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Article:
Matthews, K., Thomas, K.S., Fox, J.R.E. et al. (2026) Eating disorders in transgender, non-binary, and gender diverse populations: A meta-synthesis of qualitative findings. International Journal of Eating Disorders. eat.70228. ISSN: 0276-3478

https://doi.org/10.1002/eat.70228

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REVIEW OPEN ACCESS

Eating Disorders in Transgender, Non-Binary, and Gender Diverse Populations: A Meta-Synthesis of Qualitative Findings

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Received: 27 April 2026 | **Revised:** 19 September 2026 | **Accepted:** 22 September 2026

Action Editor: Kelly L. Klump

Keywords: disordered eating | eating disorders | gender diverse populations | non-binary individuals | trans individuals

ABSTRACT

Objective: Some evidence suggests that gender diverse people may be disproportionately affected by eating disorders in comparison to the general population. This review aims to further understanding of the relationship between gender identity and disordered eating/exercise, as understood by gender diverse individuals.

Method: Qualitative papers were identified through systematic searches of key databases, using relevant search terms. Eligible studies were critically appraised using the Critical Appraisal Skills Programme (CASP) checklist and analyzed using Thematic Synthesis.

Results: In total, 18 studies were included in the review. Six superordinate themes were identified, exploring the interconnectedness of gender dysphoria and eating disorders; the use of disordered eating to modify the body to better align with gender identity and socially prescribed expectations of gender; disordered eating as a means of coping emotionally; and the roles of structural, societal, and interpersonal experiences of discrimination and marginalization. The impact of gender-affirming care on disordered eating, eating disorder treatment experiences, as well as recovery and protective factors; including the importance of understanding and connecting with gender identity, connection with others and wider communities, and resistant narratives were also explored.

Discussion: The findings highlight the complex and multifaceted relationships between gender identity, gender dysphoria, and disordered eating. Several important clinical implications were identified, including the need to better address systemic inequalities and improve inclusivity of eating disorder services and clinical awareness of disordered eating presentations in gender diverse populations (within both gender and eating disorder services). Limitations and further research directions are further discussed.

1 | Introduction

Recognition and visibility of gender diversity continue to grow in wider society and health research (Pearce 2018; Gordon et al. 2021). One area of growing focus is eating disorders (EDs), where several studies have identified that gender diverse individuals experience disproportionate body image concerns and disordered eating/exercise compared to cisgender populations (e.g., Ålgars et al. 2010; Diemer et al. 2015; Duffy et al. 2019). Rasmussen et al.'s (2023) meta-analysis found high rates of ED symptomatology among transgender individuals, with an overall ED prevalence estimate of 17.70%;

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significantly higher than estimates typically observed within the general population.

In this paper, "gender diverse" refers to gender identities outside of cisgender (where gender identity matches assigned sex at birth), including transgender, non-binary, and gender-expansive identities (Coleman et al. 2022).

Body dissatisfaction (negative evaluation of one's body) is a known risk factor for EDs (e.g., Phelps et al. 1999) and is a commonly reported (though not universal) difficulty experienced by gender diverse individuals, particularly those who experience gender dysphoria (the distress or discomfort experienced when gender identity and sex assigned at birth differ) (McGuire et al. 2016). Body dissatisfaction may motivate disordered eating and exercise to align the body more closely with gender identity (Jones et al. 2018), often according to societal expectations of gender, reinforced through media, peers, and family, which can become internalized (McCabe and Ricciardelli 2003).

Objectification theory (Fredrickson and Roberts 1997), although originally developed based on assumed cisgender women's experiences, may be relevant in understanding ED inequities among gender diverse populations. The theory proposes that individuals routinely perceived and evaluated based on appearance can internalize an outsider's perspective and evaluate themselves against these expectations. This internalization can heighten body dissatisfaction and increase risk for disordered eating. Gender diverse communities are often subjected to heightened scrutiny regarding whether their bodies are perceived as sufficiently masculine, feminine, or androgynous (Comiskey et al. 2020). In cisnormative social contexts, individuals may therefore engage in monitoring gendered physical characteristics to align their appearance with their gender identity and maximize social recognition, safety, and acceptance. Disordered eating and exercise may emerge as strategies for modifying appearance to reduce gender incongruence and/or seek gender affirmation. This is supported by research linking body surveillance, body shame, and internalization of cultural attractiveness standards with disordered eating among transgender women (Comiskey et al. 2020), and internalization of sociocultural appearance standards with compulsive exercise among transgender men (Velez et al. 2016). Jones et al.'s (2018) review suggests that pressures to conform to culturally prescribed ideals of gender may contribute to body dissatisfaction and disordered eating among gender diverse individuals.

Another important consideration is the role of marginalization and stigma. Minority Stress Theory (MST; Meyer 1995, 2003) proposes that minority groups experience unique stressors beyond general life stress. Applied to gender diverse individuals, MST highlights discrimination, marginalization, violence, anticipated stigma, and internalized transphobia as sources of chronic psychological distress (Hendricks and Testa 2012). Some individuals may adopt maladaptive coping strategies, including disordered eating, to manage this distress or facilitate successful "passing" by conforming to societal gender expectations (Aversa et al. 2022). Disparities in EDs among gender diverse people are also shaped by broader social and structural determinants of health. Structural stigma, cisnormative institutions, barriers to gender-affirming care, and exposure to discrimination influence the conditions under which body dissatisfaction and disordered eating emerge (Brewster et al. 2019; Heiden-Rootes et al. 2023; United Nations Human Rights Council 2022). From this perspective, elevated ED symptoms among gender diverse populations can be understood as consequences of broader social inequities that regulate and devalue gender diversity.

Despite evidence suggesting that experiences of disordered eating in gender diverse individuals may differ from cisgender populations (e.g., Gordon et al. 2021), ED treatment remains largely aligned with the experiences of cisgender women (e.g., Ferrucci et al. 2023). Duffy et al. (2016) explored ED treatment experiences within US transgender populations; participants reported practitioner ignorance and discrimination, invalidating approaches, and that links between gender dysphoria and EDs were often ignored. Some participants felt treatment focused excessively on the body without considering other relevant factors. Many also described having to educate and challenge practitioners themselves (Duffy et al. 2016; Ferrucci et al. 2023). These findings suggest ED services should better address the needs of gender-diverse people, requiring greater understanding of the etiology and presentation of disordered eating in this population.

1.1 | Research Gaps

As research examining disordered eating among gender diverse populations has grown substantially, there is a need for a comprehensive synthesis bringing together existing findings to inform research, clinical practice, and service development.

Scoping reviews exploring disordered eating among gender diverse adults (Heiden-Rootes et al. 2023), and youth (Coelho et al. 2019), and the broader LGBTQ+ community (Parker and Harriger 2020) have provided valuable overviews. However, scoping reviews prioritize breadth and do not typically involve the same level of methodological appraisal and synthesis as systematic reviews. Jones et al.'s (2018) systematic review advanced understanding of body dissatisfaction and eating pathology within trans populations, but broader factors contributing to disordered eating among gender diverse individuals remain underexplored.

To the authors' knowledge, no comprehensive, up-to-date systematic review of qualitative research exists. For a population underserved by psychological and healthcare research and facing significant barriers to care, synthesis of qualitative evidence can center lived experiences and provide a nuanced understanding of factors shaping disordered eating. These findings may inform clinical support and efforts to reduce health inequalities through prevention and improved access to evidence-based care.

This review therefore aims to advance understanding of the relationship between gender identity and eating disorder/disordered eating symptoms as experienced by gender diverse individuals through a systematic review and thematic synthesis of qualitative research.

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2 | Method

This review was developed using the Preferred Reporting for Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al. 2021) and was pre-registered on PROSPERO (CRD42023427773).

An inductive, critical realist approach was adopted to understand and describe participants' experiences. Critical realism recognizes that understandings of reality are shaped by individual worldviews (Bhaskar 2010), allowing interpretation of participants' accounts alongside the broader mechanisms and contextual factors influencing them. It also encourages reflexivity by acknowledging the researchers' own positions throughout the process. The authors therefore often discussed codes and themes and considered whether themes adequately reflected participants' accounts. Personal biases, lived experience, and research knowledge relating to LGBTQ+ identities and EDs were considered to avoid settling prematurely on themes, which were developed iteratively with continual reference to the codes. The authors also recognize that study context, including the predominantly Western cultures represented, shaped participants' views and responses and consider this when discussing the findings and limitations.

2.1 | Search Strategy

A systematic search of the literature was conducted in July–August 2023 by the first and second author (independently, with selections discussed once completed). No date restriction was included. OVID interface, Scopus, PubMed, CINAHL, Web of Science, and ProQuest databases were reviewed. Databases were screened again in January 2026.

Studies were identified using two blocks of terms: the phenomenon of interest (EDs and disordered eating) and population (trans individuals). Table 1 comprises the search terms and Boolean operators utilized. Several websites (e.g., GIRES, Stonewall) were consulted to identify gender identity terms; the authors recognize this is not a comprehensive list, but felt it adequately encompassed terms most likely to be used in research. Several terms no longer commonly utilized were included, given older papers may have used this terminology. Table 2 describes the population and phenomenon of interest which guided the screening process.

2.2 | Eligibility Criteria

Eligible studies included qualitative research exploring gender diverse individuals' perceptions of the relationship between gender identity and disordered eating/exercise. Case studies were excluded due to their distinct methodology. An ED diagnosis was not required to capture a broader range of experiences; however, studies that did not specifically examine disordered eating/exercise were excluded. No country restrictions were applied, but only English-language papers were included to minimize potential loss of meaning through translation (Van Nes et al. 2010). The authors did not identify any non-English language papers of relevance to the current review in a later screening in August 2026. See Table 3 for full outline of inclusion/exclusion criteria.

TABLE 1 | Search terms.

Block one—eating disorder terms	Block two—gender terms
"eating disorder*" OR anorexi* OR bulimi* OR purging OR fasting OR "binge eat*" OR "disordered eating" OR EDNOS OR "Eating Disorder Not Otherwise Specified" OR OSFED OR "Otherwise Specified Feeding and Eating Disorder" OR ARFID OR "avoidant and restrictive food intake disorder" OR "restrict* eat*" OR "selective eating disorder" AND	transgender* OR "trans individual*" OR "trans person" OR "trans people" OR "non binary" OR "gender divers*" OR "gender dysphori*" OR nonbinary OR "gender minorit*" OR "non-binary" OR "gender fluid" OR "gender queer" OR "Genderqueer" OR "gender varian*" OR "gender non-conform*" OR "Gender nonconform*" OR transsexual* OR agender OR "gender expansiv*" OR "gender identit*" OR "gender express*" OR "Gender incongruen*" OR "Gender Identity Disorder*"

TABLE 2 | Key elements of the research question as identified with the PICo tool.

Population	Individuals who identify as a gender other than cisgender. This is inclusive of any minority gender identity such as transgender, non-binary, gender fluid and agender.
Phenomenon of interest	Opinions of individuals with experience of an eating disorder who identify as gender diverse, on the relationships between their gender identity, gender expression and eating disorder/disordered eating, and risk/protective factors perceived as unique to this population/specific gender identity.
Context	Any context.

2.3 | Screening Process

Figure 1 depicts the screening process utilizing PRISMA 2020 guidelines (Page et al. 2021). All papers were screened by the first and second authors, who met on multiple occasions to

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TABLE 3 | Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
(1) Qualitative studies which include individuals with experience of an eating disorder/disordered eating symptoms AND who identify as a gender other than cisgender.	(1) Solely quantitative studies
(2) Mixed or "hybrid" studies that include qualitative information on eating disorders within this population.	(2) Studies solely focused on experiences of eating disorder screening/assessment/treatment in gender minority populations (whether qualitative or quantitative)
(3) Scientific articles, dissertations.	(3) Studies about other mental health problems (not inclusive of eating disorders) within this population
(4) English language only.	(4) Case studies/series
	(5) Book chapters
	(6) Studies solely exploring cisgender individuals
	(7) Studies solely exploring intersex individuals
	(8) Studies solely exploring views of professionals/family members/carers/partners

discuss selection. Fourteen final references were shortlisted following screening of title and abstract, using EndNote. Papers which did not make some reference to eating/exercise behaviors and gender identity, or were solely quantitative were excluded at this stage. The first author then screened reference lists of the shortlisted papers, as well as the citations using Google Scholar. An additional 8 papers were identified and, following discussion with the second author, added to the shortlist for full-text read-through. Databases were screened again in 2026, and 4 additional papers were added. Full-text read through was completed by the first and second author separately and discussed, with both agreeing final selection of 18 studies.

2.4 | Quality Appraisal

Quality appraisal was conducted independently by the first and second authors using the Critical Appraisal Skills Programme (CASP 2018) qualitative checklist. The CASP comprises 10 questions assessing study quality and risk of bias (Table 4) and is the most widely used appraisal tool in qualitative systematic reviews (Long et al. 2020). Two modifications were made: first, the response option *partially* was added alongside *yes*, *no*, and *can't tell*, to better capture variation in study quality; and second, an additional question recommended by Long et al. (2020) was included: *Are the study's theoretical underpinnings clear, consistent, and conceptually coherent?* The theoretical and philosophical underpinnings of data collection and analysis can have implications on findings (Long et al. 2020); researchers' basic assumptions of how reality is constructed and knowledge gained will inform how data is collected and analyzed (Chamberlain 2015). To fully appraise the research, therefore, it was important to know the lens through which the data had been collected and analyzed.

The first and second authors independently appraised all included studies before meeting to resolve discrepancies. Where consensus was not reached, the final author was consulted. Formal inter-rater agreement was not calculated, as consensus discussion was considered more appropriate for qualitative appraisal.

2.5 | Data Extraction

Data were extracted by the first author, using a bespoke data extraction form which included aims, setting, theoretical background, sample size, demographics, data collection and analysis methods, and a summary of key themes. Data extraction tables were reviewed by the second author, and interpretations were discussed with the wider team.

2.6 | Data Synthesis

Thematic Synthesis (Thomas and Harden 2008) was utilized; an inductive approach frequently employed in healthcare research. The three stages of Thomas and Harden's (2008) thematic synthesis were followed. The results sections of each paper were entered as-presented into an Excel spreadsheet. The first author coded each line-by-line, with codes inductively created to identify context and meaning. A "bank" of codes was developed. New codes were created to capture the meanings of groups of codes, with similar concepts translated into common themes. The first author then identified several superordinate themes to summarize key groups, similar themes were combined and themes only supported by one paper were removed or weaved into other larger themes. The second author reviewed the coding for a selection of papers, and interpretations, codes, and themes were discussed on multiple occasions with the research team.

2.7 | Positionality

Consideration of the position of the researchers is of significance within qualitative research (e.g., Lencucha 2025). Interpretations of meaning can differ depending on the "lens" with which one reviews the information. As a team, we discussed and reflected upon our individual interpretations and assumptions throughout, including differences in interpretations. The authors all have clinical, research, and/or lived experience expertise within the field of eating disorders, allowing for multiple ways of understanding participant accounts and enriching our interpretations. One of the authors is a member of the trans community and has experience of an eating disorder and accessing eating disorder and gender services, which allowed more sensitivity to

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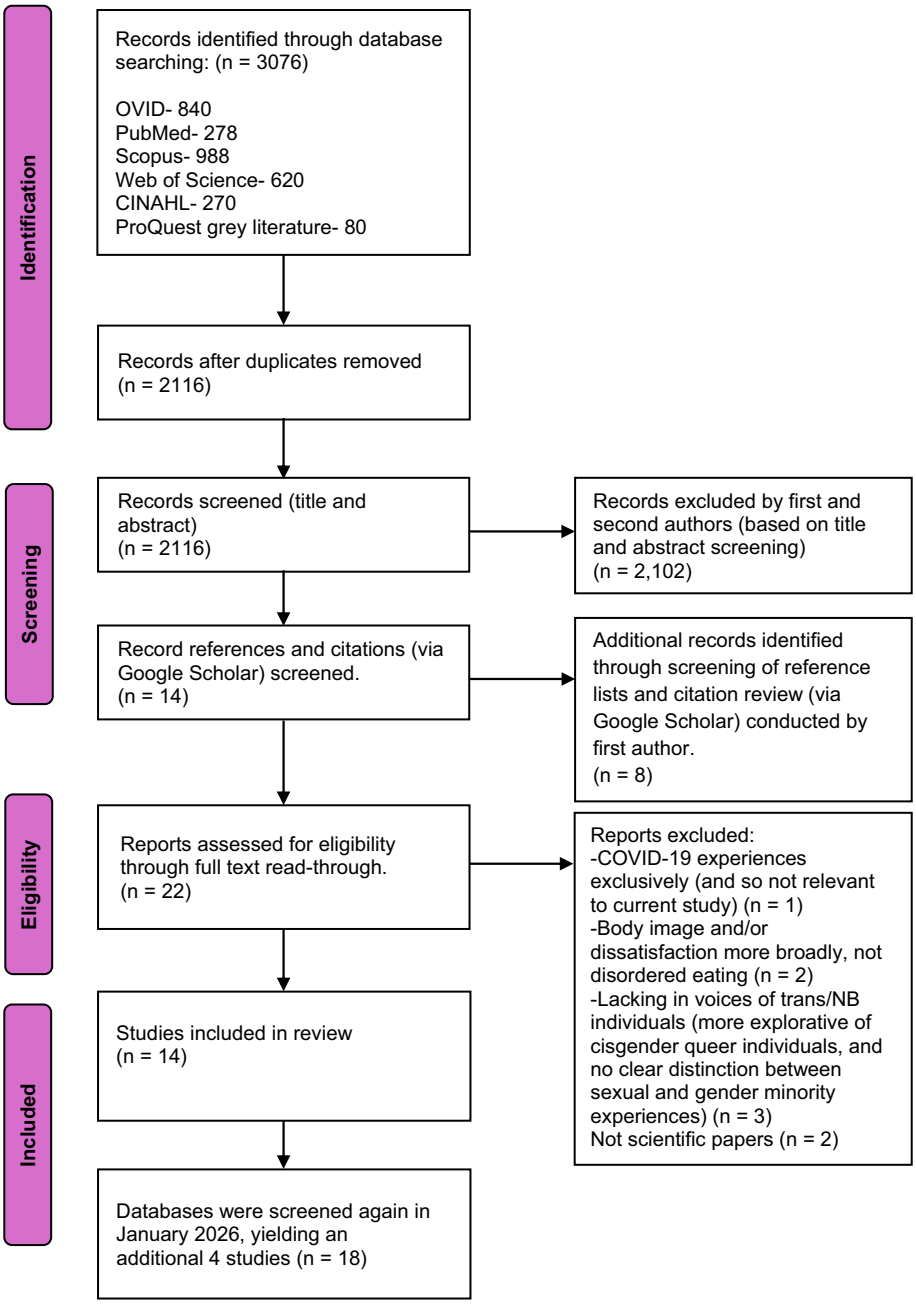


FIGURE 1 | PRISMA flow diagram of screening process.

nuances which otherwise may have been overlooked. We also represent other LGBTQ+ identities, backgrounds, ethnicities and genders as a research team.

3 | Results

3.1 | Study Characteristics

Twelve of the 18 papers were published; 6 were unpublished theses/dissertations (disseminated/published between 2012 and 2026). Most used semi-structured interviews for data collection ($n = 14$). The review included 235 interview participants, 66 focus group attendees, 82 survey respondents, 13 bloggers, 4 vloggers, 13 YouTube videos, and 19 Reddit posts. Participants ranged from 14 to 71 years, with diverse gender identities, ethnicities, sexualities, classes, and socioeconomic status. Most ($n = 16$) were conducted in predominantly English-speaking countries, with two from predominantly non-English-speaking countries (Finland and Italy). Twelve studies were conducted in the USA (see Table 7 for summary of study characteristics and participant demographics).

3.2 | Quality Assessment

As the CASP does not provide a scoring system, studies were rated according to the proportion of criteria met and whether limitations were likely to influence conclusions, following NICE (2012) guidance (see Table 5). Papers meeting most criteria

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TABLE 4 | CASP questions.

Question number	CASP question
1	Was there a clear statement of the aims of the research?
2	Is qualitative methodology appropriate?
3	Was the research design appropriate to address the aims of the research?
4	Are the study's theoretical underpinnings clear, consistent and conceptually coherent?
5	Was the recruitment strategy appropriate to the aims of the research?
6	Was the data collected in a way that addressed the research issue?
7	Has the relationship between researcher and participant been adequately considered?
8	Have ethical issues been taken into consideration?
9	Was the data analysis sufficiently rigorous?
10	Is there a clear statement of findings?
11	How valuable is the research? – Is there discussion of the contribution the study makes to existing knowledge or understanding – Are new areas where research is necessary identified? – Is there discussion of whether findings can be transferred to other populations?

TABLE 5 | NICE (2012) scoring system guidelines.

Quality score	Criteria
++	All or most of the checklist criteria have been fulfilled, where they have not been fulfilled conclusions are very unlikely to alter.
+	Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.
–	Few or no checklist criteria have been fulfilled, and the conclusions are likely or very likely to alter.

were rated as high quality, and those meeting fewer criteria were rated as moderate. No low-quality studies were identified in this review. Unpublished theses ($n = 6$) were rated moderate quality at most due to the absence of peer review. Overall quality ratings were agreed by the first and second authors. Table 6 presents CASP scores for each included paper (Table 7).

3.3 | Thematic Synthesis

Themes do not represent all participants, gender identities, disordered eating experiences, or backgrounds. Experiences also varied across stages of transition, ED recovery, and life. Although most participants described a connection between gender identity and disordered eating, this was not universal. Where available, participant ethnicity and gender identity are reported alongside quotations. Table 8 summarizes superordinate and subthemes identified.

3.3.1 | Theme 1: Interconnectedness of Gender Dysphoria and EDs

This theme was represented by all included papers, across gender identities. As one participant explained, "...being trans doesn't necessarily cause an eating disorder but does inform how that eating disorder is experienced..." (White trans man; Zamantakis and Lackey 2022).

Some participants reported that gender dysphoria and ED are difficult to separate: "...I recognise just how interlinked the two are, that whenever I talk about my eating disorder issues, basically gender has to come up..." (Acadian trans woman; Joy et al. 2022). A generalized sense of body dissatisfaction was described: "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" (White/Latinx non-binary person; Chung 2020). This interconnectedness was cause for concern for some: "I don't know how much is eating disorder and how much is dysphoria and that's really challenging, cause I don't want to just like feed into it and change a bunch of things and have it not be enough. But I also don't want to just continue living in being upset about it constantly" (Bowman 2018).

Limited understanding of gender identity was reported by some to be of relevance to EDs, where complex feelings of gender dysphoria become confused: "...without having an idea of gender dysphoria or trans identity, you have to find other things that describe how you feel...that can often be confused for as eating disorders and hating your weight and body image" (Schweizer et al. 2026).

3.3.2 | Theme 2: Disordered Eating as a Strategy for Achieving Gender Affirmation

One key facet of this interconnection was the use of disordered eating/exercise to manage gender expression, reported across all papers. Participants described engaging in disordered behaviors, both consciously and unconsciously, as a means of influencing their gender expression. Such motivation is deeply influenced by structural and interpersonal factors, which are discussed further in theme 4.

Participants discussed engaging in disordered eating/exercise to suppress characteristics of their sex assigned at birth and adapt their body to better align with their gender identity. One participant described how "...[an eating disorder] seems like the easiest way to like not look like a girl..." (Bowman 2018).

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TABLE 6 | Quality appraisal.

	1	2	3	4	5	6	7	8	9	10	11	Overall score
Ålgars et al. (2012)	Yes	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes	+
Bowman (2018)	Yes	Yes	Yes	Partially	Yes	Yes	Partially	Yes	Yes	Yes	Yes	+
Brewer et al. (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	Yes	++
Calzo et al. (2025)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	++
Chung (2020)	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Yes	+
Cusack et al. (2022)	Yes	Yes	Yes	Yes	Partially	Yes	Partially	Yes	Yes	Yes	Yes	++
Garvis (2021)	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Can't tell	Yes	Yes	Yes	+
Gavnik (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	+
Gordon et al. (2016)	Yes	Yes	Yes	Yes	Partially	Yes	Partially	Yes	Yes	Yes	Yes	++
Harrop et al. (2023)	Yes	Yes	Yes	Partially	Yes	Partially	Partially	Yes	Yes	Yes	Yes	++
Joy et al. (2022)	Yes	Yes	Yes	Yes	Partially	Yes	Partially	Yes	Yes	Yes	Yes	++
Kester (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Partially	Yes	Yes	+
Mirabella et al. (2020)	Yes	Yes	Partially	Can't tell	Partially	Partially	No	Yes	Yes	Yes	Yes	+
Pham et al. (2023)	Yes	Yes	Yes	Can't tell	Yes	Yes	Partially	Yes	Yes	Yes	Yes	++
Pinelli (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	+
Romito et al. (2021)	Yes	Yes	Yes	Can't tell	Yes	Yes	Partially	Yes	Yes	Partially	Yes	+
Schweizer et al. (2026)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	++
Zamantakis and Lackey (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	++

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TABLE 7 | Study characteristics.

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Ålgars et al. (2012)	Finland	20	21–62 years MtF mean age = 42.22, SD = 13.82, FtM mean age = 29.45, SD = 6.7.	Gender identities: 11 FtM, 9 MtF. 16 diagnosed with "Gender Identity Disorder," and had undergone/were undergoing gender reassignment.	Not Reported (NR): race, ethnicity, SES, sexuality, disability or neurodivergence. Participants were all recruited in Finland. Eating disorder characteristics: No formal diagnoses. 14 participants self-reported disordered eating difficulties.	Semi-structured interviews, EDI-3 subscales drive for thinness, bulimia and body dissatisfaction. BMI. Grounded Theory coding (Auerbach and Silverstein 2003)
Bowman (2018)	USA	14	19–65 years Median age 24 years	8 non-binary, 3 Agender. Other identities: "trans dude," "two-spirited transfeminine," "nonbinary/agender/genderqueer," and one individual declined to specifically identify, saying, "I'm not super tied down on that." 11 AFAB, 3 AMAB.	Self-reported race: 10 white participants; 2 Asian participants; 1 Native American and Black participant; 1 mixed-Arab participant. NR: ethnicity, SES, sexuality, disability or neurodivergence. A self-reported history of eating disorder(s) was included in eligibility criteria.	Semi-structured interviews. Reviewed by expert members of the trans community. Inductive thematic analysis (Braun and Clark)
Brewer et al. (2022)	UK	22	Ages 19–71 years.	17 identified as female, 5 were not living "full-time" as women. Four were transgender men (all living as males "full-time").	Self-reported race: all identified as white. NR: ethnicity, SES, sexuality, disability or neurodivergence. ED diagnosis not requirement for study, none had formal diagnoses.	Semi-structured interviews developed in collaboration with a member of the transgender community. Inductive thematic analysis (Braun and Clark)

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TABLE 7 | (Continued)

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Calzo et al. (2025)	USA	66	18–30 years	NR	Self-reported race and ethnicity recorded together: 56% White; 18% Multiracial; 12% Latina/o/x; 8% Asian or Asian American; 3% Black or African American; and 3% another racial/ethnic group. Education backgrounds: 38% had at least a college degree; 49.3% reported having attended some college, but not graduated; and 12.7% reported not graduating high school. SES information: 12.7% of participants reported experiencing unstable housing in the past 6 months. NR: ethnicity, sexuality, disability or neurodivergence. ED diagnosis not a requirement, no information on diagnoses reported.	Asynchronous online focus groups- researchers posted prompts that participants could respond to at their convenience. Data analyzed using "rapid and rigorous qualitative data analysis" (RADaR) technique (Watkins 2017).
Chung (2020)	USA	15	20–33 years	Non-binary, agender, genderflux/ agender, non-binary/ Gender-free	Self-reported race, ethnicity and cultural identities: Biracial (Asian and White, born in East Asian, occupied land); Black; Chinese (culturally, part of Chinese ethnic diaspora, from a South Asian country); Black and Native American Wiccan (culturally connecting with African American culture); Black (identifying with African diaspora, family are connected to culture from an African country); Ethnically Chinese, from a South Asian country (recent immigrant to the US); White-passing Pagain multiracial (White and Latinx); White; White-passing South American Mestizo/Spanish; Chinese American; White (French American); White; Asian (recent immigrant to the US from an Asian country); White (spiritual). Sexualities: Pansexual/fluid; asexual; queer; demi panromantic asexual; queer/bisexual; bisexual; pansexual; biromantic asexual; gray asexual panromantic. SES: All mostly financially secure, with 6 experiencing periods of financial insecurity/reliant financially on parents or partner. Majority middle or upper middle class. Majority attended college. Disability and neurodivergence: 1 identified as neurodivergent; one person identified as neurodivergent and disabled; 1 person identified as disabled. Participants needed to report any history of restricting, binging, or other disordered eating behaviors to be included.	Semi-structured interviews. Interview piloted on a non-binary peer with history of disordered eating and adapted following feedback. Grounded theory Glaser and Strauss (1967), Corbin and Strauss (2015)

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TABLE 7 | (Continued)

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Cusack et al. (2022)	USA	82	Mean age: 24.65 years (SD = 5.32)	Transgender woman: 24 (29.3%) Nonbinary: 22 (26.8%) Transgender man: 16 (19.5%) Gender queer/ fluid: 7 (8.5%) Woman with a transgender history: 4 (4.9%) Man with a transgender history: 3 (3.7%) Agender: 3 (3.7%) Bigender: 1 (1.2%) Other: 2 (2.4%) 50 AFAB, 30 AMAB, 1 intersex, 1 prefer not to say.	Race/ethnicity reported together: Asian/Asian American 1 (1.2%), Biracial/Multiracial 3 (3.7%), Hispanic/Latinx 4 (4.9%), White 72 (87.8%), Prefer not to disclose 2 (2.4%) Self-reported SES: Working class 64 (32.99%), Lower-middle class 37 (19.07%), Middle class 38 (19.59%), Upper-middle class 18 (9.28%), Upper class 2 (1.03%), Don't know/no answer 15 (7.73%) Education level: High School degree/GED 38 (46.3%); Associate degree 7 (8.5%); Bachelor's degree 21 (25.6%); Master's degree 8 (9.8%); Doctorate 1 (1.2%); other (trade school) 5 (6.1%). NR: sexuality, disability, neurodivergence. Eating disorder diagnoses: Community sample recruited via social media. Participants who self-reported experience of disordered eating.	Online survey. Data collected as part of a larger parent study. Participants who reported experience of disordered eating completed the EDE-Q and responded to a qualitative prompt: "How does your eating disorder, disordered eating, or eating and/or body image concerns relate to your gender identity and expression?" Inductive thematic analysis (Braun and Clark)
Garvis (2021)	USA	13 YouTube videos (one video per YouTuber), 19 Reddit posts and comments	Unknown-social media posts analyzed.	Transfeminine, transmasculine individuals, non-binary, genderfluid individuals. Limited transfeminine content-just 1 video by a transwoman on YouTube.	The majority of posters self-reported diagnosis of an eating disorder. NR: race, ethnicity, SES, sexuality, disability or neurodivergence.	Content analysis of YouTube and Reddit posts Content analysis axial coding

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TABLE 7 | (Continued)

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Gavnik (2023)	USA	20	20–33, average age was 25.6 years	7 transmasculine participants, 6 transfeminine, and 7 identified their gender identity without static specifications of femininity or masculinity.	18 participants in the US, 1 in Canada, and 1 in Australia. 15 participants identified as White, 2 participants identified as Latino, 1 participant identified as Latino and White, 1 participant identified as Indigenous, Latino, and White, and 1 participant identified as White and Middle Eastern. Educational background: 1 participant had a GED, 2 participants had high school diplomas, 7 had completed some college, 8 had bachelor's degrees, and 3 had graduate degrees. 11 participants were middle class and 9 were working class. Sexuality: 0 participants identified as heterosexual. 11 identified as bisexual, 7 identified as queer, 1 identified as pansexual, and 1 identified as asexual. NR: disability or neurodivergence.	Semi-structured interviews (4 in person, 16 video). Grounded Theory approach was used for analysis.
Gordon et al. (2016)	USA	21	18–32 years	Transgender woman, MTF, transsexual, genderqueer, demi-girl.	Race and ethnicity reported together: Black/African American ($n = 4$), Latina ($n = 4$), White ($n = 4$), Asian/Asian American ($n = 1$), Multiracial ($n = 8$) Sexual orientation: Straight ($n = 11$), homosexual ($n = 2$), bisexual ($n = 2$), queer ($n = 2$), pansexual ($n = 1$), transgender woman ($n = 1$), don't know ($n = 1$). Participants were all low-income, ethnically diverse transfeminine individuals. All were living with or at risk of HIV (pts recruited from an HIV behavioral intervention trial) Education level: middle school (1); some high school (3); HS grad or GED (9); some college (5); college degree (3). NR: disability and neurodivergence. Participants self-reported engagement in disordered eating behavior, no formal diagnoses.	Semi-structured interviews, post-interview questionnaire capturing demographics and weight and shape control behaviors. Data analyzed in iterative phases using the Template Organizing Style

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TABLE 7 | (Continued)

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Harrop et al. (2023)	USA	9	18–38 years	7 non-binary/ genderqueer, 1 FTM, 1 MTF	Race: 7 white, participants, 1 white and Hispanic participant, 1 African-American and white participant. 6 participants on public assistance as a child, 3 not. All had completed high school, 3 had a Bachelor's, 2 had a master's and 2 had doctorates. Sexualities: queer, queer/lesbian, homoflexible, bi queer, pansexual, bisexual/queer. NR: ethnicity, current SES, disability or neurodivergence. Eating disorder diagnoses: Atypical Anorexia Nervosa, confirmed with DSM-5 criteria.	Semi-structured interviews at baseline, 6 and 12 months. Thematic analysis (Braun and Clarke 2006)
Joy et al. (2022)	Canada	7	20–40 years	3 non-binary individuals, 1 genderqueer person, 1 non-binary trans woman, 1 trans woman, 1 genderfluid non-binary person.	Race: 6 white participants, 1 Acadian Eating disorder diagnoses: All were accessing treatment for ED or disordered eating. NR: ethnicity, current SES, disability or neurodivergence.	Semi-structured interviews. Thematic Analysis (Braun and Clarke 2006)
Kester (2023)	USA	7	23–60 (average = 34.1 years)	3 transgender, 2 participants identified within the nonbinary umbrella. 2 participants self-identified outside of transgender and nonbinary- 1 "non-binary trans woman" and 1 "gender queer" person.	Race: All 7 participants were white and based in the US. NR: ethnicity, current SES, disability or neurodivergence reported. All participants exhibited disordered eating behaviors.	Measures: demographics questionnaire, "The Transgender Identity Survey" (Bockting et al. 2020), and semi-structured interview. Data analyzed using Interpretive Phenomenological Analysis (IPA).

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TABLE 7 | (Continued)

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Mirabella et al. (2020)	Italy	36	16–30 years (mean = 21.11 years)	All participants were waiting to begin hormone therapy at the Unit of Endocrinology of the Policlinico Umberto I Hospital of Rome. 15 AMAB and 21 AFAB-all identified as transgender.	Information regarding race, ethnicity, SES, sexuality, disability and neurodivergence were not reported. All participants were recruited in Rome, Italy. Eating Disorder diagnoses: No formal diagnoses, this was not a requirement for the study. Participants all described difficulty with disordered eating.	Clinical Diagnostic Interview (CDI) Data analyzed using Consensual Qualitative Research (CQR) methodology
Pham et al. (2023)	USA	23	13–19 years (average = 16.9 years)	44% of participants identified as having a transfeminine gender identity, 39% as transmasculine, and 17% as nonbinary or gender fluid.	Race: 2 Asian participants (8.7%); 2 Native American participants (8.7%); 19 White/Caucasian participants (82.6%). 82.6% of participants were enrolled in school. Type of school: Public 10 (43.5%); Online 2 (8.7%); Charter 1 (4.3%); Private 1 (4.3%); College or University 5 (21.7%) NR: ethnicity, SES, sexuality, disability and neurodivergence. Eating disorder diagnoses: No formal diagnoses, paper focused on themes from the wider study exploring eating and exercise behaviors.	Semi-structured interviews Thematic analysis (Braun and Clarke 2006)
Pinelli (2019)	Canada	7	3 participants age 21–30, 3 age 31–45, 1 over 50	2 participants identified as transgender males, 1 identified as non-binary trans masculine, 1 identified as a trans female, 2 identified as non-binary and 1 identified as genderqueer.	Race and ethnicity reported together: 57% identified as white or Caucasian. Of the remaining 43% the races were evenly spread between Chinese, White and Indigenous and Mixed Race. NR: SES, sexuality, disability and neurodivergence. Eating disorder diagnoses: All had ED diagnosis (past or present) specific diagnosis not collected.	Semi-structured interviews Thematic analysis (Braun and Clarke 2006)

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TABLE 7 | (Continued)

Authors	Country	Sample size	Age range	Gender identities	Sample demographics	Data collection and methodology
Romito et al. (2021)	USA	9	14–20 years	Identities: transfemale, transmale, agender, non-binary, genderqueer.	Ethnicity and race reported together: the majority of participants identified as White ($n = 7$); 2 were identified as "ethnic minorities." All participants under the age 18 were attending high school ($n = 8$). 1 participant was age 20. NR: ethnicity, SES, sexuality, disability and neurodivergence. Eating disorder diagnoses: No formal or self-reported diagnoses.	Semi-structured interviews A holistic multiple-case study design, cross-case analysis (Creswell 2013)
Schweizer et al. (2026)	Australia	25 total-13 healthcare workers and 12 with lived experience. 6 were both.	HC: 25–54 years (mean = 33 years) LE: 19–54 years (mean = 28 years)	He/him = 5, she/her = 1, he/they = 2, she/they = 5, they/them = 5 Trans man = 5, trans femme = 3, non-binary = 7	Of the LE participants, 86% were neurodivergent. No specific information on race and ethnicity reported, however all participants were Australian and the study was conducted in a "Western, Anglo-Christian, colonized context, with all participants reporting their gender within a Western framework." NR: SES and sexuality.	Individual semi-structured interviews for LE participants and group ($n = 7$) interviews for HC. Data analyzed using a reflexive thematic analysis (Braun and Clarke 2022).
Zamantakis and Lackey (2022)	USA	13 bloggers and 4 vloggers	Information on age not available due to nature of data	7 content creators were nonbinary individuals assigned female at birth (AFAB), 1 nonbinary individual assigned male at birth, 5 trans men, and 2 trans women.	Race: 1 Southeast Asian American creator, and 1 Mixed Race, Asian- American creator. The remaining 13 were assumed White as they made no mention of race. Two identified as disabled. Five identified as queer. NR: ethnicity or SES. All content creators self-reported experiencing eating disorders.	Content analysis of blogs and vlogs Grounded theory methodology (Charmaz 2006)

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TABLE 8 | Summary of themes.

Superordinate theme	Subtheme
Theme 1: Interconnectedness of Gender Dysphoria and EDs	
Theme 2: Disordered eating as a strategy for achieving gender affirmation	
Theme 3: Disordered eating as a means of coping	*Subtheme 1*: Coping with gender dysphoria
	Subtheme 2: Sense of control
Theme 4: Negotiating safety within a cisnormative society	*Subtheme 1*: conforming to survive in a cisnormative society
	Subtheme 2: Negative psychological impacts of marginalization and discrimination
Theme 5: Links between gender-affirming care and ED services	*Subtheme 1*: The impact of gender-affirming care on ED recovery
	Subtheme 2: The cis-centric nature of ED treatments is a barrier for gender diverse people
Theme 6: Recovery through gender affirmation, connection and resistance	*Subtheme 1*: Exploration and connection with gender identity
	Subtheme 2: Positive connections with family, peers and the LGBTQ+ community
	Subtheme 3: Active resistance of sociocultural appearance norms and expectations

Disordered eating was driven partially by a need to suppress or compensate for sex characteristics (such as height, curves, and menstruation): "...the goal is to be so underweight that you don't have a period anymore, that you don't have breasts, and that you don't have hips..." (Schweizer et al. 2026); "Because of my [male] height it is easier for me if I am thinner" (Trans woman; Ålgars et al. 2012).

For some who identified outside the gender binary, disordered eating meant removing gendered aspects of their body. "I didn't really come out as trans. Instead, I came in–into an adolescent health clinic with my blood pressure at 89/58 and a heart rate of 44 beats per minute...I finally voiced what I had known all along: controlling my eating was about making the contours of gender melt away into straight lines of androgyny" (White non-binary person; Zamantakis and Lackey 2022).

Participants described feeling intense pressure to control gender expression: "I have to be like this ultra-feminine woman...'Cause at the end of the day, they [cis women] don't stop being women because they were born women. Meanwhile, I have to constantly prove to myself, to people, that I fit the bill" (Gordon et al. 2016). Pressure to pass, avoid others questioning their gender, and prove themselves as feminine/masculine/androgynous was a key influencer of disordered eating for many.

A few participants discussed the significance of misgendering experiences: "...when they used 'she' to refer to me, I heard 'you need to lose more weight...'" (White non-binary person; Zamantakis and Lackey 2022).

Use of disordered eating and exercise to influence gender expression was discussed in the context of societal appearance expectations of gender in most papers. Meeting socially prescribed standards of femininity/masculinity/androgyny, for some, meant more effectively "passing" and proving their gender to themselves and others: "My disordered eating is directly related to how I feel I have to make myself look in order to be a 'real' woman. I feel that I have to follow feminine beauty standards more strictly than others otherwise my gender will be called into question and as such I require myself to be quite thin" (White trans woman; Cusack et al. 2022). Thinness was commonly associated with femininity and androgyny, particularly in White Western cultures, although many trans-masculine participants also pursued thinness to reduce feminine characteristics. While gender ideals varied across cultures, participants consistently described them as influencing disordered eating.

Gender and appearance ideals intertwined, seemingly intensifying body dissatisfaction for many. Such standards were observed and perpetuated within LGBTQ+ communities: "Almost every trans man that's widely followed on Instagram or YouTube...is really obsessed with fitness, and super ripped...there is a huge focus on bodies, and I think part of it is that you can really masculinize your body by being really muscular...Hyper muscular types of bodies being celebrated, and other bodies were not represented at all" (Pinelli 2019).

Some felt such standards centered around "cis-ness." Several participants discussed societal pressure to conform to what cisgender populations expected and valued. This was shaped by transphobic ideologies, which devalue individuals who differ from the norm. "The type of people that straight cis people want to follow are the trans people they can get behind...They want to see that; they don't want to see the like super queer people" (Pinelli 2019).

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3.3.3 | Theme 3: Disordered Eating as a Means of Coping

Alongside gender affirmation, many papers highlighted the emotional function of disordered eating. Across studies, disordered eating helped participants cope with the distress associated with gender dysphoria, shame, and feeling out of control.

3.3.3.1 | Subtheme 1: Coping With Gender Dysphoria. Disordered eating was reported by both non-binary and binary transgender participants as a method of coping with body dissatisfaction and gender dysphoria; feelings of shame associated with their gender identities (shaped by internalized transphobia); the pain of being misgendered; and being unable to live authentically.

Disordered eating was a way of soothing this pain; "Sometimes when I feel very sad and I hate my body, I hate myself, I feel better if I eat. It's like it soothes the pain" (Person assigned female at birth; Mirabella et al. 2020). It also provided a distraction from dysphoria: "Pouring my energy into anorexia meant I didn't have as much time to worry about my gender" (Biracial non-binary person; Cusack et al. 2022). For others, disordered eating offered a way of disconnecting from and hiding a body incongruent with their gender identity: "I just sort of wanted to be invisible...Let's not acknowledge that I have a body..." (White non-binary/genderqueer person; Harrop et al. 2023).

Disordered eating was also identified as a method of harming or punishing their bodies in this context: "I definitely had fantasies of just, like, my organs breaking down and, like, stopping working...trying to destroy this body that's been sort of attacked and, you know, invaded by outward expectations of gender..." (White, agender person; Romito et al. 2021).

3.3.3.2 | Subtheme 2: Sense of Control. Disordered eating also provided a way of feeling more in control of their bodies and lives, particularly when feeling less in control (for a variety of reasons, including gender incongruence). "...I really do think there was an element of 'I can't control my body all the way to the direction that I wanted to really go'. While, as an anorexic, at least, I have control over my body. If I control my weight, I have some control over it, and so I do think being Trans was an issue, you know, (it) was one of the things that led me down that road..." (Kester 2023).

This was especially relevant during puberty, a time of confusion, fear, and discomfort for many (when participants often lacked the language to make sense of and express experiences with their bodies), as their bodies developed in ways that were incongruent to their felt sense of gender. ED symptoms developed in the context of this distress and provided a way of gaining control of a body that was betraying them. "I was trying to starve myself out of puberty happening because I hated absolutely everything my body was doing and wanted it to stop" (Garvis 2021). For some, this was conscious; for others, the relationship between their ED and puberty did not become clear until later: "Looking back, it was definitely a control thing, even though I wasn't able to recognise it or have the words to express it. To compensate for having no control over my body or who I am..." (White, non-binary trans woman; Joy et al. 2022).

3.3.4 | Theme 4: Negotiating Safety Within a Cisnormative Society

Participants' accounts suggested that disordered eating/exercise was shaped by broader interpersonal and structural forces, alongside gender dysphoria. Most papers mentioned the impact of discrimination and marginalization, structural barriers to gender-affirming care, and cisnormative societal expectations. This theme was seen across gender identities, although experiences differed.

3.3.4.1 | Subtheme 1: Conforming to Survive in a Cisnormative Society. Some participants reported disordered eating in the context of discrimination, othering, marginalization, and harassment. "I definitely dealt with weight stigma... homophobia and transphobia...I still struggle with body image stuff...knowing I would be treated differently every day in my life if I was smaller...knowing my gender expression would be different if I was smaller..." (White, non-binary/genderqueer person; Harrop et al. 2023). Another commented: "It was very much about protecting myself and changing the way that my body looks to others. So that the response I got from others would be safer for me" (Kester 2023).

Safety was sought by some through conforming to societal expectations and appearance ideals, achieved through disordered eating/exercise. Participants reported that being slender, appearing as close to cisgender as possible, and meeting societal expectations of appearance offered protection in society. "I don't want to say that if you express your gender in a certain way that you have more of a privilege. I don't think that it's a privilege, but I think that if you do conform to what people's expectations of what a non-binary person looks like, you're more likely to get recognition and respect" (Genderqueer person; Pinelli 2019). One white, non-binary participant remarked: "...It's like, well, maybe if I. Was, you know. [Pause]. Skinnier, then I could more easily fit into a category that is more. Like, digestible for people" (Gavnik 2023), indicating that conforming to societal expectations around weight could make them seem less other and thus more acceptable. A non-binary participant noted that their disordered eating was partially fueled by a need to shrink their body, "...reducing the amount of space you take up in a capitalist, racist heteropatriarchy fundamentally against people like you..." (White, non-binary person; Zamantakis and Lackey 2022).

Participants also described how access to gender affirmation was constrained by structural factors, particularly the financial costs of transition and barriers to gender-affirming care. Where transition was inaccessible, disordered eating became one of the few available means of aligning their bodies with societal expectations of gender. These experiences were primarily reported in US studies, where variable health insurance coverage limited access to gender-affirming care. Additional transition-related costs, including new clothing, were also described. This concern is illustrated by a quote from Calzo et al. (2025): "Transitioning is 100% an accessibility issue...Transitioning is not cheap and many people cannot do it for financial and safety reasons..." (Black non-binary person). One participant felt that access to gender-affirming care would likely mitigate the risk of disordered eating in some trans people: "I guess in an ideal world, there would be free, low barrier gender affirming medical care

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available. Obviously, that's not the reason for all disordered eating in trans people, but I imagine that...there would be a significant reduction if there was that kind of access to those aspects of medical care" (Schweizer et al. 2026).

3.3.4.2 | Subtheme 2: Negative Psychological Impacts of Marginalization and Discrimination. Participants identified the psychological impact of marginalization on well-being and disordered eating. Participants commented on experiences of bullying, exclusion, discrimination, and aggression. For example: "I was really, really heavy, because you're comfort eating...you're trying to mask pain...The...stress of being laughed at, being joked at, being humiliated, you know all that stuff. Then you have your marriage break down and...it's all because of being transgender..." (Transgender woman; Brewer et al. 2022). Discriminatory views of others were often internalized, paving the way for a shame-based relationship with themselves and their bodies, manifesting in part through disordered eating. For example, one participant commented: "I have a lot of internalized homophobia/transphobia that sometimes creates shame and feelings that I don't deserve to eat" (Biracial/multiracial non-binary person; Cusack et al. 2022).

Some participants outlined how enforced gender binaries in society and lack of representation, too, can affect one's relationship with oneself, and subsequently disordered eating: "To be non-binary in a binary society is to feel less than human...You learn that you are not normal..." (Zamantakis and Lackey 2022). "... There's this idea that monsters don't have reflections in a mirror...if you want to make a human being into a monster, deny them, at the cultural level, any reflection of themselves" (White, non-binary person; Zamantakis and Lackey 2022).

3.3.5 | Theme 5: Links Between Gender-Affirming Care and ED Services

Disordered eating often functioned as a means of achieving gender affirmation (consciously and unconsciously). Participants frequently described how accessing gender-affirming care altered disordered eating habits.

3.3.5.1 | Subtheme 1: The Impact of Gender-Affirming Care on ED Recovery. Most papers cited the effects of gender-affirming care (GAC) on disordered eating and recovery; however, perspectives varied.

For many, accessing GAC meant no longer having to rely on disordered eating to alter their bodies: "I am not having to starve myself to get the no hips, it's happening" (Pinelli 2019). Other participants cited a new motivation to take care of their bodies post-transitioning: "I want to look after myself when I'm Chantelle" (Trans woman; Brewer et al. 2022). Although some commented on the limitations of GAC in improving disordered eating: "Even though [Testosterone] did a ton for my confidence, it didn't magically cure my disordered behaviours" (Garvis 2021).

Some described the impact of unwanted weight gain from hormone therapy, for example: "...it changes your weight distribution which is obviously very potentially triggering as someone with an eating disorder and also just like the loss of like sense of control of your body..." (Bowman 2018).

Participants also commented on weight targets for gender-affirming surgery. Several disclosed rapid and unhealthy weight loss to be eligible for surgery and to ensure the effectiveness of surgical procedures. For example, on discovering she may not meet the size requirements for surgery, one participant commented: "I was frightened to death! So, four weeks I had a five hundred calorie a day diet" (Trans woman; Brewer et al. 2022).

3.3.5.2 | Subtheme 2: The Cis-Centric Nature of ED Treatments Is a Barrier for Gender Diverse People. A majority of the papers reported barriers to ED treatment. For some participants, the perceived narratives of disordered eating as a cisgender female's problem prevented them from acknowledging difficulties and seeking help. "...Most of the messaging I've seen around getting help for disordered eating has been like, young women who really want to be skinny...that was not my experience, so I sort of thought well, this can't really be like something that I seek out because I don't fit the profile" (White, genderqueer person; Joy et al. 2022). Another reflected that seeking ED treatment felt invalidating of their gender: "I was very reluctant to seek help with it because EDs are a 'girl thing' and it felt like admitting I was struggling with one would mean I was actually a girl" (Garvis 2021).

Similarly, the cis-centric nature of ED treatment meant that many gender diverse individuals experienced interventions as unhelpful and harmful. One participant commented: "[When] I got specific ED treatment I felt...like I didn't really belong there..." (White non-binary/genderqueer person; Harrop et al. 2023). Participants also outlined how ED practitioners often ignored gender identity: "It's an aspect of myself and the way in which I view my body...If we're just not talking about it, that's ignoring an entire segment of this treatment" (White non-binary/genderqueer person; Harrop et al. 2023). Another commented how there's "...so much emphasis [in treatment] on like accepting your body as it is, and that your body is perfect as it is... [conflicts with what] you want to do as a trans person" (Garvis 2021).

Other barriers to accessing healthcare included discriminatory attitudes of healthcare professionals, a lack of understanding of gender identity in professionals and having to educate staff, a lack of safe queer spaces, and a lack of representation of different gender identities in healthcare professionals.

3.3.6 | Theme 6: Recovery Through Gender Affirmation, Connection, and Resistance

Participants described several protective factors in recovery, which often reflected a reversal of the processes maintaining EDs.

3.3.6.1 | Subtheme 1: Exploration and Connection With Gender Identity. Exploring and connecting with gender identity was an important aspect of ED recovery for many: "The more comfy I get in my gender, the farther away my ED gets" (White, genderqueer/fluid person; Cusack et al. 2022). This included

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distancing themselves from norms and expectations and living more authentically; "[Recovery] means not conforming. A lot of my ED was connected to conforming or trying to conform" (White, non-binary/genderqueer person; Harrop et al. 2023).

However, recovery from ED also meant weight gain and a return of some secondary sex characteristics. For some, this was distressing: "What the doctors called 'progress' was to me the methodical undoing months of my hard work. I could actually feel my body changing, feel myself sliding away from where I wanted to be. Gender was size, and size was gender" (White, non-binary person; Zamantakis and Lackey 2022).

Reconnection with the body was of importance. ED recovery requires reconnection to the body, which can be painful: "Going from a robot body to a fleshy body...[was] very disruptive to my identity and sense of self" (White, non-binary/genderqueer person; Harrop et al. 2023). But for some participants, "reclaiming my body" and "letting my body be and listening to my body..." were an important part of recovery (White, non-binary/genderqueer person; Harrop et al. 2023).

Recovery from disordered eating allowed participants to better understand their gender identity and find alternative ways of seeking gender-affirmation: "Only now that I have been more committed to recovery have I allowed myself the space to explore gender and the other options for bringing my body into alignment with my internal sense of gender" (White trans man; Cusack et al. 2022).

3.3.6.2 | Subtheme 2: Positive Connections With Family, Peers, and the LGBTQ+ Community. Participants described the benefits of supportive social networks "...I came out to my partner and my family and friends...that's definitely helped with body image stuff..." (Bowman 2018). Connection to LGBTQ+ and gender diverse communities was also referenced: "I kind of just stuffed that down and said and thought to myself, 'Well, if that's not a thing that's recognized, then I'll just try my hardest to be a girl.' But then, in my late twenties...I met another genderqueer person, and we talked about gender stuff, and that's when I was introduced to the idea that it wasn't just me..." (Kester 2023). This was important in eating disorder recovery for some: "I think that isolation is one of those things that helps contribute to eating disorders so being able to connect with people and relate to them in certain ways I think helps with getting past that" (Pinelli 2019).

3.3.6.3 | Subtheme 3: Active Resistance of Sociocultural Appearance Norms and Expectations. Connection with narratives of resistance was also protective for some, including recognition of the negative effect of societal beauty ideals and critical consumption of the media. For example, a message one participant wished to share with others: "...People don't always need to conform to one specific body type to be the kind of person they want to be...body image does not necessarily need to fit one particular stereotype and that there are multiple options that are okay to be" (Transfeminine person; Pham et al. 2023). As well as connecting with others who actively resist these expectations: "...the people I'm around are not enforcing these stereotypes, or upholding them, or engaging in them at all. We are actively against that" (White, non-binary/genderqueer person; Harrop et al. 2023).

Several participants who identified outside of binary genders described the importance of connecting with their non-binary identity; the category-less and unrepresented nature allowed some people to free themselves from societal expectations: "... When you're not represented, there is no person that you can hold up as an ideal...All of that [body ideals] is just thrown out of the fucking window. I don't have any expectations that I'm trying to live up to" (White, non-binary/genderqueer person; Harrop et al. 2023). Freedom from societal expectations supported freedom from disordered eating for many.

4 | Discussion

4.1 | Summary of Findings

This review sought to synthesize qualitative literature exploring experiences of disordered eating within gender diverse populations, as identified by gender diverse individuals. Six overarching themes were identified: interconnectedness of gender dysphoria and EDs; disordered eating as a strategy for achieving gender affirmation; disordered eating as a means of coping; negotiating safety within a cisnormative society; links between gender-affirming care and ED; and recovery through gender affirmation, connection, and resistance.

The findings highlight the complex relationship between gender identity, gender dysphoria, and disordered eating. Many participants commented on the inseparability of disordered eating from their gender identity and gender dysphoria. Of importance is the experience of uncertainty some gender diverse individuals faced when making sense of this relationship. Many participants only recognized these underlying influences on their disordered eating later in their journey. Limited education and support to safely explore their gender identity led some to attribute their body dissatisfaction to weight concerns, with disordered eating becoming an attempted solution. Others worried about the possible ED-driven motivations behind choosing to access gender-affirming interventions (whilst recognizing the importance of these interventions).

A key aspect of the relationship between gender identity, gender dysphoria, and disordered eating was body dissatisfaction, influenced by cultural and societal gender expectations and body ideals. These findings echo previous research, such as Jones et al.'s (2018) review. Conforming to societal expectations was associated with disordered eating for many but allowing themselves to let go of the pressure to conform, recognizing that there is no one "right" way to do gender, and live authentically meant freedom and gender euphoria.

To live authentically, however, was not without risk or difficulty. In the context of a society that devalues difference, non-conformity can be dangerous. Gender diverse people face discrimination, aggression, and harassment, or the threat of these, daily. This is seemingly on the rise: transgender hate crimes in England and Wales rose significantly over recent years (Office for National Statistics 2023). Hate crime statistics only show a small snapshot of the true extent of the marginalization and oppression that trans and gender diverse populations face (Ellis et al. 2016; Puckett et al. 2023). Participants in the current review reflected on the

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profound impact of marginalization. Exploring gender identity, developing an understanding and acceptance of who you are, and living outside of the confines of societal expectations is challenging and potentially dangerous in this context. Particularly when discrimination and stigma, as well as lack of financial resources, can significantly impact the accessibility of gender-affirmation and adequate healthcare (e.g., Carlile 2020; Hobster and McLuskey 2020). These findings are in line with previous research (Brewster et al. 2019), which found significant associations between anti-transgender discrimination and disordered eating. Findings also support the application of the minority stress model to disordered eating within gender diverse populations (Hendricks and Testa 2012; Gordon et al. 2021) and intersectionality theory (Crenshaw 1989), which outlines the unique ways in which interactions between differing marginalized identities can shape the experience of discrimination.

For many, disordered weight and shape control behaviors provided a way of coping: with the emotional distress of marginalization, internalized transphobia, and the resultant shame-based relationship with oneself that can manifest; with gender dysphoria, the distress of going through puberty in the wrong gender, and the lack of control felt over their bodies and lives. This echoes understanding of EDs more broadly (e.g., Fairburn 2008); but the unique stressors that can be faced by gender diverse individuals are of importance.

The findings provide support for Gordon et al.'s (2021) proposed model of disordered eating in transgender and gender diverse populations. This model draws on sociocultural understandings of EDs (i.e., the influence of societal expectations), as well as Minority Stress Theory (Meyer 2003; Hendricks and Testa 2012) and the influence of oppression and stigma; outlining how these factors may impact body dissatisfaction and disordered eating/exercise. The model also draws on the gender-affirmation framework (Sevelius 2013), which posits that if an individual's needs for affirmation are high, but access to gender affirmation (e.g., medical, social, and legal) is low, individuals may be pushed to seek affirmation in maladaptive ways, such as using disordered eating behaviors to alter their body.

However, also reflected in the current review and in support of Gordon et al.'s (2021) model, are the numerous protective factors reported by gender diverse people. Support, acceptance, and validation from friends and family, as well as wider systems (including healthcare professionals), and LGBTQ+ and gender diverse communities can be vital in ameliorating the risk of and supporting recovery from disordered eating. Individual and community resilience factors, such as narratives of resistance, were also recognized in the review. This provides further support for Gordon et al.'s (2021) model and echoes previous research, such as Parker and Harriger's (2020) review of risk and protective factors of EDs within LGBTQ+ populations.

4.2 | Strengths, Limitations, and Future Research Directions

The present review has several strengths. First, the quality of the included papers was mostly high. Studies were methodologically sound, with rigorous analyses and clearly presented findings. Many papers considered reflexivity and bias in data collection and analysis, and included participants of different ages, backgrounds, ethnicities, socioeconomic status, gender diverse identities, and disordered eating experiences. This breadth of experience and diversity of the samples makes the current review more representative of a broader range of populations. However, overall, there is still a lack of representation of trans voices in research, in particular those outside of the gender binary. Variety in data collection methods is another strength; while most papers utilized semi-structured interviews, the inclusion of papers which collected data from blogs, vlogs, and social media posts, as well as from written responses to an open question, appeared to gather more naturalistic views of individuals which may be difficult to access through formal interview techniques.

There are also limitations. First, several papers explored treatment experiences of EDs within this population, and many participants provided recommendations. It was beyond the scope of the present study to review treatment experiences in-depth; further analysis of these would be important. Research was also solely conducted in Western countries, and the majority in the USA. Inclusion of research not in the English language was beyond the scope of the current review; future research should consider this and explore further cultural and ethnic diversity in gender diverse experiences. Additionally, several papers did not report demographic information including ethnicity, race, and socioeconomic status, and a significant proportion of participants (when this was reported) were white. Future research would benefit from seeking to include more diverse populations across different nationalities and ethnicities.

While the current review included participants under the age of 18, younger participants were in the minority. Given the importance of puberty and that adolescence is a known period of increased risk of disordered eating (e.g., Keel and Forney 2013), further research exploring gender diverse youth is of importance.

4.3 | Clinical Implications

Such findings may be of significance in both informing support for gender diverse individuals, and in addressing health inequalities at the population-level; when considering prevention and improved access to evidence-based support. Consideration of barriers (financial, social, and political) to gender-affirmation was discussed by several participants as a key influence on disordered eating. Access to gender-affirming support was a key theme; and of particular importance to consider within the increasingly restrictive legislation in some areas (including the US and UK; e.g., Williamson 2024). Access to education and language to help understand and put words to their experiences, and representation of different gender identities in the media was also cited as of significant importance. Problems are likely to persist for this population without addressing the systemic injustices faced daily (Roberts et al. 2026).

In considering support for individuals, several recommendations emerged in the current review. First, while many participants were consciously aware of the relationship between disordered eating and gender, this was not universal; many participants described being unconsciously motivated to engage in disordered

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eating behaviors. Individuals may require support to explore this link between gender identity and disordered eating in validating and sensitive ways. Pham et al. (2023), for example, recommended screening of disordered eating difficulties within gender identity services, to identify concerns and open conversations about disordered eating, and reduce the shame around these difficulties. Inclusive services, which support individuals to explore and make sense of the role of intersecting stigmas, and which are more accessible to individuals from different backgrounds, cultures, and socioeconomic backgrounds, would go some way to improving the experiences of gender diverse individuals; many have cited the inaccessibility of both ED and gender-affirming treatments as a key influencer of disordered eating.

Participants across gender identities reported puberty as a particularly high-risk period for disordered eating, but many did not recognize their distress in puberty as related to gender until later. This confusion only added to their distress. Gender diverse young people may present to healthcare services during this period of their lives and may benefit from a safe, validating, and accepting space to start to explore gender and identity.

ED specialist services could benefit from improving clinician awareness of the impact of gender identity and gender dysphoria on eating difficulties, and how presentation and treatment needs may differ. The benefits of gender-affirmation in reducing reliance on disordered eating and exercise to alter one's body are important, and ED services should consider this when offering intervention. Additionally, services should be aware that recovery may present additional challenges, with weight changes potentially increasing gender dysphoria. Professionals could be more conscious of this and offer support to find safer ways of seeking gender affirmation and gender euphoria. Services should also be aware of the potentially invalidating narratives of body acceptance in treatment: adaptations to treatment may be required.

Importantly, not all gender diverse individuals will experience gender dysphoria and co-occurring mental health difficulties. Gender diversity is not a cause of mental health problems, including disordered eating, and the findings of this review should be understood to reflect the importance of improving support and challenging discrimination of gender diverse populations in society, as opposed to pathologizing gender diverse individuals. Everyone can help to challenge stigma and marginalization, in and out of healthcare settings, and provide safe and affirming spaces for gender diverse populations seeking support.

Author Contributions

Kirsty Matthews: conceptualization, investigation, writing – original draft, methodology, validation, visualization, writing – review and editing, formal analysis, project administration, data curation. **Kai S. Thomas:** writing – original draft, methodology, validation, writing – review and editing, formal analysis, supervision. **John R. E. Fox:** supervision, writing – review and editing, methodology, conceptualization. **Falguni Nathwani:** conceptualization, methodology, writing – review and editing, supervision. **Marc O. Williams:** conceptualization, writing – original draft, methodology, validation, visualization, writing – review and editing, formal analysis, supervision.

Acknowledgments

We would like to thank all of the authors and participants of studies included in this review. ChatGPT (OpenAI, GPT-5.5: https://chatgpt.com) was utilized in final edits made following peer review to consider ways of improving flow and refining wording in the introduction and results sections. The first author reviewed all suggestions made and included those deemed beneficial. The authors remain responsible for the final content. No additional use of generative AI was utilized.

Funding

K.S.T. is funded by Health and Care Research Wales (AF-24-04). This work was completed in partial fulfillment of a doctorate in clinical psychology funded by Health Education and Improvement Wales (HEIW). No other financial support was received for the research, authorship, and/or publication of this article.

Disclosure

The review was registered on Prospero 18th May 2023, registration ID: CRD42023427773. There were changes made to the review following registration of the protocol. First, the ProQuest database was also screened for papers to allow for inclusion of gray literature. Second, databases were screened again in January 2026 to screen for additional papers published after the initial screening; this search yielded an additional 4 papers, taking the total number of included papers from 14 to 18.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Example data extraction forms, coding data, and the pool of codes, as well as a list of included studies represented by each theme are not publicly available but can be sought from the corresponding author upon reasonable request.

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