family and society regarding gender and their bodies, messages around acceptable bodies and food choices, access to food, neglect, trauma, and other situations. Misgendering and other forms of disempowerment and marginalization led participants to experience the gender tension and self-questioning. Sometimes, this self-questioning occurred in spite of feeling okay with themselves and their bodies when alone. I believe this points to the dual responsibility of: (a) outward factors such as society, environment, relationships; and (b) the individual to relieve these expectations. Bennu, like others, described a gender tension within them.

The confusion and like the tension between like how I feel about my gender, but then how people see me and kind of the space between of like, okay, well, if I were able to adapt my body in these ways, then maybe the world would see me as I want to be seen. And so for me, this is obviously just for me, because every person's experience is different. But for me, I think really, like, I'm happy with my body and I like my body, but it's when I have to go out into the world that then misgenders me because of my body that I feel that pressure and that dysphoria and that desperation to alter my body so that I am seen as I want to be seen, if that makes sense.

I also see the second responsibility to also fall on the individual, from moment to moment, to make the conscious choice to let go of what they cannot change, even acceptance that this tension may continue to exist. Ceres particularly captured this phenomenon when they reflected on whether their efforts to avoid misgendering were futile.

I wonder what, if it, on some level I thought it's kind of futile. No matter what I do, I'll

still be seen as a girl for reasons I don't completely know of and can only speculate about. A part of me is also like, "Well that means I shouldn't be trying to restrict my gender expression just for the purpose of being seen as not a girl..." And there would be certain things that would be pretty clearly seen as feminine that I would probably want to wear, if I wasn't worried about, "If I do this, maybe I'll be more likely to be seen as a girl." I think those—I do wonder a lot of times if I were racialized differently, my gender would be perceived differently as well.

As Ceres described, efforts to avoid misgendering may not get the outcome nonbinary individuals wish to have: to be seen. And if they continue to focus on trying to be seen, they inadvertently will recreate this dynamic within themselves, such that they don't see themselves. Thus, I agree with Ceres in the futility of trying to manage others' views of their gender. I have had this thought often, sometimes multiple times a day when experiencing microaggressions, and misgendering. For example, even with individuals that gender me correctly, they may very well still see me as a woman or some other gender which I am not. However, the way I have learned to manage my emotions continues to reinforce this illusion of control over others' perceptions of my gender. Thus, I think I could even take a step further and radically accept like Ceres and those of us who struggle with this worry, gender noise, disordered eating, feelings of shame, that one cannot necessarily change these coping skills and shame-based relationship with self, at this very moment. And, we, as nonbinary individuals, may continue to rely and use these coping skills. These coping skills of worry, gender noise, disordered eating, and shame proneness developed for a reason, and maybe, as long as we are in these circumstances, maybe we need to have the choice to continue to use them.

Uranus discussed the dynamic of continuing to need control over her body when

discussing her efforts to find treatment with a radical intuitive eating nutritionist. She described that that provider pushed a certain form of recovery, despite her fears of further fatphobia. In other words, the provider was recreating this dynamic of disempowerment—that there is only one right choice, and if Uranus did not make that choice, she would be wrong. Thus, there would not be space for Uranus to decide for herself what was right for her.

And I've actually turned down a pretty radical intuitive eating nutritionist... We had a conversation of what would happen 'cuz I'm really afraid of gaining more weight. I just can't handle any more stigmatization or having any more restriction on clothing or anything like that. And she said, "While I would never want to compromise your recovery." And that was actually a red flag for me because I was like, you know what, it's ok for people to decide for themselves what they want to be, and who they are. And with the nutritionist I'm with now it's more nuanced in her approach, and it allows for that kind of gray area, where I get to decide what our values are, while still ultimately working towards recovery. And that's been really healthy for me, is knowing I get to make my own choices. I get to be the kind of person I want to be.

Uranus turned down her first nutritionist, despite the seemingly fitting recovery model, intuitive eating. She spoke about the important dynamic underneath, *choice*. I have been caught in this dynamic with myself often. When I go for a run, when I have a strong urge to include vegetables with every meal, I have thoughts of, "am I engaging in disordered eating? Am I reinforcing diet culture?" Or, in considering gender, when I notice I deepened my voice meeting a stranger, or changed my shirt because my neck looked too feminine, I sometimes think, "am I being incongruent? Am I letting internalized transphobia win?" I think these thoughts and ways of relating to myself speak more to what I have discovered through this dissertation: a lack of

acceptance of myself, a relationship with myself based on never being good enough. No matter the content, I often experience a process that recapitulates this dynamic of shame.

Like these participants, my relationship with myself was very much shaped by my lived experiences of trauma, disempowerment, and marginalization. When I notice myself feeling shame, sometimes my first reaction is to typically get mad at myself. However, as described through the data around healing, perhaps a different response that encapsulates healing is acceptance. Acceptance is important of not just my gender, and my eating, but radical acceptance that this relationship with self exists. There also needs to be acceptance that I sometimes struggle, that I do not necessarily want this, but that it is there and how I am feeling at that moment.

Through radical acceptance, if people choose to work to change, they can. But if people continue to resist the idea that these ways of relating that are part of them (e.g., the shame, the worry, disordered eating, self-hatred), they continue to resist themselves, and recreate this dynamic of shame. Thus, to have this acceptance from themselves and from others, they can create and reveal the choice and power they have always had. This process of healing reminds me of this Carl Rogers quote, “The curious paradox is that when I accept myself just as I am, then I can change.” Within Pluto’s, Haumea’s, Bennu’s, and many others’ narratives was the importance of agency. Nonbinary individuals learn to give up their power to survive, by acquiescing and shaping themselves to the world. Thus, owning autonomy can be scary, painful, and yet freeing. Owning autonomy encompasses both giving up an illusion of control and taking responsibility for oneself.

I have discussed the factors that led to the development and perpetuation of disordered eating in nonbinary people (or, at least, my participants and myself, to an extent). That is the

water we swim in. Regarding the fish, I think of it as: when I focus on how the world has hurt me, hurt stops when the world stops hurting me. Unfortunately, I do not have much say over the world. I am relying on something that may or may not ever change, or at least at a pace that is not sustainable for me. Thus, within this greater context, it is essential to find where my power lies: the choices I have within my own life, gender, recovery, and beyond. Thus, healing occurs concurrently, as we are seen by others and actively choose to see ourselves, no matter who we see ourselves to be.

Grounded Theory: Combatting Shame through Choice and Being Seen

A grounded theory explanation emerged at the selective coding level through analysis of participants' unique and shared experiences as nonbinary people with disordered eating. When I started this study, I believed I was doing a study about nonbinary identity and disordered eating. However, through the analysis and writing process surrounding the axial-level categories, I began to see I was doing a project on shame. Participants spoke about disordered eating as manifestation of underlying concerns, as captured by the axial-level category, *Food is the Band-Aid*. Underlying concerns included experiences of trauma, anxiety, socialization around food, and marginalization which provoked emotions of shame in these participants. People turned to disordered eating in order to change them to belong and connect with others. That is, shame manifested in behaviors to shape and alter themselves to be acceptable to others and themselves, e.g., hiding disordered eating, body hatred, self-blaming regarding misgendering. Marginalization fueled this shame, since societal erasure of nonbinary genders creates frequent opportunities to be misgendered.

These participants also described frequent experiences of disempowerment in their lives, such as puberty and bodily changes, lack of choice regarding recovery, and erasure of their

gender identities. These individuals internalized the shame, in part because of the repeated nature of misgendering, social dysphoria, and oppression, and in part to give a sense of control; if the issue is within oneself, one feels they are in control to change the issue. However, these findings also illustrate how self-blame can exacerbate or redirect negativity toward the self, particularly after repeated failures to change the situation. Disordered eating became a similar coping tool of control of the body and of emotional regulation. As participants discussed, disordered eating gave feelings of control and supported coping with emotions through avoidance. However, disordered eating, over time, can reinforce feelings of shame due to stigma surrounding disordered eating and the increased sensitivity to emotions because of the lack of exposure to emotions. Further, disordered eating also became a place of shame, and eventual place of loss of control.

The process that emerged from this study is also one of healing. *Food Is the Band-Aid* showed that to understand disordered eating, one has to look beyond just the behavior. To heal, one has to go beyond addressing disordered eating, specifically by addressing the shame that is perpetuated by chronic disempowerment, rejection, and erasure. Choice and facilitating being seen were necessary parts of recovery for these participants. For example, these nonbinary individuals discussed the importance of choice around their gender expressions and the community spaces they were in. Also, to heal, one must concurrently address the environmental nature of disempowerment. For example, when participants had support in being seen, accepted by others, they experienced more self-acceptance.

Birch Tree: Impact of Marginalization on Disordered Eating Among Nonbinary Folks

To summarize the grounded theory model of this process, I will use an analogy of birch trees where nonbinary individuals are various birch trees in a forest. The forest is the context. For

example, trauma can be seen as efforts to cut down individual trees, and marginalization can be represented by contaminated water surrounding the tree that infects it. Despite these circumstances, trees often are still able to grow. To protect itself, the tree develops a tough outer layer of bark, which is representative of coping, like disordered eating and gender noise. Depending on the tree and the circumstances in which it has grown up, the thickness, the gnarly patterns, scars, growth pattern, and general appearance can vary, just like these participants' experiences varied, although they are all trees in the same forest and had this bark of protection. Over time, this tree bark can thicken to the point where some sunlight (e.g., being seen) cannot reach the inner layers. The bark may also become overgrown, and take away nutrients from other parts of the tree, the way disordered eating negatively impacted participants. Thus, to support a tree in this circumstance, to help its inner bark be shown to the light, it may need to release the outer bark. The outer bark naturally will break off, if and when the tree is in the right conditions which include cleaner water (e.g., affirming community and relationships, reducing marginalization) and development of other protective mechanisms like moss (e.g., other coping skills, support groups, therapy). However, if the tree bark is torn off prematurely (e.g., disempowerment through forcing recovery, forcing coming out), even if the intention is to allow more sunlight, the tree may re-experience the scarring, perhaps develop an even thicker outer layer. It may even experience sunburn from excessive sunlight.

When a tree is ready to shed its bark, it naturally will, but that process cannot be forced without unintended consequences and possible damage to the tree. And even when the tree has shed much of its bark, it may still have patches, necessary to protect it, given that the water, air, and conditions persist. Similarly, when experiencing ongoing trauma, marginalization, and pain, prematurely taking away coping skills like disordered eating and worry can damage the

individual, especially if systems of oppression and harmful environments are not changed. The individual will naturally heal, when given the proper conditions of support, changing systems of oppression, and choice and empowerment in their life. Thus, it is important to make space to hold both: that coping skills, like disordered eating, may need to persist at times; and an individual can concurrently heal, when given the support and empowerment to do so.

CHAPTER 5

DISCUSSION

The goal of this study was to develop a grounded theory to better understand the etiology and maintenance of disordered eating symptoms in nonbinary people. I was also interested in the influence of developmental experiences. I was also curious whether gender dysphoria played a role, whether gender transitioning ameliorates disordered eating symptoms, and what about participants' environments was implicated in exacerbating symptoms. Through the process of Selective Coding, the model that emerged was that disordered eating was the surface-level manifestation of experiences of trauma, marginalization, and overlapping mental health concerns like anxiety. In other words, *Food Is the Band-Aid*: participants experienced disempowerment that took away choice within their lives and reinforced a shame-based relationship with the self. Experiences of disempowerment occurred in different identity domains, as represented by *Intersectionality*. Disordered eating served to *Make the Feelings Go Away*, although disordered eating also furthered difficulty with shame tolerance and healing. Participants engaged in recovery through enacting choice and combatting shame through methods related to nonbinary identity such as congruent gender expression and finding community, i.e., *Gender Is a Social Construct* and *Healing*.

Previous theory regarding disordered eating among cis men and women aligns with this study's findings that disordered eating develops from a multitude of factors, i.e., *Food Is the Band-Aid*. Maine and Bunnell (2010) described how for cis women, disordered eating stems from what they labeled the Perfect Biopsychosocial Storm. According to Maine and Bunnell, cis women experience disproportionate rates of violence, trauma, and distress. Further, during puberty, there are often difficulties understanding bodily changes. Sexism also creates an

external view of self and self-worth. Cis women are then socialized to idealize thinness, and learn norms surrounding dieting from family and other social institutions. These biopsychosocial circumstances are thought to create the conditions for a higher risk of disordered eating. Davis (2009) outlined that once disordered eating develops, it becomes a separate form of distress. Bunnell (2010) described that cis men do not experience similar drives for thinness, but instead a drive for muscularity. Bunnell also indicated that cis men did not report the same levels of body dissatisfaction.

Participants in this study showed similar biopsychosocial experiences regarding marginalization, trauma, and distress. They also described distress surrounding puberty and bodily changes. However, similar to Bunnell's (2010) description of differences between cis men and cis women, these participants' body ideals varied (e.g., some strove for thinness, some for specific body measurements, some for muscularity), despite all identifying under the nonbinary umbrella. Thus, perhaps across genders, whether cis or nonbinary, individuals with disordered eating internalize a sense of inadequacy regarding their bodies. Whether it is needing to be more thin, muscular, or something else, when one experiences disordered eating, there is a sense of needing to be more, or being not enough as they are. Thus, findings from this study indicate that some individuals who experience disordered eating may have dissatisfaction with their bodies in comparison to a certain body ideal.

Perhaps the primary difference between body dysmorphia, feeling of inadequacy within one's body, among cis populations and nonbinary individuals would be the possible factor of gender body dysphoria. As was revealed in these results, there was an overlap with body dysmorphia and gender dysphoria for some participants. For example, Makemake described difficulty differentiating the two. An overlap between body dysmorphia and gender dysphoria

does not mean that once body dysmorphia is addressed, gender dysphoria will no longer be a concern or vice versa. For individuals that experience primarily gender dysphoria, gender-affirming procedures may be a primary treatment, as was the case for Pluto. Pluto noted that when their anorexia started, they experienced a feeling of inadequacy surrounding thinness. However, they later recognized that their bodily distress was gender dysphoria, and that insight helped to alleviate disordered eating symptoms. Since their distress was tied to gender, they were able to pursue gender-affirming methods to relieve their dysphoria, rather than relying on restriction and exercise. Pluto described that once they were able to present more congruently with their gender, they felt more at peace with their body and eating. Pluto's experience was similar to findings from Testa and colleagues' (2017) and Kozee et al.'s (2012) studies which indicated that greater congruence with identity and appearance led to more satisfaction with one's body. In Pluto's experience, congruence also led to reduced disordered eating as well as body satisfaction.

Given the connection between body dysmorphia and gender dysphoria, during assessment for disordered eating among nonbinary individuals, or more broadly, individuals who may experience gender dysphoria and disordered eating, questions regarding global feelings toward body may be necessary to guide treatment. If elements of gender dysphoria are overlooked, providers may run the risk of suggesting interventions designed to promote body acceptance. For example, in Pluto's case, their therapist told them to accept their assigned gender and body, because they were "beautiful," which disregarded their gender dysphoria. For nonbinary individuals, gender dysphoria and feelings toward their gendered characteristics can be impacted by marginalization. Participants described sometimes feeling congruence and acceptance of gendered parts of themselves until they encountered marginalization. For example,

Pluto described only feeling dysphoric around their voice when others would misgender them only after hearing them speak. Thus, when they were chronically misgendered, they would sometimes experience dysphoria. The nature of dysphoria, thus, may be contingent on the construction of gender in the moment. West and Zimmerman (1987) describe the process of how individuals prescribe gender to others, based their own socialization. Thus, for Pluto, others are prescribing their understandings of gender on Pluto. Understanding the sociocultural context of this misgendering would be important in helping, for example, externalize the misgendering. As Pluto emphasized, without inclusion of identity, and understanding of the client, treatment may not be successful. Couturier et al. (2015) discussed two case studies of two adolescents with gender dysphoria. The authors had similar recommendations to include identity in treatment. Authors wrote that weight restoration treatment for anorexia increased dysphoric feelings for the patients. Thus, they recommended attention to the overlap of gender dysphoria with symptoms associated with anorexia, such as body uneasiness, and body dissatisfaction.

For some nonbinary individuals, there may be greater overlap between dysmorphia and dysphoria. For example, Ceres identified that since puberty, they experienced dysmorphia surrounding height and size unrelated to their nonbinary identity. However, when they began to identify as nonbinary, and began to experience misgendering, they also began to experience gender dysphoria surrounding height and size, fearing that their height and size led them be misgendered. Thus, for Ceres, there was an overlap between dysmorphia and gender dysphoria. In this case, this does not mean that treating gender dysphoria was unhelpful or ineffective. It may lead to reduced distress related to dysphoria and reduced experiences of misgendering. However, treating only gender dysphoria may not resolve their sense of inadequacy located in their body; as Uranus noted, “in terms of body hatred, when you hate your body for one reason,

it's sort of easy for that to transfer to hating it for other reasons." Ceres experienced self-hatred regarding parts of their body, which at times overlapped with gender dysphoria. Kozee and other researchers (2012) found that trans congruence had an inverse correlation with body dissatisfaction. In other words, the more congruent trans participants felt in their trans identity, the more satisfied they felt with their bodies. Since this was a correlational finding, the correlation may also be bi-directional: the more satisfied a trans person feels with their body, the more congruent they may feel in their trans identity. Thus, in Ceres case, addressing gender dysphoria through medical intervention may support more congruence with their trans identity. They may also experience further trans congruence if they also experienced more body satisfaction. Relationship with body, as noted in my study, was shaped by external influences like trauma and marginalization. Therefore, being able to hold the dialectic that gender dysphoria is influenced by body dysmorphia and vice versa, can serve as further support for changing environmental influences like trauma and marginalization that increase feelings of inadequacy/shame in the body.

Shame

Shame was an underlying process of disordered eating for the nonbinary individuals in this study. Thus, it makes sense to direct some further attention to the construct of shame. Shame is an emotion that arises from judging oneself for a social transgression. Kim (2020), in a presentation regarding disordered eating among LGBTQIA+ people of color, described shame in relation to eating disorder. Shame is an evolutionarily necessary and adaptive emotion, that facilitates society development. Shame is an emotion that arises from the human ability to reflect about how one is seen, rejected, or not seen by others. Shame helps to foster societies, because individuals try to reduce perceived social transgressions to belong, facilitating cooperation and

connection. However, as shown in *Intersectionality*, marginalization can create chronic experiences of shame, due to repeated messaging that it is one's identity that is transgressive. Chronic shame led to participants seeking to change or hide parts of themselves to receive connection and avoid rejection. For example, Aidan withheld preference for no pronouns, perhaps to avoid being seen. However, if one continues to act to avoid rejection, they may not experience being seen or belonging; the piece of them that is deemed unacceptable continues to be shamed and tucked away. Thus, according to Kim (2020), behaviors rooted in shame are based in strivings for connection, despite shame-based behaviors can recapitulate disconnection.

The underlying aspects of shame in disordered eating is supported by Fallon and Lannon's (2016) recommendations in their chapter on gender and assessment of eating disorders. They indicated that individuals who experience disordered eating may have a tendency toward perfectionism and shame. Shame is inherently linked to the self (i.e., self-evaluation), but through repeated marginalization, shame may encompass the self. Kim (2020) described this repeated marginalization effect as Shame of Existence. When shame is tied to one's being, the only relief from this shame would be to cease to exist, taking up as little space as possible. Kim observed that shame tied to existence explains the high rates of suicidality in eating disorder populations, and predicts suicidality more than the internalization of the thin ideal. This Shame of Existence can be seen in Uranus's experience, when she described that self-harm through restriction/disordered eating was motivated by wanting to exist less.

Why May Nonbinary Individuals Have Higher Prevalence of Disordered Eating?

Previous research on nonbinary individuals and disordered eating was limited, and indicated that nonbinary individuals may have increased odds of disordered eating (Watson et al., 2017; Diemer et al., 2018; Tabaac et al., 2018). Watson et al.'s (2017) study of Canadian

trans youth showed that experiences of stigma, such as discrimination, were positively correlated with disordered eating behaviors whereas protective factors, such as family support, were negatively correlated with disordered eating behaviors. The authors postulated that participants may be motivated to engage in disordered eating to attain more masculine or feminine appearance. Participants' experiences in the current study shared a larger variation of motivations for engaging in disordered eating including more masculine and/or feminine appearance, as well as appearances shaped by race and other identity factors. The possible shared body ideal was the pressure to meet the Nonbinary Body ideal (White, thin, masculine/androgynous, ablebodied, assigned female, pursuing top surgery) to be seen as the gender they embodied. At times, participants described feeling inadequate in the ways they did not meet the Nonbinary Body ideal. Feeling inadequate would be a source of distress that then lead to disordered eating to cope. However, participants did not directly engage in disordered eating to meet the Nonbinary Body; it was instead the knowledge that the Nonbinary Body stereotype existed and their body's incongruence to this stereotype that led to distress.

Diemer and colleagues (2018) found higher prevalence of eating disorder diagnoses among nonbinary individuals compared with trans men and women in their study. Their explanation was that nonbinary individuals experienced more enacted stigma due to being visibly gender-nonconforming. However, the type of enacted stigma and gender-nonconformity were not assessed. Within the current study, participants may have been gender nonconforming in ways that may not have fit the Nonbinary Body stereotype. However, these participants did not necessarily associate enacted stigma with this form of gender nonconformity. Instead, they described the lack of general awareness of nonbinary gender, and fear of being unseen as their gender because they did not meet this stereotype. In fact, these nonbinary individuals were

frequently misgendered (i.e., identified as their assigned gender), although some participants were not gender nonconforming in the sense that others assumed they were cis or identified them as their assigned genders. Thus, distress came from others' subsequent assumptions that they were cis. In other words, not being seen as who they are was the basis of enacted stigma for these nonbinary individuals. With that said, some participants did embody gender nonconformity as previous researchers defined and expressed distress surrounding others' reactions to this experience. For example, Makemake described experiences of distress following their discrimination in gendered public restrooms and locker rooms. Social dysphoria, misgendering, and fear of being misgendered were the most common forms of distress described, rather than enacted stigma from gender nonconformity.

The current study's findings regarding shame and impact on the relationship with self may also explain the findings from Tabaac and colleagues' (2018) study of trans women, trans men, and nonbinary individuals. The mediation model indicated that self-esteem and satisfaction with life fully mediated the association between harassment/rejection and body appreciation. In other words, their model showed that harassment/rejection does not directly impact body appreciation; harassment/rejection impacted participants' self-esteem and life satisfaction, which then influenced body appreciation. Data from the current study appear to support the mediated relationship between one's experiences of marginalization and their relationship to their body. Marginalization related to gender identity, size, race, disability and other identity factors created conditions of rejection associated with identity. When shame is tied to the self, it can manifest as body shame, revolving any part of the body that may appear to lead to rejection (Kim, 2020). In *Intersectionality*, identity often influenced the manifestations of body shame, i.e., those associated with areas of marginalization. For example, Mars described shame surrounding body

size as a fat person.

Implications

Previous research on nonbinary individuals illustrated possible elevated rates of disordered eating, but researchers did not provide data that would help professionals understand why this may be the case. Researchers generally implicated minority stress, but they did not necessarily explain how or why minority stress influences disordered eating. From the current conceptualization developed in this study, it would appear that experiences of discrimination led to more frequent distress and shame associated with one's identity. In order to make sense of harm, to have a sense of control, participants located the cause of their distress within their bodies and identities. Further, disordered eating helped these nonbinary individuals cope with this distress and other experiences, such as trauma and other mental health concerns.

Disordered eating for participants also facilitated a sense of control. In the current cultural context, White culture may influence this dynamic of control. Helms (1992) described White culture as action-oriented and focused on efforts to control ourselves and the environment. Controlling environment among my participants appeared as efforts to criticize and shame themselves in order to avoid misgendering, gender noise, and food anxiety to attempt to predict and prevent discrimination, and disordered eating to reduce distressing feelings/shape one's body. In other words, efforts to control were rooted in avoidance of pain. However, as Ceres described, there can be a futility to these efforts to control, that they may be misgendered "for reasons [they] don't completely know of and can only speculate about." Treatment modalities that borrow from non-White cultures, like Acceptance and Commitment Therapy, embody a different dynamic of acceptance—acceptance of emotions like shame, grief, sadness, anger that can stem from experiences of marginalization and trauma. Acceptance, in this case, does not

mean approval or endorsement of harm, but instead placing the cause of harm outside of the self, and working toward combatting what can be changed rather than what cannot.

A study surrounding self-criticism and shame elicits perhaps an important point regarding relationship with shame to disordered eating and control. Porter, Zelkowitz, and Cole (2017) conducted a study of 186 undergraduate students and depression and disordered eating. Shame proneness, or tendency to experience shame, and self-criticism, negative evaluation of self when there is a discrepancy between ideal and real self, were significantly correlated with depression and disordered eating. However, it was self-criticism that accounted for the relationship between depression and disordered eating rather than shame proneness. Therefore, it may not be the emotion of shame itself that leads to mental health concerns, but the coping mechanisms developed over time, like self-criticism. That is to say that while experiences of trauma and marginalization can lead to shame-based relationship with self, the relationship to shame, rather than shame itself, may be more important to address. If one can alter that relationship with the emotion and the self, perhaps then one can facilitate change related to mental health concerns.

Nonbinary Identity Implications for Treatment

This research regarding influences on disordered eating for nonbinary individuals increases inclusivity in future treatment, research, and diagnosis. This conceptualization of disordered eating for nonbinary individuals highlights the importance of understanding the influence of shame in treating disordered eating. Shame serves as an emotion to facilitate connection, through self-regulation of possible social transgressions (Kim, 2020). However, when shame becomes chronic, as it is in cases of marginalization, one's relationship with self reflects the greater social dynamic of marginalization. In other words, the marginalized individual internalizes negative messages of their identity, a proximal stressor of trans minority

stress (Testa et al., 2012). Marginalization, in addition to other experiences of trauma and distress, can be overwhelming. The participants in this study described efforts to cope with stressors through disordered eating, behaviors learned from family and society at large. This shame-based relationship with the self may drive disordered eating as well as anxiety, depression, self-harm, suicidality, and other concerns. Thus, to treat disordered eating and correlated concerns, it may be beneficial to treat the underlying factors of shame tied to identity and self.

To address impact of shame, it may be important to include aspects on identity. In other words, nonbinary identity may be a domain in which a shame-based relationship can occur and be healed. For example, participants described frequent misgendering and not being seen, leading at times to self-criticism and further shame. Nonbinary identity was also a domain where experiences of shame were healed through being seen (e.g., congruent gender expression, support through community). Brown (2006) described this healing process of shame through her Shame Resilience Theory. Brown developed this theory using grounded theory methodology to analyze interviews with 215 women regarding how they: (a) experience and identify shame and (b) develop shame resilience. Brown posited that healing shame requires developing resilience to shame through connection, vulnerability, and empathy—shame cannot be avoided without strengthening it. Shame has to be moved through and spoken about. In support of the Shame Resilience Theory, these participants described their experiences of finding community and encountering emotions. For example, they described the importance of safe spaces, experiencing acceptance and community, acknowledgement of their nonbinary identity, and labeling dysphoria as ways that supported their healing.

I believe developing shame resilience can also be seen in Matsuno and Israel's (2018)

description of their Transgender Resilience Intervention Model (TRIM). Mastuno and Israel divided resilience into group and individual. Group resilience factors can protect individuals from impact of distal and proximal stressors (discrimination, rejection, victimization, nonaffirmation) on mental health outcomes (anxiety, depression, substance use, suicide). Individual resilience factors (hope, self-acceptance and identity pride, self-definition, self-worth, and transition) can protect the individual from impact of proximal stressors (expectation of rejection, internalized transphobia) on mental health. While Mastuno and Israel do not include disordered eating among mental health outcomes within their model, the current research supports its inclusion. They note that concealment may not indicate feelings of shame, which can be a counterpoint to the current study's findings. Concealment may be purposeful and protective; for example, concealment can reduce experiences of harassment. Individuals may also choose to conceal in certain contexts and not others. With that said, I think within oppressive contexts where concealment is needed for safety and one experiences of rejection, an individual may experience shame associated with identity. Thus, to be accepted for that identity, I believe, is a form of resilience that can reduce the impact of stressors on mental health outcomes. By changing the external factors (through reducing marginalization, increasing support, acceptance, community, etc.), one can experience the impact of being seen safely, reducing feelings of shame associated with identity, strengthening resilience.

Nonbinary identity, as a marginalized identity, can also support a level of freedom from expectations and self-determination. Freedom through a marginalized identity can be seen in Halberstam's explanation of the *Queer Art of Failure* (2011). Halberstam describes how society's focus on success, often tied to heteronormativity and capitalism, can be limiting. When one no longer lives constrained to social definitions of success, they may be able to find great joy

and liberation that is inherently queer. For example, in Jupiter's case, the gender binary and associated expectations limited autonomy as to who they felt they and how they were perceived. For Jupiter, binary genders were linked to racist images of Black men and women, and at times, identifying as nonbinary brought reprieve and freedom from racist expectations surrounding gender.

Limitations

In this study, a qualitative approach was used to explore and develop a grounded theory conceptualization of disordered eating among nonbinary individuals. Although these findings provide greater conceptual understanding of disordered eating phenomena, generalizability may be limited due to the qualitative design and small sample size. Further, the majority of participants were assigned female; there may be implications regarding this shared experience that may not be applicable to individuals assigned male, although assessment of impact of gender socialization may be important moving forward. Implementation of this methodology may also be limited, since this was my first qualitative and grounded theory project.

Future Directions

Moving forward, it may be beneficial to research specific intersections of identities such as size, disability, class, and/or race regarding nonbinary experiences and disordered eating. For instance, self-described fat participants reported greater stigmatization from providers and discrimination related to body. These dimensions of identity appeared to be salient to participants in the development of their genders as well as relationships with food. It may also be of interest to research different phenomena of disordered eating, and variation in experience based on clinical severity. A larger scale quantitative study measuring impact of shame among nonbinary participants with disordered eating can support generalizability of this research. It may be

beneficial to have repeated interviews to build rapport and trust. Building trust may be particularly important with participants that experience disordered eating and marginalization, due to the interconnectedness with shame and motivation to avoid disclosing things that may provoke shame

Lastly, further exploration of encounters with the mental health and medical systems may be important areas of study and advocacy. When asked, all participants provided advice for providers, including expanding gender options on paper work, reducing assumptions related to gender and size biases, and providers having a process to learn and support nonbinary people. Participants described emotional labor and stressors associated with situations like having to educate their providers or feeling unseen/unwelcome due to providers lack of inclusion of participant identities. Situations such as these that led to participant distress when seeking help can recreate the dynamic of not being seen by greater society in their everyday lives. Further, transgender individuals tend to have higher utilization of mental health and medical services (St. Amand, 2016). It is thus important as mental health, and medical providers, to prevent further marginalization of the patients they serve.

Contributions

This research project had several contributions. The findings of the study have deepened understandings of the impact of shame on disordered eating for nonbinary individuals. More specifically, I believe the study has illustrated the impact of marginalization on reinforcing a shame-based relationship with the self. The study findings have also shown the importance of connection, being seen, and choice in healing from disordered eating, especially when one has experienced marginalization. I hope this study will support future research and more equitable treatment, advocacy and systemic change given the impact of marginalization on disordered

eating and internalized shame, and facilitate greater awareness of nonbinary individuals with disordered eating.

EXHIBITS

TABLES

Table 1 – Axial-Level and Open-Level Categories

Axial-Level Categories	Open-Level Categories	Descriptions
Food is the Band-Aid: Developmental Contributors of Disordered Eating	Cultural Eating	Influence of one's cultural background(s) regarding eating, food choices, etc. Can be related to race/ethnicity, class, etc.
Food is the Band-Aid: Developmental Contributors of Disordered Eating	Puberty	Salience of puberty as the beginning of distress around body image. Gender-related. possible gender dysphoria.
Food is the Band-Aid: Developmental Contributors of Disordered Eating	Trauma	Experiences of trauma, whether repeated, single instance, etc.
Food is the Band-Aid: Developmental Contributors of Disordered Eating	Family of Origin	Influence of family of origin, trauma in family.

Axial-Level Categories	Open-Level Categories	Descriptions
Food is the Band-Aid: Nonbinary Disordered Eating Connection	Social Dysphoria	Incongruence between how others see one's gender vs. how they see their gender.
Food is the Band-Aid: Nonbinary Disordered Eating Connection	Dysphoria or Dysmorphia?	The overlap, at times, of dysphoria and dysmorphia, and difficulty discerning between the two.
Food is the Band-Aid: Nonbinary Disordered Eating Connection	Food Is the Band-Aid	Participant explanation that their disordered eating did not stem from food and therefore cannot be addressed by solely addressing food. Self-conceptualization around why the participant may have disordered eating symptoms; merged with conceptualization.
Food is the Band-Aid: Nonbinary Disordered Eating Connection	Gender Influence Eating	Distress from gender (oppression, confusion, expectations/messages around assigned gender, gender dysphoria) leading to disordered eating coping (controlling emotions, controlling body).

Axial-Level Categories	Open-Level Categories	Descriptions
Food is the Band-Aid: Nonbinary Disordered Eating Connection	Conceptualization	Participant conceptualizations of nonbinary & disordered eating; same as food is the band-aid.
Food is the Band-Aid: Nonbinary Disordered Eating Connection	Gender Dysphoria	Experience of incongruence between gender, body, how others see themselves, and/or how they see themselves.
Healing: Gender Is a Social Construct	Gender Presentation	How one presents their gender.
Healing: Gender Is a Social Construct	Gender Uncertainty	Process of fluctuating between cis and non-cis identity.
Healing: Gender Is a Social Construct	Gender Importance	Determining importance of gender in one's life.
Healing: Gender Is a Social Construct	Identities That Shape Gender	Other identities that influence gender for participants.
Healing: Gender Is a Social	Language Shapes Reality	Process of learning more about gender, learning more words

Axial-Level Categories	Open-Level Categories	Descriptions
Construct		to describe gender that leads to connection with non-cis identity
Healing: Gender Is a Social Construct	Noncis Awareness	When participant begins to recognize they're not cis.
Healing: Gender Is a Social Construct	Youth Gender Beliefs	One's gender beliefs as a youth.
Healing: Gender Is a Social Construct	Identity Ebb-And-Flow	Fluctuations surrounding gender identity.
Healing: Gender Is a Social Construct	Nonbinary Culture	Experiences surrounding being nonbinary. Includes: expectations for a nonbinary body, presentation, narrative, identification, way of relating; freedoms granted; community; experiences of misgendering; social dysphoria due to lack of institutional recognition/dominant cultural recognition; drag, performance
Healing: Gender Is a Social Construct	Nonbinary Community	Learning about nonbinary, connecting with other nonbinary

Axial-Level Categories	Open-Level Categories	Descriptions
Construct		people.
Healing: Gender Is a Social Construct	Gender Definition	Participants' definitions of gender and their own gender(s).
Healing: Gender Is a Social Construct	Identity Choice	Choosing one's identity.
Healing: Being Seen	Fat Positivity	Discussing positive representation, culture around fatness and fat folks.
Healing: Being Seen	Heat of the Sun	Discomfort, psychological distress in being seen. Experience of being out for the first time, which can be emotionally jarring—old coping skills don't work.
Healing: Being Seen	Community	Importance of finding social support.
Healing: Being Seen	Recovery Precipitant	Whatever triggered choice of starting recovery process (recovery can be in the midst of disordered eating, can be periodic).
Healing: Being Seen	Safe Spaces	Spaces that validate identity, that do not pathologize, that

Axial-Level Categories	Open-Level Categories	Descriptions
		encourage healing.
Healing: Being Seen	Self-Acceptance	Resilience, self-affirmation, self-recognition.
Healing: Being Seen	Being Seen	Everyone wants to be seen, loved. Code encompasses our yearning for that, receiving it, missing it, and the impact.
Healing: Being Seen	Connection Needed	Humans need connection, even if that is found in groups that encourage disordered eating or where one experiences marginalization. May be way to combat shame.
Healing: Being Seen	Shame	Evidenced often by lack of self-compassion for previous self, self-deprecating humor; comparing oneself to others, feeling less than or feeling more than.
Healing: Choice	Choice	Deciding carefully what matters to yourself, who matters. importance of choice in identity, recovery for empowerment.
Healing: Choice	Recovery's Gray	Capture's that recovery is not usually all good or all bad. Often, it happens in steps, and maybe, for example, one can say that moving from eating 800 calories a day to

Axial-Level Categories	Open-Level Categories	Descriptions
		intermittent fasting for 1200 calories is that gray—still restricting, using an app, but part of someone's journey and what progress looks like for them. Maybe even hitting rock bottom is that gray. We can find community within struggle, even disordered eating.
Healing: Gender Is a Social Construct	Nonbinary Freedom	Identifying as nonbinary can give freedom from gender/expression, release from masculine/feminine expectations.
Healing: Gender Is a Social Construct	Femme Expression	Importance of femininity to one's gender; expressing as femme, identifying as femme.
Healing: Gender Is a Social Construct	Gender Identity	Participants' gender identities.
Intersectionality	Intersectionality	Participants talking about their experiences from multiple identities.
Intersectionality	Queer Salience	Interconnectedness of gender and queerness.

Axial-Level Categories	Open-Level Categories	Descriptions
Intersectionality	Disability	Influence of disability on gender identity.
Intersectionality	Spirituality	Influence of spirituality/religion on gender identity.
Intersectionality	Straight size Privilege	Possible role of straight size privilege—less severe disordered eating, less awareness of size, less discrimination from providers, family of origin, and peers around size.
Intersectionality	Race Representation	Impact of racial identity being represented in nonbinary/trans communities.
Intersectionality	Racialized Gender	Gender shaped by race, racism.
Intersectionality	White Reign	Whiteness determining validity of identity as the baseline, gatekeeping culture.
Intersectionality	Mental Health	Overlap of mental health concerns. Support of mental health providers.
Intersectionality	Minority Stress	Negative influences on mental health from marginalization.
Intersectionality	Dating	Impact of dating on identity (as nonbinary).
Intersectionality	Sizeism	Fatphobia, discrimination surrounding body size.

Axial-Level Categories	Open-Level Categories	Descriptions
Intersectionality	Cissexism	Culture of erasure, discrimination, marginalization of trans people. Includes the cumulative effect of nonbinary folks being erased, ignored, not thought of. According to the Trans Minority Stress Model (Testa et al., 2012), this leads to direct impact on mental health, including disordered eating, dysphoria/dysmorphia.
Intersectionality	Racism	Influence of oppression/privilege based on race on experiences.
Intersectionality	Female Disordered Eating Bias	Expectation/assumption disordered eating is very female, rooted in wanting to appear more feminine, thin.
Intersectionality	Assigned Gender Influence	Culture around one's assigned gender affecting relationship with self, others, values, behaviors, thoughts, expectations.
Intersectionality	Small Size	One's body size is considered small. May impact expectations, dress, food intake.
Intersectionality	Body Ideals	Internalized messages of the seemingly ideal body type.

Axial-Level Categories	Open-Level Categories	Descriptions
Intersectionality	POC Body Ideals	Body ideals shaped by culture as a POC, separate from White body ideals that pervades general discussion.
Intersectionality	Colonization/Globalization	Explicit discussion about impact of Western colonization. impact of this.
Intersectionality	Intersectional Rejection	Experiences of discrimination, separation, rejection from one's own group given other salient marginalized identities, particularly gender and sexuality.
Intersectionality	Medical Influence	Impact of medical and mental health providers.
Intersectionality	Intersectional Invalidity	Questioning validity of nonbinary identity because being outside Nonbinary Body (White, masculine, straight size).
Intersectionality	Misgendering	Being called the wrong pronoun or referred to as the incorrect gender.
Intersectionality	Perceived Gender	Gender participants feel others see them as.
Intersectionality	Nonbinary Masculinity	Pressure to adhere to masculinity, particularly for AFAB Nonbinary folks. Can be valid presentation, and recognizing

Axial-Level Categories	Open-Level Categories	Descriptions
		there may be influences of mainstream narratives of trans people, maybe also privileging of masculinity in general makes it more alluring or safer.
Intersectionality	Gatekeeping	Barriers to identifying how one truly wants to identify, or exist in the world.
Intersectionality	10X More	<p>The impact that comes from people they have learned to trust as safe. This can be expectations/trust built within a community, with family, friends, lovers, who surprise them in their ability to hurt, negatively impact, make them question who they are.</p> <p>Can arise with more trust with similarly marginalized people, and due to learned guardedness/protection from privileged spaces.</p>
Intersectionality	Not Trans Man or Trans Woman, So Not Trans	Lack of awareness of non-cisgender identity due to narrow representation of non-cisgender identity as a specific way of

Axial-Level Categories	Open-Level Categories	Descriptions
		being trans.
Intersectionality	Performing Assigned Gender	Participant feeling like gender felt like drag before they identified outside of cis. Feeling like their performed this assigned gender, internalized pressure of assigned gender.
Intersectionality	Emotional Labor	Work done to explain, understand what nonbinary is. Can be done by participants or participants might recognize that work and opt to not do it. Can be done by others to support participants, or a deterrent for others to learn.
Intersectionality	Nonbinary Isn't Valid	Or perhaps it is valid. Code encompasses messages of Nonbinary not being real or valid or known affect participant experiences.
Intersectionality	The Nonbinary Body	External and sometimes internalized projection of the seemingly ideal nonbinary body—often described as White, straight size, androgynous but masculine-leaning, AFAB. People feeling they need to be this way to be valid/seen.

Axial-Level Categories	Open-Level Categories	Descriptions
Intersectionality	Diet Culture	Societal promotion of thinness/muscularity as health, efficiency/productivity, encouragement of disordered eating, fatphobia. Aspect of sizeism.
Make the Feelings Go Away	Disordered Eating Ebb-and-Flow	Disordered eating fluctuating over time.
Make the Feelings Go Away	Disordered Eating	Examples of relationships with food that participants view as distressing. Can include restricting, bingeing, control of food, avoidance of foods. Sometimes tied to control/wanting to change/influence body shape, size, gender. Sometimes about the food itself, fears around certain foods.
Make the Feelings Go Away	Bingeing	Participants self-described bingeing, stress eating, feeling out-of-control when eating.
Make the Feelings Go Away	Disordered Eating Precipitant	A salient event or experience that started the person's disordered eating journey.
Make the Feelings Go Away	Disordered Eating Trigger	Triggers for disordered eating behaviors and thinking, e.g.,

Axial-Level Categories	Open-Level Categories	Descriptions
		stress, events, emotions.
Make the Feelings Go Away	Picky Eater	Being choosy with food.
Make the Feelings Go Away	Moralistic Eating	Attaching value judgments of good and healthy vs. bad and unhealthy.
Make the Feelings Go Away	Disordered Eating Shame	Shame and isolation that can come from stigma and fears of judgment surrounding disordered eating. May explain draw of community regarding disordered eating, restriction, weight loss, etc. to combat this isolation.
Make the Feelings Go Away	Food Anxiety	Experiencing discomfort eating in front of others. Can have various causes.
Make the Feelings Go Away	Body Dysmorphia	Focus and labeling of body as "bad" and needing to change (separate from gender dysphoria), particularly around thinness.
Make the Feelings Go Away	Height	Body concerns revolving around height.
Make the Feelings Go Away	Gender Noise	Olson-Kennedy 2016: Multiple thoughts regarding gender,

Axial-Level Categories	Open-Level Categories	Descriptions
		body, physical safety. Can impact mental space, functioning.

Table 2 – Participant Identities

Pseudonym	Pronouns	Age	Gender	Assigned Sex	Racial Identity/Cultural Identity	Sexual Orientation	Interview Format: Video or Audio
Mar	They/He	28	Nonbinary	Female	Asian	Queer	N/A
Mercury	They	23	Agender	Female	Biracial, Asian and White	Queer/Bisexual	Video
Venus	They	23	Nonbinary	Female	Black	Pansexual	Video
Earth	They	23	Nonbinary (Tied to Neurodivergence)	Female	Chinese	Asexual and Biromantic	Audio
Mars	They	31	Nonbinary/Agender	Female	Black and Native American	Gray Asexual	Video
Jupiter	They	25	Nonbinary/Gender-Free (Out Here)	Female	African Diaspora	Bisexual	Audio
Saturn	They/He	20	Nonbinary	Female	Chinese	Queer	Audio
Uranus	She	30	Nonbinary	Female	White-Passing, White and Latinx	Bisexual	Video
Neptune	They	23	Nonbinary	Female	White	Pansexual	Audio
Pluto	They	21	Agender	Female	White-Passing, Mestizo	Bisexual	Audio
Ceres	They	23	Nonbinary	Female	Chinese American	Asexual, Panromantic	Video
Makemake	They	33	Genderflux/Agender	Female	White	Queer	Audio
Haumea	They	22	Trans-Masculine, Nonbinary	Female	White, French American	Queer	Video
Aidan	None	30	Agender	Female	White	Asexual	Video
IB	They	29	Nonbinary	Male	Asian	Queer	Audio
Bennu	They/He	26	Nonbinary	Female	White	Pansexual/Fluid	Video

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APPENDIX A

DEMOGRAPHICS QUESTIONS

1. What is your age?
2. What are your pronouns?
3. What is your assigned sex?
4. How do you believe others perceive your gender?
 - a. Does this change based on context? I.e., who you're around, where you are, etc.?
5. What is your sexual orientation? i.e. What gender or genders are you attracted to?
6. What is your racial/ethnic identity and/or cultural background?
7. How would you describe your ethnic/cultural identity?
8. How would you describe your financial situation growing up?
9. How would you describe your financial situation now?

APPENDIX B

EATING DISORDER SYMPTOM FREE-RESPONSE

1. Please describe your disordered eating pattern. i.e., how does disordered eating show up in your life?

APPENDIX C

EATING DISORDER SYMPTOMS SCREEN (ADAPTED WATSON ET AL. (2017) & STANFORD-WASHINGTON UNIVERSITY EATING DISORDER SCREEN (SWED))

1. Have you done any of the following to lose weight or control your weight?
 - a. Made yourself throw up
 - b. Used diuretics or laxatives
 - c. Exercised excessively, i.e. pushed yourself very hard; had to stick to a specific exercise schedule no matter what—for example even when you were sick/injured or if it meant missing a class or other important obligation; felt compelled to exercise
 - d. Fasted, i.e. intentionally not eaten anything at all for at least 24 hours in an attempt to prevent weight gain (e.g., that is feared as a result of binge eating) or to lose weight

2. During the past 12 months, have you done any of the following to lose weight or control your weight?
 - a. Made yourself throw up
 - i. [Enter number]
 - b. Used diuretics or laxatives
 - i. [Enter number]
 - c. Exercised excessively, i.e. pushed yourself very hard; had to stick to a specific exercise schedule no matter what—for example even when you were sick/injured or if it meant missing a class or other important obligation; felt compelled to exercise
 - d. Fasted, i.e. intentionally not eaten anything at all for at least 24 hours in an attempt to prevent weight gain (e.g., that is feared as a result of binge eating) or to lose weight

3. Have you had a sense of loss of control AND you also ate what most people would regard as an unusually large amount of food at one time, defined as definitely more than most people would eat under similar circumstances?
 - a. Yes
 - b. No

4. In the past 12 months, how many times have you had a sense of loss of control AND you also ate what most people would regard as an unusually large amount of food at one time, defined as definitely more than most people would eat under similar circumstances?
 - a. [Enter number]

5. Do you consume a small amount of food (i.e., less than 1200 calories/day) on a regular basis to influence your shape or weight?
 - a. Yes
 - b. No

6. Are you currently in treatment for an eating disorder?
 - a. Yes
 - b. No
 - c. Not currently, but I have been in the past

APPENDIX D

INTERVIEW PROTOCOL

1. How do you define gender?
 - a. What does it mean to you?
2. How did you come to know your gender?
3. How does gender shape your body or your relationship with your body?
4. What are struggles you've had with eating?
 - a. Ways you've felt uncomfortable with your eating?
5. How may your gender influence your problems with eating?
6. In what ways do societal pressures influence how you identify yourself?
 - a. Your eating?
 - b. Probe: How may pressures to be feminine/masculine be influences?
7. What other identities do you hold that may shape your gender?
 - a. Relationship to eating?
8. How have you managed problems with eating?
 - a. Probe: Specifically as a nonbinary person?

Post questions

9. What feedback would you like to give to providers that treat disordered eating and nonbinary individuals?
10. What feedback do you have regarding this interview?

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