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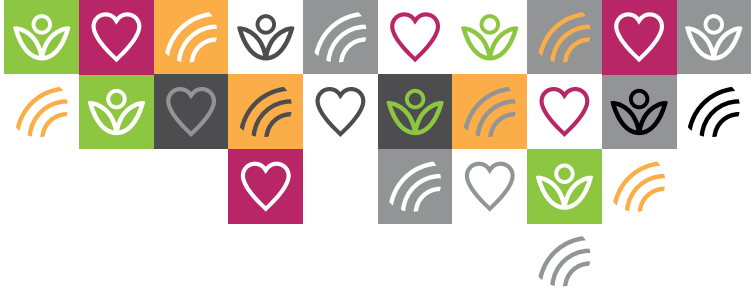
# health in focus: relationships with food and disrupted eating behaviours in LGBT2SQ communities

An evidence review and practical guide designed for healthcare providers and researchers

## PURPOSE

This Health in Focus document offers information to care providers on how the social determinants of health and other systemic factors contribute to a unique and complex relationship with food within LGBT2SQ populations.

This document will encourage you to think critically about existing biases and offer strategies for implementing an LGBT2SQ affirming approach to practice.



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# the social determinants of health

Health outcomes are determined by more than genetic and lifestyle factors. It can also be determined by an individual's socioeconomic status and the dynamics that influence this status, namely the social determinants of health. Examples of the social determinants of health are: [1,2]

- Income and social status
- Education and literacy
- Employment and working conditions
- Early childhood experiences
- Housing
- Access to food and health services
- Experience of discrimination, racism, trauma

These factors either advantage or disadvantage an individual and ultimately impact health outcomes. The social determinants of health must be considered when assessing the root cause of health conditions.

## ECOSOCIAL THEORY OF DISEASE DISTRIBUTION

The social determinants of health directly relate to health inequities in Canada.[1] The ecosocial theory of disease distribution, first proposed by Krieger in 1994, explains how individuals who experience unjust and preventable inequities, will embody their effects, ultimately altering their health status.[3] This theory highlights the connection between population health and disease within a social and ecological context and the ways in which exposures and experiences are integrated into an individual's biological being.[4] There is an increasing need for research that aims to measure the impacts of discrimination and other experiences of social inequities on health status.

## THE SOCIAL DETERMINANTS OF HEALTH, HEALTH INEQUITIES AND LGBT2SQ POPULATIONS

Current health systems do little to address health inequities faced by LGBT2SQ populations. Instead, there is a focus on illness (e.g. HIV/AIDS) rather than on the social determinants of health that affect this community and contribute to persistent and complex health issues.[5]

Heteronormative/cisnormative assumptions and practices, stigma, discrimination, and social exclusion are social factors that compound to affect this population's health access, status, and outcomes.[6] Many LGBT2SQ individuals avoid disclosing their identity to health practitioners, particularly LGBT2SQ youth who may fear a breach in patient confidentiality upon disclosure.[6] Experiences of stigma or discrimination can cause individuals to withhold information especially for those with intersecting identities.[7]

LGBT2SQ people experience several inequities that effect health status.

LGBT2SQ individuals are:

- Often lower income earners than non-LGBT2SQ individuals.[8] In 2018, 41% of LGBT2SQ people had an income of less than $20,000 compared to 26% of non-LGBT2SQ people.[9]
- Two times more likely to have experienced homelessness than their cisgender, heterosexual counterparts.[8] LGBT2SQ youth comprise 25-40% of the Canadian youth who experience homelessness.[10]
- More likely to experience food insecurity, especially transgender men.[11]

The Trans PULSE Canada 2021 survey (data collected in 2019) highlights some important findings for trans and non-binary people and

their experience within the health system.[12] Notably:

Youth respondents (aged 14-24 years old)

- 47% had unmet health needs
- 65% avoided several public spaces due to fear of harassment
- 72% had experienced verbal harassment within the last five years
- 57% had a primary care provider that used correct name and pronoun
- 32% had a primary care provider who demonstrated knowledge of trans or non-binary health issues
- 25% had a health provider who used inclusive medical forms

Adult respondents (aged 25+ years)

- 43% had unmet health needs
- 63% avoided several public spaces due to fear of harassment
- 66% had experienced verbal harassment within the last 5 years
- 69% had a primary care provider that used correct name and pronoun
- 44% had a primary care provider who demonstrated knowledge of trans or non-binary health issues
- 37% had a health provider who used inclusive medical forms

Health findings from Indigenous trans, two-spirit and non-binary people in the Trans PULSE Canada survey show:[13]

- 51% had unmet health needs
- 76% avoided several public spaces due to fear of harassment
- 79% had experienced verbal harassment within the last 5 years
- 80% experienced challenges accessing traditional ceremonies

These statistics demonstrate the social/economic inequities and barriers to adequate care that affect some LGBT2SQ people. There is a need to address the social and structural systems in which health inequities occur.

However, this can pose difficultly for care providers without dedicated training, adequate resources and organizational support in which to do this.[6] The lack of LGBT2SQ focused competence is both implicit through heteronormative and cisnormative protocols as well as explicit through lack of LGBT2SQ specific care guidelines and education for care providers.[6] These barriers further exacerbate the health inequities experienced by LGBT2SQ populations.

## MINORITY STRESS AND INTERNAL/EXTERNAL STRESSORS

The minority stress model describes the stigma and discrimination experienced by LGBT2SQ individuals that produces the stressors that manifest into undesirable health outcomes, experienced as mental and physical disorders.[14] External stressors such as stigma and discrimination and internal stressors such as internalized homophobia and suppression of identity interact to form minority stress and can contribute to a negative body image.[14] Higher rates of internalized homophobia are also connected with higher rates of depression and anxiety.[15]

Minority stress present with gender or body dysphoria can lead to disordered eating patterns.[16]

Gender dysphoria is an incongruence or disconnection of the external physical body and the internal gender identity.[16] Important to note, is that both minority stress and gender dysphoria need to be addressed to treat disordered eating in these instances.[16]

The Gender Minority Stress and Resilience measure (GSMR) is a tool for care providers to assess external and internal stressors and identify resiliency areas that can positively affect mental health in transgender and gender expansive people.[16] This population may experience additional and unique stressors, therefore the GSMR can be used to better capture their experiences.[15]

## fat phobia and weight bias

Fat phobia, also called weight bias is the explicit or implicit negative behaviours towards people with obesity.[17] This bias is observed across many health disciplines and can also be expressed through structural barriers such as inadequate gown sizes or examination equipment for larger bodies.[17]

As with minority stress, weight bias increases the risk of poorer health outcomes.[17] Individuals that experience the effects of weight bias from a health practitioner are less likely to receive adequate health information and are less likely to be referred for diagnostic testing.[17]

Weight bias contributes to the risk of disordered eating as the prevailing goal imparted on patients with obesity is around weight loss, whether or not solicited by the patient or indicated by their presenting symptoms.[18]

Fat phobia has historical roots in which a thin, white, Western style of beauty is upheld as the ideal, thus serving as a tool of oppression towards all other bodies.[18] This ideal continues to be promoted by vilifying fatness and promoting thinness in the name of 'health'.[18] Thin bodies are seen as healthy while fat bodies are seen as a problem that can and should be 'fixed'.

## complex food relationships

The social determinants of health, minority stress, weight bias and the subsequent health inequities that form from these factors, contribute to complex relationships with food among many in LGBT2SQ populations. Some of these inequities contribute to food insecurity of which this population is at a greater risk, or they can manifest through disordered eating patterns.[10, 16] Disordered eating can be a manifestation of trauma, experienced through ongoing discrimination, identity stress and rejection.[16]

### DISORDERED EATING

Transgender and gender expansive people are more likely than cisgender people to be diagnosed with an eating disorder or to experience disordered eating.[19] The stigma and discrimination that this group is subjected to is likely connected to this increased risk as disordered eating may be used as an avoidant coping strategy to these stressors.[19] High rates of reported stigma among LGBT2SQ populations has been connected to an increased risk of disordered eating behaviours such as binge eating, fasting or vomiting.[20] Important to note are protective factors that relate to a lower risk of disordered eating such as social support, connection to school and connection to family.[20]

As noted earlier, disordered eating patterns can also arise from a disconnection between gender and body.[16] Disordered eating might be used to achieve or conform to social gender norms in order to limit discrimination or harassment, and it may be used to achieve congruence between the body and identity.[19] However, engaging in disordered eating to achieve body changes can result in decreased long-term body acceptance.[16] Care providers need to consider how minority stress and gender dysphoria may interact to increase an individual's risk of disordered eating.

## DIET CULTURE WITHIN LGBT2SQ COMMUNITIES

Diet culture within LGBT2SQ communities persists by perpetuating an ideal of what a 'desired body' must look like while shaming and excluding those who fall outside of this aesthetic.[21] There can be pressure to conform to this societal ideal in order to reduce internalized feelings of stigma or shame.[21] This can be particularly true in the gay male community with ideals being those that represent 'peak masculinity'- often toned and muscular bodies, while larger bodies are rejected.[22] This form of weight stigma intensifies feelings of exclusion and social rejection, compounding the effects of minority stress.[22] Diet marketing efforts from various companies increase as Pride month approaches and further pushes this exclusionary societal ideal of what LGBTQ2S bodies should look like.[21]

# for care providers

Care providers should be aware of the unique systemic and social stressors that LGBT2SQ people face and understand how these complexities impact health outcomes. Assessments and treatments should be altered to minimize barriers to care. Removing assumptions and bias in practice as well as initiating referrals to services that address inequities, and the social determinants of health should be incorporated into practice.[6] Care providers should seek to become competent in LGBT2SQ issues and care.[19]

## INCLUSIVE ELECTRONIC HEALTH RECORDS

It is essential to recognize that a client may have a name or gender that differs to those listed on legal documents.[23] It is recommended that providers adjust intake forms and client health records to reflect this. Ensuring that clients are able to communicate their pronouns will minimize stressors and reduce the risk of providers mis-gendering or using the incorrect pronouns with clients.[23] A two-step process, in which both gender and birth-assigned sex information is collected, is recommended to ensure that health providers are able to offer preventative care depending on anatomy while also ensuring that the client is seen and referred to by their correct gender.[23]

RHO recommends the following fields be included on intake forms:

- Legal name
- Name (name client will be addressed by)
- Pronoun
- Gender identity (present this as an optional field and include a blank space so that clients are not confined to a pre-determined list)
- Sex assigned at birth (include an option for clients to refrain from disclosing)
- Sexual orientation (present this as an optional field and include a blank space so that clients are not confined to a pre-determined list)

## HEALTH AT EVERY SIZE (HAES), CONFRONTING WEIGHT BIASES

Care providers should be aware of the risk of disordered eating patterns, gender dysphoria and minority stressors and encourage healthy ways to achieve body acceptance.[16] Understanding that weight bias exists both explicitly and implicitly and confronting any internal biases is an important step in providing competent care. Providers can adopt a weight neutral or Health at Every Size (HAES) approach to care to minimize this risk. A HAES approach removes the focus from weight and instead promotes a respect for body diversity and welcomes clients to engage in self-compassion.[24] This approach to care has been found to have positive effects on eating behaviours.[25, 26]

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