

# Unheard voices: The impact of the COVID-19 pandemic on disordered eating in people with marginalized identities: Commentary on Devoe et al. (2022), Linardon et al. (2022) and Schneider et al. (2022)

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## Abstract

Reviews by Devoe et al. (2022), Linardon et al. (2022), and Schneider et al. (2022) illustrate the profound impact the COVID-19 pandemic has had on people with eating disorders (EDs) or disordered eating (DE) and their families. However, there is a dearth of research on how the pandemic has affected individuals with marginalized identities, who have been historically underrepresented in ED/DE research. The few studies conducted to date suggest that people with marginalized identities, including people of color, LGBTQ + people, women, and people experiencing socioeconomic disadvantage, may have had even greater increases in EDs/DE than people without marginalized identities. In this Commentary, I discuss who is missing from research on EDs/DE during the COVID-19 pandemic, strategies for breaking down barriers to participation in research for diverse groups, and the implications of existing research findings for people with marginalized identities. Improved measurement of salient aspects of participants' identities and increased recruitment and retention of participants from diverse backgrounds is necessary to more fully understand the impact of the COVID-19 pandemic on all people affected by EDs and DE. Concurrently, increased access to affordable and culturally sensitive care is urgently required to meet the extensive treatment needs already documented

## KEYWORDS

COVID-19, disordered eating, eating disorders, ethnicity, gender, identity, race, socioeconomic status, underrepresented

“We are in the same storm, but not in the same boat.”— Damian Barr

The three reviews in this special issue (Devoe et al., 2022; Linardon et al., 2022; Schneider et al., 2022) illuminate the profound impact the COVID-19 pandemic has had on people with eating disorders (EDs) or disordered eating (DE; i.e., distressing symptoms such as binge eating or body dissatisfaction) in Western countries (unfortunately, research in non-Western contexts remains limited). The storm of the pandemic has brought with it increased stress, isolation, anxiety, body image

concerns, and both DE and EDs that have led to a dramatic increase in hospitalizations for adults and youth (Devoe et al., 2022). Yet, the impact of the pandemic has not been equally distributed. Emerging research highlighted in these three reviews suggests that people with marginalized identities (e.g., LGBTQ + individuals, people of color) and preexisting stressors such as socioeconomic disadvantage may have been affected particularly profoundly. For example, both Schneider et al. (2022) and Linardon et al. (2022) found that people facing food insecurity or broader financial stressors were more likely to experience increased DE during the pandemic. Because stress is a well-

documented risk factor for EDs and DE, it is not surprising that people undergoing financial hardship during the pandemic would experience the greatest increases in DE. People facing financial stressors may have also experienced fewer reported benefits of the pandemic, such as increased time for self-care. Similarly, Schneider et al. (2022) reported that people of Asian heritage with EDs reported higher psychological distress during COVID-19, which could in part reflect increased discrimination and hate crimes against this group (see Supplemental Material for additional resources addressing this issue). These are important findings that can help guide screening and treatment to ensure we are reaching all individuals in need of care, many of whom do not fit the historical white, wealthy, cisgender/heterosexual stereotype of those affected by EDs/DE.

Concurrently, and as highlighted by Schneider et al. (2022), there is much we still do not know regarding the impact of the pandemic on people with marginalized identities. Partially, this is a measurement problem—specifically, what has not been measured and what we do not know about the identities of those participating in research on EDs/DE. In all three reviews, only a minority of studies (~25% to 43%; Devoe et al., 2022; Linardon et al., 2022; Schneider et al., 2022) reported participant demographics such as race/ethnicity, with even fewer reporting sexual orientation or socioeconomic status. When demographic characteristics were reported, individuals with marginalized identities tended to be lumped together (e.g., analyzing all non-white participants as one group), obscuring potential differences across groups (Schneider et al., 2022). Notably, insufficient measurement and reporting of participant demographics is not specific to research conducted during COVID-19, but is an ongoing problem in the ED/DE literature (Mikhail & Klump, 2021; see Supplemental Material for additional citations). Categories such as race/ethnicity are socially based, and different identities may be salient in different contexts. Different cultural settings also have different norms around soliciting information about race/ethnicity (e.g., in the US versus Europe). Questions around demographic characteristics should themselves be culturally sensitive and modified to fit the cultural context in which the research is being conducted (for example, it may be more appropriate in some cases to ask about nationality rather than race/ethnicity; see Supplemental Material for additional references). Nevertheless, we must obtain a greater understanding of who is participating in research to understand where improvements in recruitment are needed and prevent inappropriate generalization of findings. Fortunately, recent updates to reporting guidelines for the *International Journal of Eating Disorders* (e.g., requirements to report age, sex and/or gender, and racial/ethnic/national background) and other journals will help support these needed advances through the remainder of the COVID-19 pandemic and beyond (see Supplemental Material for other examples of inclusive reporting guidelines).

Equally important to improving reporting of demographic characteristics is ensuring that research opportunities are accessible to the full population of individuals with EDs/DE, including those with marginalized identities, those from non-Western countries, and those with socioeconomic or other stressors. Nearly all studies on COVID-19 and EDs/DE have been conducted in Western countries, limiting

our understanding of how the pandemic has impacted people in other regions of the world. Among the studies that reported participant demographics, most participants were white, socioeconomically advantaged, cisgender/heterosexual, and female, with limited representation of participants with other identities (Devoe et al., 2022; Linardon et al., 2022; Schneider et al., 2022). Relatedly, attrition rates were greater for participants with marginalized identities (Schneider et al., 2022), a result that replicates findings on research in the ED field prior to the pandemic (Mikhail & Klump, 2021). Barriers to participation for marginalized and historically underrepresented groups are multilayered, encompassing logistical barriers (e.g., lack of childcare, limited time for completing lengthy assessments), lack of trust in researchers and the research process (linked in part to historical abuses of marginalized groups in research; e.g., the Tuskegee syphilis study – see Supplemental Material for more on the impact of such abuses), lack of recruitment, outreach, or communication, misalignment between community research priorities and study questions chosen by researchers, stigma, and inadequate cultural sensitivity throughout the research process (Erves et al., 2017; see Supplemental Material for additional references). There may be additional ED specific barriers (e.g., lack of recognition of EDs/DE in people with marginalized identities), but there is currently little research on this issue in the ED field. Many barriers were likely exacerbated during COVID-19, which may have amplified logistical barriers and curtailed efforts at community outreach and engagement (though notably, moving to online research designs may have enabled greater participation in some cases).

The ED field must begin to research and implement strategies for breaking down these multiple barriers for participation to ensure that the voices of all people with EDs/DE are heard in future research, including ongoing research regarding the consequences of the pandemic. This may include partnering with community organizations in marginalized communities to help build trust and increase awareness, structuring study visits to reduce logistical barriers (e.g., offering childcare or transportation vouchers, continuing to offer remote study options and study sessions outside of typical working hours), and actively engaging individuals from marginalized communities with lived ED/DE experience to understand their experiences of the pandemic and research priorities. Qualitative/mixed methods and community-based participatory research (CBPR) methods that include community members as co-creators of knowledge may be particularly fruitful (see Supplemental Material for more on these methods).

As research on EDs in marginalized populations expands, researchers must carefully consider the framing of research questions and pay attention to structural factors that may inform findings. Research on differences across groups often stops at a purely descriptive level (e.g., “group A was different than group B”). However, it is important to go further to understand why such differences exist, particularly contextual factors that may shape risk and resilience. For example, both Linardon et al. (2022) and Schneider et al. (2022) found that women were at greater risk for increased DE during the pandemic than men. Many potential factors could contribute to this finding, including greater appearance-related pressures for women, but also greater childcare responsibilities and related stressors during

school closures, higher rates of job loss, and more frequent employment in essential jobs associated with elevated infection risk (e.g., nursing). Such structural factors may have even more strongly impacted women facing other forms of marginalization, such as financial hardship or racial discrimination. Similarly, Schneider et al., (2022) found that LGBTQ+ individuals reported increased stress and DE during the pandemic if they lived with family members who did not accept their identity, but more positive experiences if they could freely explore their identity and expression. These examples illustrate how observed group differences can result from prejudice, minority stress, unequal access to resources, and unequal social/economic burdens rather than from intrinsic qualities of people with marginalized identities. It is vital to consider these kinds of contextual factors to avoid reliance on stereotypes and deficits-based explanations that may increase stigmatization of marginalized groups and incorrectly attribute group differences to identity rather than contextual stressors.

As emphasized by Schneider et al., (2022), attention should also be paid to intersectionality and the ways in which stressors that can increase risk for EDs/DE may be magnified for those with multiple marginalized identities. For example, weight stigma stemming from public health messages around pandemic-related weight gain could be particularly detrimental for those with multiple marginalized identities, including women experiencing socioeconomic disadvantage and women of color (see Supplemental Material for references regarding the intersectional impact of weight stigma). Finally, it is important to consider strengths and resilience factors that may buffer against EDs/DE in marginalized groups, rather than only focusing on vulnerabilities. For instance, Schneider et al., (2022) highlighted a finding that Black participants with EDs reported less psychological distress and loneliness during the pandemic. This may reflect strengths such as robust family connections and networks of social support, while not negating significant stressors such as discrimination/prejudice faced by many Black individuals.

One final finding worth emphasizing for its special relevance to marginalized groups is the increase in barriers to treatment during the pandemic described in all three reviews. Even among the relatively advantaged populations included in most studies, participants reported difficulties finding professional ED care, treatment delays, and technical issues with remote treatment. These barriers were likely amplified for people with marginalized identities, especially individuals experiencing financial stress who may have been unable to afford treatment (particularly in countries such as the US where insurance constraints and the frequent need to pay out of pocket are often considerable impediments). Though moving to online treatment may have improved access for some (e.g., people living in remote areas with few ED specialists), exclusively virtual treatment may have also been a barrier for people with limited access to the internet or a private space for therapy. While continuing to offer online treatment is an important strategy for increasing access for marginalized populations, some individuals may have been reluctant or unable to seek care virtually, underscoring the importance of offering treatment through a variety of modalities once safe. More generally, additional work is needed to increase the availability of affordable care and improve awareness and

ease of accessing treatment for people regardless of their identity, financial means, or country of residence. The suggestion by Linardon et al. (2022) to develop a centralized system to help people navigate treatment options and insurance barriers is one strategy that may be effective in increasing knowledge of and access to care. Partnering with primary care physician's offices or other community health providers could also help ED specialists reach more diverse communities and decrease treatment delays. Beyond reducing barriers to initially seeking care, clinicians must also develop the skills necessary to demonstrate cultural sensitivity and respect for the nuances of clients' identities and sociocultural backgrounds, including how these may influence their experience of their ED, the pandemic, and treatment. Cultural humility, or awareness that each person has a unique cultural experience and cultural learning is a lifelong process, is key to developing welcoming practices.

The COVID-19 pandemic has presented many challenges for people living with EDs/DE and their families. While research on EDs/DE in diverse populations during the pandemic is still sparse, initial findings from systematic reviews suggest that the impact of COVID-19 may have been especially pronounced for those with marginalized identities. Risk factors for EDs/DE in non-pandemic times, including food insecurity, stress, discrimination, and weight stigma, may have been magnified among those with marginalized identities during COVID-19, leading to greater increases in EDs/DE and associated distress. Nevertheless, much regarding the impact of the pandemic on EDs/DE in marginalized populations remains unknown. More consistent measurement of participants' identities, more (and more nuanced) research on the impact of the pandemic on those holding marginalized identities, and, above all, more efforts to increase access to high quality, culturally sensitive, and affordable care for people from all backgrounds are needed.

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#### SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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