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Exploring the roles of gender identity and neurodivergence in the development of eating disorders among trans and gender diverse people – a large-scale qualitative study

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Abstract

Background

Trans and gender diverse (TGD) people experience disproportionately high rates of eating disorders and are more likely to be autistic and/or have attention deficit hyperactivity disorder (ADHD) than their cisgender peers. Qualitative research shedding light on the mechanisms underlying these intersections remains limited. This study explored how gender identity, autism, and ADHD intersect to shape the development and lived experience of eating disorders in TGD people.

Methods

We conducted an online survey with 272 TGD adults (76.1% assigned female at birth; *M* age = 28.0 years) in the UK, all with current and/or past experience of an eating disorder. Participants responded to two open-ended questions about factors contributing to their eating disorder. Responses were analysed using reflexive thematic analysis.

Results

Participants' accounts are represented in one theme: 'Eating disorders function as a way of managing both internal experiences and external challenges'. Within this theme, we discuss four subthemes that represent unique and intersecting contributors to distress for TGD and neurodivergent adults with lived experiences of eating disorders: (1) Gaining control in an overwhelming world, (2) Living in a body that does not reflect your gender, (3) Negotiating identity and belonging in a cisnormative and neuronormative society, and (4) The dangers of being visible.

Conclusions

Findings highlight the heterogeneity of eating disorder experiences in TGD people and the roles of autism and ADHD. They situate eating disorders within a complex interplay of sociocultural and interpersonal environments that all impact on experiences of distress and capacity to cope with this distress.

Plain English summary

Trans and gender diverse people, whose gender identity does not align with their sex assigned at birth, are more likely than cisgender people to experience eating disorders. They are also more likely to be autistic or have attention deficit hyperactivity disorder (ADHD). However, we do not fully understand how gender identity, autism, and ADHD affect people's experiences of eating disorders. We analysed written responses from 272 trans and gender diverse adults in the UK with a current or past experience of an

eating disorder. Participants answered open-ended questions about the factors they thought contributed to their eating disorder via an online survey. Participants described their eating disorder as a way of coping with challenges they faced. Some of these challenges were linked to their gender diversity, autism, and/or ADHD. These challenges included feeling overwhelmed by sensory experiences, feeling uncomfortable in their body, struggling to fit into others' expectations, feeling isolated and different to others, as well as worries about being judged, targeted, or unsafe. These findings show that there is no single reason why trans and gender diverse people develop eating disorders. Support and treatment need to take into account people's identities, life experiences, and neurodivergent characteristics.

Introduction

Trans and gender diverse (TGD) people, whose gender identity does not align with their sex assigned at birth, experience disproportionately high rates and greater severity of eating disorders compared to their cisgender peers (1, 2, 3, 4). TGD identities include binary trans identities, such as trans men and trans women, as well as identities that exist between or outside of the gender binary, such as nonbinary, gender fluid, or genderqueer (5). A recent meta-analysis estimated that 17.7% of binary trans individuals experience eating disorders (3), with evidence suggesting these rates may be even higher among nonbinary individuals (6, 7). In contrast, prevalence rates are 1.8% in cisgender women and 0.2% in cisgender men (8). Despite these elevated rates, existing treatment models and assessment tools often overlook the specific needs of TGD people (9). Understanding TGD people's unique lived experiences of eating disorders and the mechanisms underlying their increased risk is essential for developing inclusive and effective approaches to eating disorder treatment and assessment.

The elevated prevalence of eating disorders among TGD individuals likely stems from a complex interplay of interpersonal and intrapersonal factors. Qualitative research suggests eating disorder symptoms may serve various functions for TGD individuals, such as suppressing or enhancing body characteristics to align with gender identity (10, 11, 12), controlling pubertal development (13), or coping with emotional distress (14). Although these functions may also be relevant for cisgender people who experience eating disorders (15, 16), TGD people are also exposed to minority-specific stressors, such as structural oppression, experiences of discrimination and violence, expectations of rejection, and internalised transphobia, in addition to general life stressors (17, 18, 19). The additional stressors experienced by TGD people have been found to increase the risk of anxiety, depression, and suicidal ideation in TGD adults (20, 21). Recent research has found TGD people with an eating disorder diagnosis are at increased odds of experiencing a minority stress event like bullying, discrimination, and harassment (22).

In addition to high levels of eating disorders, TGD individuals commonly report co-occurring autism and attention deficit hyperactivity disorder (ADHD) (23, 24, 25), with prevalence estimates 2–6 times higher than in cisgender populations (26). Autistic people and people with ADHD are also found to be at

heightened risk of developing eating disorders and often experience poorer treatment outcomes than their non-neurodivergent peers (27, 28, 29, 30, 31). Previous qualitative research exploring autistic people's experiences of eating disorders have proposed autism-specific mechanisms, such as sensory sensitivities, preference for predictability, and social interaction and communication differences (32, 33). However, these studies have focused on the overlap between autism and anorexia nervosa, with far less known about the overlap between autism and binge eating/purging eating disorder presentations. Recent research suggests ADHD-relevant factors like impulsivity, executive functioning differences, and emotion regulation differences may contribute to the development and maintenance of eating disorders, particularly those characterised by binge eating and purging (34, 35, 36, 37).

While there is now evidence highlighting the common co-occurrence of gender diversity, autism, and ADHD (23, 26, 38, 39, 40), and some evidence to suggest TGD people who are also autistic may be at greater risk of developing eating disorders compared to TGD people who are not autistic (41, 42), previous research has not yet explored how gender identity intersects with autism and ADHD to shape the lived experience of eating disorders. The current study aimed to address this gap by exploring TGD participants' perspectives on the mechanisms underlying the development and maintenance of their eating disorders. Using reflexive thematic analysis (43) of open-ended responses from a UK-wide survey, we aimed to explore the diverse lived experiences of TGD adults who represented a broad spectrum of TGD identities, neurotypes, and eating disorder diagnoses and symptom presentations.

Method

Participants

We recruited TGD individuals who had living or lived experience of an eating disorder, were 18 years or older, currently residing in the UK, and fluent in English. Participants were not required to have a formal eating disorder diagnosis to be eligible for the study; however, they were asked to indicate whether they had ever received such a diagnosis. This approach was intended to promote the inclusion of a diverse and representative sample of TGD individuals, acknowledging existing research that highlights substantial barriers to accessing eating disorder assessments within this population (9, 44). A sample of cisgender adults who met the inclusion criteria listed above were also recruited at the same time as part of our larger programme of research, but their data were not included in this study. All participants were recruited through social media (Instagram, Facebook, BlueSky, Reddit), national and local eating disorder, LGBTQ+, autism, and ADHD charities, support organisations, social groups, and at LGBTQ+ events. Recruitment materials indicated that the study aimed to explore the relationships between eating disorders, gender identity, and neurodivergence.

Two hundred and ninety-eight TGD participants provided consent to participate in the current study. From these, 26 participants were excluded due to incomplete qualitative responses (17 did not provide any response and 9 did not provide a response that had sufficient detail for meaningful analysis). This resulted in a final sample of 272 TGD participants (*M* age = 27.97 years, *SD* = 8.20, ranged from 18–62

years). One hundred and fifty-two participants reported a formal neurodivergent diagnosis (Autism, ADHD, or AuADHD), an additional 101 participants self-identified as neurodivergent (Autistic, ADHD, AuADHD, or otherwise neurodivergent). Twelve participants reported that they had not received a neurodivergent diagnosis and did not self-identify as neurodivergent. Further demographic information and diagnostic history are presented in Table 1.

The project received ethical approval from the [Blinded for review] University's School of Psychology Ethics Committee (EC.24.11.12.7066A). Informed consent was obtained online from all participants before completing the questionnaires. Following participation, participants were given the option to enter a prize draw to win one of ten £50 monetary vouchers as compensation for their time.

Table 1

Sample characteristics (N = 272).

Sex assigned at birth	**Frequency (%)**
Female	207 (76.1)
Male	60 (22.1)
Prefer not to say	5 (1.8)
Gender	
Agender	20 (7.4)
Gender fluid	14 (5.1)
Genderqueer	9 (3.3)
Non-binary	76 (27.9)
Trans man	73 (26.8)
Trans woman	44 (16.2)
Other	36 (13.2)
Born with variation of sex characteristics	
Yes	4 (1.5)
No	221 (81.3)
Unsure	46 (16.9)
Prefer not to say	1 (0.4)
Ethnicity	
Asian/Asian British	6 (2.2)
Black/African/Caribbean/Black British	3 (1.1)
Mixed/multiple ethnic groups	16 (5.9)
Other ethnic group	3 (1.1)
White	243 (89.3)
Prefer not to say	1 (0.4)

Note. ED = eating disorder, OSFED = Other Specified Feeding and Eating Disorder, ADHD = Attention Deficit Hyperactivity Disorder, AuADHD = co-occurring autism and ADHD. Participants were able to provide multiple responses for certain questions, meaning the total percentages may exceed 100%.

Sex assigned at birth	**Frequency (%)**
Formal ED diagnosis	
Yes	126 (46.3)
Anorexia nervosa	84 (30.9)
Avoidant restrictive food intake disorder (ARFID)	18 (6.6)
Binge eating disorder	18 (6.6)
Bulimia nervosa	21 (7.7)
OSFED	13 (4.8)
Other	10 (3.7)
Unsure	6 (2.2)
No	142 (52.2)
Prefer not to say	4 (1.5)
Self-diagnosed ED	
Yes	137 (50.4)
No	132 (48.5)
Prefer not to say	3 (1.1)
Currently receiving ED treatment	
Yes	28 (10.3)
No	240 (88.2)
Prefer not to say	4 (1.5)
Formal Autism diagnosis	
Yes	120 (44.1)
No	149 (54.8)
Prefer not to say	3 (1.1)
Formal ADHD diagnosis	
Yes	62 (22.8)

Note. ED = eating disorder, OSFED = Other Specified Feeding and Eating Disorder, ADHD = Attention Deficit Hyperactivity Disorder, AuADHD = co-occurring autism and ADHD. Participants were able to provide multiple responses for certain questions, meaning the total percentages may exceed 100%.

Sex assigned at birth	Frequency (%)
No	208 (76.5)
Prefer not to say	2 (0.7)
Formal diagnosis of both Autism and ADHD	
Yes	30 (11.0)
No	242 (89.0)
Other diagnoses	
Anxiety disorders	188 (69.1)
Depressive disorders	190 (69.9)
Schizophrenia	3 (1.1)
Obsessive compulsive disorder	33 (12.1)
Bipolar disorder	15 (5.5)
Post-traumatic stress disorder	81 (29.8)
Personality disorder	38 (14.0)
Other	51 (18.8)
Neurodivergent self-identities	
ADHD	87 (32.0)
AuADHD	85 (31.3)
Autistic	162 (59.6)
Neurodivergent	181 (66.5)
Did not identify with a neurodivergent identity	19 (7.0)

Note. ED = eating disorder, OSFED = Other Specified Feeding and Eating Disorder, ADHD = Attention Deficit Hyperactivity Disorder, AuADHD = co-occurring autism and ADHD. Participants were able to provide multiple responses for certain questions, meaning the total percentages may exceed 100%.

Procedure

The study formed part of a broader mixed-methods survey administered via an online platform (45; version July 2023). To ensure data quality, participants first completed a screening question designed to identify irrelevant or low-quality responses from bots (46). In this question, they were shown an image of

a snow sculpture and asked to briefly describe what they predicted would happen to it on a warm, sunny day. We screened individual free-text responses to confirm that participants provided a plausible description consistent with snow melting. All participants passed this screening process and were included in the final sample.

Following the screening, participants provided demographic information as well as details regarding gender transition, neurotype, eating disorder history, and eating disorder treatment experience, if applicable. They then completed a series of self-report questionnaires examining eating disorder behaviours and cognitions, autistic and ADHD traits, gender dysphoria, and internalising symptoms. As the present study focused solely on the qualitative data, quantitative questionnaire responses are not discussed further and will be analysed separately.

At the end of the survey, participants were first presented with two open-ended questions concerning their experiences of an eating disorder, followed by an open-ended question on their experience of eating disorder treatment and services. Only responses to the first two open-ended questions were analysed in the present study as we focused on the development and maintenance of the eating disorder. Experiences of eating disorder treatment and services will be analysed separately.

Measures

The first open-ended question was “What factors or experiences do you think may have contributed to the development of your eating disorder?”. The second open-ended question was “What role, if any, does your gender identity play in your experience of an eating disorder? If relevant, does your neurodivergence (autism and/or ADHD) also play a role in your experience of an eating disorder?”. Participants were presented with a free-text box for each question and told that responding was optional.

Analysis

We followed Braun and Clarke (47)’s guidelines to conduct reflexive thematic analysis on the open-ended responses. An inductive approach was used to analyse the data, ensuring our interpretations of meaning were driven by the data. However, it is important to acknowledge that our question generation was guided by our prior knowledge and expertise in the area and this is likely to have also impacted on our coding of the data. The dataset was coded by two TGD coders who had lived experience of an eating disorder. One of the coders is also autistic and has ADHD. In line with guidance from Braun and Clarke (43), our inclusion of multiple coders followed a collaborative and reflexive approach which aimed to develop a rich and nuanced understanding of the data. The research team includes clinicians and academics who have published extensively on the lived experiences of autistic people with gender dysphoria, and autistic cisgender women with restrictive eating disorders. We have previously conducted quantitative work examining the associations between eating disorder symptoms, autistic traits, ADHD

traits, and gender dysphoria; however, this is our first qualitative investigation of the lived experiences of eating disorders among TGD people.

We used a combination of semantic and latent coding to uncover mechanisms underlying eating disorder development that were not explicitly described by participants, as well as representing the factors identified by participants as contributing to their eating disorder. We adopted a critical realist approach which focuses on the individual truths and realities of the participants (48) and emphasises the importance of context within interpreted reality. In this study, our findings reflect the experiences of TGD individuals based in the UK who have lived experience of an eating disorder.

Questionnaire responses were first imported into NVivo 14 (49), sorted by questions, and attributes assigned (these were: age; eating disorder diagnosis; formal diagnosis of eating disorder status; gender identity i.e., trans man, trans woman, nonbinary, genderqueer; gender identity was then categorised to aid analysis: binary trans, nonbinary; neurotype; sex assigned at birth, eating disorder treatment geographical location). To ensure familiarisation, the responses were read several times by each coder. Each coder made notes during this process to capture meaningful and common answers that resonated with the research question. These notes were used to independently generate a list of initial codes. Both coders then met to compare their codes and develop a shared list of codes that could be applied to the data, discussing the meaning of each of these codes to ensure shared understanding. They independently identified data items that represented each of the codes, which were compared and reviewed by the two coders to check understanding and reflect on individual interpretations. Each coder used the shared list of codes to complete coding for half of the responses each. Responses were read and coded for binary trans people and nonbinary people separately, to help identify any meaningful differences in codes or interpretations of codes across each group. The two coders came together to discuss further iterations to the coding after each reviewing 20 participants' responses to each question. Following these changes, the coders communicated throughout the coding process, clarifying any uncertainties regarding data items. Additional codes were added to the shared list when both coders agreed this was necessary.

Upon completion of coding, both coders worked together to group codes into initial themes and subthemes, which were conceptualised within a thematic map. During this process, the coders presented their work to members of the research team at several points and further developed their analysis based on these discussions. The dataset was re-read in its entirety to ensure no meaningful information had been overlooked and a final set of themes that reflected patterns of sharing meaning in the data were produced. Illustrative quotes were selected based on their relevance to the theme/subtheme being described. Efforts were made to select quotes from a diverse range of individuals representing different gender identities, neurotypes and eating disorder presentations. Spelling errors were corrected in the quotes presented for readability.

Reflexivity

Both coders adopt neurodiversity- and gender-affirming frameworks, recognising that neurodivergence and TGD identities are part of natural human variation and valid expressions of human diversity, rather than pathology that require correction. This commitment shapes our language and interpretation when discussing autism, ADHD, and gender diversity. Given our own experiences of eating disorders, we reflected on how the experiences described by participants were similar or different to our own as we coded. We specifically discussed and reflected on our individual gender diverse identities and neurotypes and the impact these had on our interpretations throughout the analysis phase.

Community Involvement

In line with calls from the eating disorder research and clinical community (50), an advisory board formed of 6 TGD and/or neurodivergent people with lived or living experience of an eating disorder advised on the aims of the study, the question relevance, accessibility of the questionnaire, and interpretations of the themes. The advisory board were presented with the initial themes and subthemes generated by the research team and reviewed these as a group to ensure they were appropriate. They also helped shape the interpretations of the themes through conversations with the research team during this meeting. Once the analysis was developed further by the research team, the advisory board members were invited to review the written draft of the results section to ensure the themes and interpretations were accessible, meaningful, and understandable.

Results

Participants discussed a variety of ways their gender diversity and/or neurodivergence intersected with their experience of an eating disorder, including its development and maintenance. All salient points are represented in one theme: ‘Eating disorders function as a way of managing both internal experiences and external challenges’. Within this theme, we discuss four subthemes that represent contributors to distress for TGD and neurodivergent adults with lived experiences of eating disorders: (1) Gaining control in an overwhelming world, (2) Living in a body that does not reflect your gender, (3) Negotiating identity and belonging in a cisnormative and neuronormative society, and (4) The dangers of being visible.

Theme: Eating disorders function as a way of managing both internal experiences and external challenges.

The development or intensification of eating disorder symptoms was commonly described by participants as a way of coping with both internal and external experiences, such as sensory overwhelm and gender dysphoria, as well as traumatic experiences of abuse, bullying, discrimination, emotional neglect, a fear of rejection and lack of belonging. For many participants, identifying with multiple minority and marginalised identities led to unique and intersecting challenges and elevated distress. Eating disorder behaviours were used to cope with and manage distressing feelings through asserting control, harming or punishing oneself, and disconnecting from traumatic memories and experiences:

“OCD, hair pulling and binge eating were all ways to help exist and cope in the world. They helped give structure, order, control and comfort, help to process feelings and experiences. On reflection I feel these were coping mechanisms actually resulting from being both autistic and trans.” [47 yo, Autistic, Trans man, Binge Eating Disorder]

The subthemes that follow provide specific examples of unique and intersecting contributors to distress for TGD people with eating disorders.

Subtheme 1: Gaining control in an overwhelming world

Many participants reported an absence of control to be a particularly distressing experience that was present across many areas of their lives, including sensory experiences, puberty, and executive functioning differences, which contributed to the development and maintenance of their eating disorder.

Routines and predictability around food and eating provided a sense of control and safety during unpredictable stressful life events and life transitions. Many participants explicitly expressed this need for control within the context of their neurodivergence, especially autism:

“I think it is mainly due to control for me. I guess from an autism perspective, struggling with change, lack of control and needing routine are the biggest things for me. Restricting allows me to control something.” [23 yo, Autistic, Trans man, Anorexia Nervosa]

Experiences of being overwhelmed by sensory input when eating, specifically around unpredictable food textures, tastes, and smells, were commonly reported by participants as a distressing experience. This often led to a desire to regain control over sensory experiences by limiting eating to foods that had predictable and tolerable sensory properties and were therefore considered ‘safe’ foods. Sensory differences were amplified for many participants when they were experiencing stressful periods or low mood: “*This is a big factor when I'm stressed or in a depressive episode; I'll barely eat for weeks because textures in my mouth feel wrong (I'm sensitive to grainy food) or because the flavour is... Not good” [25yo, Autistic, Trans man, Self-diagnosed eating disorder].*

Conversely, some participants, especially those with ADHD, identified a sense of emotional comfort from sensory stimulation, primarily through eating foods that were satisfying at a sensory level, such as their taste or texture. This was often in the context of dopamine seeking behaviours: *“…a lot of my eating habits may be influenced by ADHD, by using food as a form of dopamine seeking. I consistently snack on anything sweet or carb-y, and like anything that gives quick hits of flavour.” [23 yo, AuADHD (co-occurring autism and ADHD), Agender, Self-diagnosed eating disorder].*

Some participants described body-oriented sensory differences as contributing to their eating disorder development, such as hypersensitivity to the sensation of touch. These experiences were mostly linked to pubertal changes, often occurring at the intersection of neurodivergence and gender diversity by increasing attention to areas of the body that exacerbated feelings of gender dysphoria: “*I do not like*

feeling my breasts. Weight loss reduced this sensory sensitivity and made my body feel nicer to be in" [35 yo, AuADHD, Gender fluid, Self-diagnosed eating disorder]. Puberty was also described as a particularly distressing experience for TGD neurodivergent (both diagnosed and self-identified) participants due to the many changes that can occur at this time and its often unpredictable nature. These participants described unique challenges associated with this combination of unpredictability, heightened sensory sensitivities, and an increase in gender dysphoria around puberty. For some, this prompted the start of their eating disorder as a way of coping with this intense distress and gaining a sense of control over their body:

"My eating disorder began […] soon after puberty started and my body started changing […] It was a very intense sensory experience, which I now relate also to my being neurodivergent. It wasn't that I wanted my body to develop and change in a different way than it did...I didn't want it to change at all.[…] I had fantasies about carving bits of flesh off in order to return my body to the shape it had previously been." [41 yo, AuADHD, Nonbinary and agender, Anorexia Nervosa]

For some TGD people with ADHD, executive functioning differences led to engagement in maladaptive strategies as a way of imposing control, but for some this also directly contributed to a reduced sense of control. For example, participants described challenges managing their eating due to difficulties remembering to eat, becoming hyper-focused on other activities, and elevated impulsivity. These differences were also compounded by interoceptive differences, such as difficulty in recognising hunger cues. One participant described: *"My time blindness and inability to keep routine make eating regularly quite difficult given the lack of appetite as a reliable cue." [21 yo, AuADHD, Nonbinary, Self-diagnosed eating disorder].* Participants described engaging in binge eating behaviours following periods of not eating, which sometimes led to compensatory behaviours like restrictive eating and excessive exercise due to feelings of guilt and shame.

However, some participants with ADHD framed restrictive eating behaviours as adaptive in the context of their executive functioning differences. In the early stages of their eating disorder, restrictive eating behaviours were a way of regulating attention and providing a sense of control, which was seen as helpful when participants were struggling to focus:

"I am always frantically thinking about so many things at once and it's exhausting. When I started skipping meals during the day my brain felt much more calm and capable of focusing on one thing at a time..." [25 yo, AuADHD, Agender, Anorexia Nervosa]

Subtheme 2: Living in a body that does not reflect your gender

Many participants described experiencing distress due to the incongruence between their gender and the appearance and feel of their body. Eating disorder behaviours, primarily restrictive eating behaviours

and excessive exercise, were described as tools for reducing gender dysphoria and affirming their internal sense of gender.

These experiences differed among gender identities, with trans men and some nonbinary people describing a desire to lower body fat and reduce the appearance of curves and breasts:

"When my anorexia began to progress, it began deconstructing my previously feminine shape. My "curves" became harder. My jawline more masculine. The downy hair I began forming on my face and body at my lowest weight, and loss of period, accidentally gave me gender euphoria…" [34 yo, Autistic, Trans man, Anorexia Nervosa and ARFID]

Gaining weight was also described to be gender affirming through increasing body fat to minimise feminine features: *"… I like appearing round, as it neutralises my body and makes it less feminine." [28 yo, AuADHD, Trans man, Binge Eating Disorder]*, or gaining muscle to create a more masculine physique: *"I wanted to put on muscle and was happy to look bigger as it was in a masculine body shape…." [36 yo, Neurotypical, Trans man and nonbinary, Anorexia Nervosa]*.

Eating disorder behaviours often developed when people were unable to access gender affirming care, such as hormones and surgery, to physically change their body:

"I was also in extreme emotional distress over lack of gender services / not being able to transition and needed a way to express that. My ED symptoms have eased since I was able to access medical and social transition, though they still flare up when I'm distressed or dysphoric." [23 yo, Autistic, Trans man, Bulimia Nervosa]

In addition, some participants described their eating disorder as being driven by a need to cope with gender dysphoria, but that these symptoms were then maintained by neurodivergent-related factors, such as impulsivity and hyperfocus:

"In hindsight a lot of the issues with my body were probably [gender] dysphoria, and I became hyper-focussed on that/food restriction etc." [26 yo, ADHD, Nonbinary, Anorexia Nervosa]

Although gender affirming care was described by many as a facilitator of their eating disorder recovery, for some participants, gender affirming care in isolation was not sufficient for eating disorder recovery and led to an exacerbation of eating disorder symptoms. Participants described specific transition-related challenges to their eating disorder recovery, such as side effects or unintended consequences of gender affirming interventions. For trans masculine people receiving testosterone, weight gain was noted by some as a side effect that exacerbated their eating disorder symptoms: **"***I think if I gain weight my breasts will grow (as I haven't had top surgery) and that's one main aspect of my dysphoria…" [25 yo, AuADHD, Trans man, Self-diagnosed eating disorder]*.

Weight restoration was described by some participants as regaining parts of their body, or bodily functions (e.g., menstruation), that were particularly distressing, exacerbating their gender dysphoria and

negatively impacting on eating disorder recovery:

"Gaining weight in recovery also meant regaining my chest, my hips, and so on. […] not only was I regaining weight, but it felt like I was regaining my femininity. I was no longer hard, sharp angles and flat chested. I was paranoid that I would stop passing." [26 yo, Autistic, Trans man, Anorexia Nervosa]

Subtheme 3: Negotiating identity and belonging in a cisnormative and neuronormative society

This subtheme presents participants' accounts of being different; a persistent and intense feeling that existed across experiences of gender, neurodivergence, and social relationships. These intersected with the development and maintenance of eating disorders as people struggled to achieve a sense of belonging and social acceptance within a society that privileges cisgender and neurotypical experiences and marginalises people who deviate from these norms. They described this as:

"Just feeling out of place, not fitting in, not feeling enough and always felt broken or to be 'fixed' and not okay as I am." [36 yo, Autistic, Nonbinary, Anorexia Nervosa]

Participants described difficulties forming and sustaining relationships with others, particularly in the context of co-occurring autism. Feelings of isolation and loneliness were often exacerbated by a lack of understanding from others, an absence of supportive relationships, and very few TGD and neurodivergent role models. Eating disorders became a way to cope with or express this loneliness, offering a sense of identity, or even community, in the absence of other forms of belonging:

"Autism made (and still makes) it very hard for me to connect with other people, form relationships and sustain friendships. The addiction of the eating disorder and food was a way for me to fill this emotional hole in my life. […] If I had known I was autistic sooner, I might have been kinder to myself." [27 yo, Autistic, Nonbinary, Bulimia Nervosa and Anorexia Nervosa]

Feelings of difference and otherness were further intensified by pressure to conform to expectations of gender and sex assigned at birth, which was a point raised across all gender identities. Participants described feeling pressure to present as a specific version of their gender to be accepted by society, as well as within TGD communities. This was particularly in relation to their body appearance and gender expression, often intersecting with the development of eating disorder behaviours as a way of aligning their appearance with body ideals.

Trans women described experiencing pressures from society to present as an idealised version of a woman to be accepted: *"As a trans woman, I feel probably even more societal pressure to 'fit in' and have an 'ideal' body than most cis-women do."* [44 yo, ADHD, Trans woman, Anorexia Nervosa]. Trans men also reported pressures to conform to idealised expectations of cisgender men's bodies through intensive exercise. This was perpetuated by discourse and attitudes within the trans masculine community: *"Online other trans men are talking about exercise and calorie deficit in the gym and how that can make the*

chest size smaller, this definitely affected the way I perceive myself and that I'm "not putting enough effort into my transition".” [24 yo, AuADHD, Trans man, Self-diagnosed eating disorder].

For nonbinary people especially, they described pressures to align with society’s expectations of androgyny, often through thinness:

“The only available representations of androgyny being those of thin people also formed a link that genderqueer = androgynous = thin […] I often feel that I cannot 'pass' as androgynous and therefore represent myself accurately without significant weight loss.” [31 yo, ADHD, Genderqueer, Self-diagnosed eating disorder]

Nonbinary people also described pressure to align their appearance with binary conceptualisations of gender to be accepted by others, either by distancing themselves from their sex assigned at birth for their nonbinary identity to be acknowledged by others, or presenting as their sex assigned at birth to be accepted: *“I also believed I had to be as traditionally masculine as possible to be taken seriously, like my identity wasn't real unless other people confirmed it...” [21 yo, Neurodivergent, Gender fluid, Bulimia Nervosa and Anorexia Nervosa].* This led to people feeling unable to live authentically as the gender they are, exacerbating gender dysphoria and making it challenging to achieve a sense of belonging and acceptance.

Subtheme 4: The dangers of being visible

This subtheme captures how participants described their eating disorders as a place of safety in response to external threats. For some participants, their desire to change their body was driven by a need to feel physically safer in society, primarily as an adaptive response to previous traumatic experiences. This was often in reference to making themselves appear smaller or less visible, to avoid being targeted: *“Significant trauma throughout my childhood which led me to believe that being smaller would keep me safer and hidden from view.” [28 yo, Autistic, Trans man, Anorexia Nervosa].*

There were some differences in responses provided by people assigned female at birth compared to those assigned male at birth. Those assigned female at birth who contributed to this subtheme mostly identified with nonbinary identities. They described intense discomfort with pubertal changes due to the fear of their body becoming sexualised. This fear contributed to the development of eating disorder symptoms as a way of desexualising their bodies and therefore avoiding sexual attention and objectification from others, particularly men. This overlaps with *Subtheme 1: Gaining control in an overwhelming world*, as participants described a lack of control of these changes led to an increase in their distress. For some participants, they felt safer at a lower body weight, so engaged in restrictive eating behaviours:

“Especially around puberty (but before too) being sexualised and touched without consent added to discomfort around my body so again through losing weight, being smaller or frailer meant I was left alone more [and/or was] *less desirable. There was less to grab so to speak…” [26 yo, Autistic, Nonbinary, Self-diagnosed eating disorder]*

While others described feeling safer at a higher body weight:

"My bulimia at 17 was somewhat about trying to not appear sexual […] As an adult I do feel safer over weight as I feel less likely to be perceived, losing weight feels scary but is also desired." [33 yo, AuADHD, Gender fluid, Bulimia Nervosa]

This was not present in responses from people assigned male at birth. Instead, there was a focus on wanting to feel smaller to be seen as worthy of protection or non-threatening, and in turn reduce the risk of being targeted for physical assault or violence. This was also described as a way of affirming gender for some participants:

"My ED serves as a way to feel smaller, more validated by my gender identity and worthy of protection/not seen as a threat […] Restrictive eating allows me to maintain a body size that people are nicer to me about/see me as more feminine." [22 yo, AuADHD, Trans woman, Self-diagnosed eating disorder]

Discussion

This large-scale qualitative study explored the diverse lived experiences of TGD adults who represented a broad spectrum of TGD identities, neurotypes and eating disorder diagnoses and symptom presentations. Our findings highlight considerable heterogeneity of experiences, with some participants describing their eating disorder as closely intertwined with both their gender identity and neurodivergence, while others described links with either their gender identity or neurodivergence. Central to participant narratives was the eating disorder functioning as a way of managing both internal experiences and external challenges. These included the distress of feeling out of control of internal and external experiences, living in a body that was not reflective of their gender identity, feelings of difference and lacking a sense of belonging, and fear of exposure to discrimination and violence. Together, these themes situate their eating disorders within a complex interplay of sociocultural and interpersonal environments that all impact on experiences of distress and capacity to cope with this distress.

Participants consistently described eating disorder behaviours (e.g., restriction, binge eating, purging, excessive exercise) as efforts to regulate overwhelming internal experiences and manage their responses to external challenges. Research has consistently described eating disorders as adaptive responses to distress and maladaptive emotion regulation strategies, including in recent meta-analyses and systematic reviews (51, 52, 53). Our findings reinforce these patterns but recontextualise them within the unique experiences of TGD neurodivergent people. For example, consistent with prior qualitative studies, many participants described eating disorder behaviours as tools for managing gender dysphoria by suppressing bodily features socially attributed to their assigned sex at birth or accentuating features socially attributed to their gender (11, 13, 54, 55). These strategies were particularly salient when access to gender affirming medical care (e.g., hormones and/or surgery) was delayed or unavailable, reinforcing findings that structural barriers to transition-related care may indirectly exacerbate eating disorder risk among TGD people (56). This is particularly important to note for TGD people who are also neurodivergent, as autistic TGD people can face even greater barriers to

accessing gender affirming care (57, 58, 59). Although not explored in our data, this could suggest that autistic TGD people may be at greater risk of developing eating disorder behaviours as a way of coping with gender dysphoria when gender affirming medical care is delayed or unavailable.

Neurodivergence also played a central role in participants' experiences of distress and coping. Autistic participants frequently described sensory sensitivities, intolerance of uncertainty, and a strong need for predictability and routine, patterns consistent with qualitative research linking autism to restrictive eating patterns and ARFID-like presentations (32, 33). Participants with ADHD more commonly described impulsivity, interoceptive differences, and dopamine-seeking behaviours that contributed to binge eating or irregular eating patterns, extending quantitative and qualitative literature linking ADHD to binge eating and purging behaviours (34, 36, 37). However, participant accounts described a more complex reality than simply aligning neurodivergent traits with specific eating behaviours. For example, some participants with ADHD described restrictive eating as temporarily adaptive for managing attention and cognitive overload, illustrating how eating disorder behaviours may be reinforced by short-term functional benefits. Interoceptive differences were also described as contributing to both restrictive and binge eating behaviours, consistent with recent qualitative findings (36). Taken together, these findings highlight the need to move beyond rigid diagnostic frameworks and to recognise the nuanced and multifaceted nature of eating disorders among TGD neurodivergent people.

Puberty emerged as a critical period of vulnerability for developing eating disorders for some participants, in line with research from cisgender populations (60). However, we found this to be particularly the case for neurodivergent TGD people. Rapid and unpredictable bodily changes intensified sensory experiences, and emerging gender dysphoria often occurred in the absence of appropriate language to describe their feelings or experiences, or necessary support. Eating disorder behaviours developed as a way of coping with this intense distress, often by attempting to halt pubertal changes. These findings align with previous qualitative research describing 'sensory dysphoria', where autistic individuals with gender dysphoria describe heightened sensory sensitivity to be exacerbated by bodily changes associated with one's assigned sex e.g., menstruation and growing facial hair (61, 62). Our findings, together with those from Cooper, Mandy (61), suggest puberty-related distress and its relation to eating disorder behaviours appears to be shaped by the intersection of gender diversity and neurodivergence, rather than by either identity alone.

Participants' accounts highlight the complex and dynamic relationship between gender affirming medical care and eating disorder trajectories. Although empirical research shows that access to gender affirming hormones and surgery is associated with improved mental health and reduced gender dysphoria for many TGD people (63), the present findings indicate that such care does not uniformly resolve eating disorder symptoms. For some transmasculine participants, transition-related weight changes contributed to the re-emergence of eating disorder behaviours. These patterns align with a recent systematic review and meta-analysis (64), which suggests that while gender affirming medical care can facilitate recovery, it may also introduce new challenges that require ongoing psychological and social support. Additional evidence from electronic medical record data likewise shows divergent risks:

transfeminine people (TGD people whose gender identity and presentation is primarily feminine and can include trans women, nonbinary, and gender diverse people) receiving gender affirming hormones appear to have an elevated risk of developing eating disorders compared to those without intervention, whereas transmasculine individuals (TGD people whose gender identity and presentation is primarily masculine and can include trans men, nonbinary, and gender diverse people) appear to have a reduced risk (65). Together, these findings caution against simplistic assumptions that eating disorders among TGD people are solely or always driven by gender dysphoria. Indeed, some participants described their eating disorder as only partially, or not primarily, related to their TGD identity. They also reinforce the importance of continued access to psychological and social support after commencement of gender affirming medical interventions.

People assigned female at birth, particularly those who identified with nonbinary identities, described the risks of being visible in society. In line with a recent qualitative study with nonbinary people (66), several nonbinary participants in our study wanted to desexualise their bodies to avoid sexual attention and objectification. For people assigned male at birth, they instead spoke about wanting to feel smaller to be seen as worthy of protection. Experiences of objectification and discrimination have also been linked to internalisation of societal appearance ideals and disordered eating in trans women (67), trans men (68), and cisgender women (69), suggesting this experience is not unique to nonbinary people. Several participants explicitly linked eating disorder behaviours to experiences of abuse, harassment, or anticipated harm, consistent with empirical research connecting trauma exposure and post-traumatic stress to eating disorder development in LGBTQ+ individuals (70) and the general population more widely (71). Within this context, altering body size or shape can be understood as a safety-seeking behaviour aimed at reducing vulnerability to future harm. Importantly, the type of eating disorder behaviours people engaged with varied across participants, highlighting that eating disorder behaviours were not driven by a singular aesthetic ideal e.g., thinness. Eating disorder behaviours functioned as strategies for modulating visibility, making the body less sexualised, less threatening, or more acceptable within cisnormative frameworks.

From a minority stress perspective, chronic exposure to cisnormative and neuronormative expectations functioned as an ongoing source of distress (18, 19). TGD autistic participants described chronic feelings of social isolation, loneliness, and difference that were exacerbated by a lack of understanding and acceptance from others. Holding multiple minoritised identities may increase vulnerability to developing eating disorders due to exposure to minority stressors specific to TGD, autistic, and ADHD identities. Prior quantitative research taking an intersectional approach has found people with multiple minority identities to be at disproportionate risk for eating disorders, including sexual minority individuals (i.e., those who do not identify as heterosexual) of lower socioeconomic status and multiracial groups (72, 73). For some participants in our study, eating disorder behaviours offered identity, structure, or community in the absence of supportive relationships, including relationships with people who have shared experiences. This echoes broader findings that eating disorders can become integral to an individuals' sense of self and identity (74, 75, 76, 77), as well as increase feelings of self-worth, achievement and success (78, 79). Furthermore, participants described pressures to conform to

narrow gendered body ideals to be recognised as legitimate and accepted, both within broader society and within TGD communities. Empirical research has similarly documented heightened appearance-related scrutiny, pressure to pass, and societal acceptance contingent on meeting cisnormative expectations (7, 10, 12, 80). Furthermore, autistic people and people with ADHD also report engaging in identity management in the form of masking behaviours (sometimes referred to as camouflaging), as a way of suppressing neurodivergent characteristics to fit in with others and/or avoid stigma (81, 82, 83).

Strengths and Limitations

This study demonstrates the value of large-scale qualitative methods for exploring intersectional experiences that are challenging to capture using quantitative designs alone. It is particularly useful in under-explored areas, such as eating disorders in TGD and neurodivergent people, where hearing a range of diverse voices is important for identifying unanticipated avenues for future research (84). Furthermore, reflexive thematic analysis enabled an in-depth examination of shared patterns while retaining sensitivity to heterogeneity within the data (84). As a result, our analysis highlights the complexity of the eating disorder experience and the need to go beyond mainstream narratives in the general public which frame eating disorders as a mechanism for control (85).

Although our sample represented a diverse spectrum of gender identities, neurotypes and eating disorder presentations, we faced difficulties recruiting people assigned male at birth. This is a challenge reported in other studies examining eating disorders in TGD people (86, 87), and requires consideration in future research due to the differences of experiences between people assigned female and male reported in our study. Similarly, the number of neurotypical TGD participants in our study was small in comparison to the number of neurodivergent TGD participants. This limited the representation of the experiences of eating disorders in TGD people who are neurotypical. Although autism and ADHD (self-identified or formally diagnosed) were not required for participation, the recruitment process explicitly referenced the aim to examine relations between gender identity, neurodivergence, and eating disorders. This may have introduced self-selection bias, whereby autistic people and people with ADHD were more likely to participate, potentially leading to an overrepresentation of these experiences.

Future studies could build on these cross-sectional findings by exploring longitudinal trajectories of eating disorders across different stages of gender exploration and transition, particularly during puberty and early adulthood. There is also a need for research that examines how TGD people who are neurodivergent or neurotypical access and experience eating disorder services. This may provide a deeper and broader understanding of how these services may mitigate or exacerbate distress for TGD people with eating disorders, including barriers to accessing integrated and affirming care, and the role of neurodivergence.

Clinical implications

Our findings highlight heterogeneity of experiences within our sample of TGD adults and underscore the need for eating disorder services to adopt formulation-driven, intersectional approaches that consider

the contribution of both neurodivergence and gender diversity when supporting TGD individuals. Standard assessment tools that privilege weight and shape concerns may fail to capture the functional motivations underpinning eating disorder behaviours in TGD and neurodivergent people, including the individuals' gender diverse identity and profile of neurodivergent traits. This may increase the risk of misdiagnosis, ineffective support and/or disengagement from care.

Although gender affirming medical care was a necessary component of eating disorder recovery for many participants, our findings suggest that this is not sufficient for resolving eating disorder symptoms in isolation. Eating disorder treatment should also consider broader mental health and neurodivergence, as well as the impact of compounding minority stress and experiences of trauma. For example, interventions that seek to reduce overevaluation of weight and shape concerns require other aspects of self-evaluation to be bolstered e.g., one's value as a friend, partner, family member, and/or member of society. Our findings highlight sociocultural challenges which may make forming a positive social role particularly difficult for TGD and neurodivergent people. These barriers have implications for the support provided by clinicians, which should be tailored to the individual and their needs.

In line with other researchers, we support the need for comprehensive information on the potential side effects of gender affirming hormones on body shape and appetite to be clearly communicated, e.g., weight gain and increase of appetite (55, 88). Furthermore, TGD people who are experiencing weight restoration require tailored support as gaining weight can lead to regaining gendered parts of their body or bodily functions that the eating disorder has previously reduced or erased. This may also be particularly important for neurodivergent TGD people, who may find the unpredictable nature of transitioning to be a source of emotional overwhelm and distress (61).

Previous research with both TGD and autistic populations with eating disorders has reported negative experiences, including iatrogenic harm, when accessing treatment, particularly cognitive behavioural therapy (31, 89, 90, 91) and exposure therapies (92). For example, traditional eating disorder treatment methods that focus on body positivity and acceptance could be harmful for some individuals who experience their body discomfort as directly related to their gender identity, if gender related needs are not sensitively considered and included in the formulation (9). Clinicians should be aware that body checking behaviours, often targeted during eating disorder interventions, may not be focused solely on indicators of body weight and fat in TGD people, but also indicators of gender signifiers. The concept of body neutrality has been recommended as an alternative goal for TGD people that focuses on the functionality of the body, rather than the appearance (9). Gender affirming eating disorder interventions may also focus on supporting the individual in managing their distress tolerance and adaptive coping strategies while exploring gender affirming medical interventions, requiring integrated care from multiple services (89). Although research describing the eating disorder treatment experiences of people with ADHD is limited, recent qualitative evidence suggests an increased need for compassionate and tailored care that validates neurodivergent experiences (36). This may be achieved through neuro-affirming adaptations to treatment, such as sensory-informed meal planning, flexible routines, and explicit support with interoception and executive functioning.

Conclusion

Eating disorders among TGD and neurodivergent adults cannot be understood in isolation from the broader social, cultural, and relational contexts in which they emerge. The desire to belong, to be seen, understood, and accepted, was often met with exclusion and invalidation. Eating disorder behaviours, in this context, were not simply about body shape and weight, but about navigating a world that felt fundamentally mis-attuned to their needs and identities. Addressing eating disorders in these populations requires approaches that extend beyond symptom reduction to engage with identity, sensory and executive functioning differences, and the broader sociocultural conditions that render disordered eating meaningful and adaptive coping strategies.

Declarations

Ethics approval and consent to participate

The project received ethical approval from the Cardiff University School of Psychology Ethics Committee (EC.24.11.12.7066A). Informed consent was obtained online from all participants before participating in the study.

Consent for publication

Consent for publication was obtained from all participants regarding the dissemination of de-identified quotations.

Availability of data and materials

Due to the sensitive nature of qualitative data and to protect participants' privacy, participants' data are not publicly available.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

KT led the study, including conceptualisation, funding acquisition, project management, and manuscript drafting. KC and CJ provided joint mentorship to KT during the research. All authors were involved in designing the study. Recruitment and data collection were conducted by KT, GW, and MK. KT and MK analysed the data and received critical feedback from all authors throughout the research process. The

LEADING Lived Experience Advisory Group comprises individuals with lived experience who contributed to the research design, analysis, and interpretation. Some members chose to be named as an individual author. All authors read and approved the final manuscript.

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