EATING DISORDERS IN TRANSGENDER AND GENDER DIVERSE INDIVIDUALS AND

RECOMMENDATIONS FOR MENTAL HEALTH PROVIDERS

by

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Submitted to the Psychology Department
School of Natural and Social Sciences
in partial fulfillment of the requirements
for the degree of Bachelor of Arts

Purchase College
State University of New York

May 2022

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Introduction

Previous research on eating disorders has mainly focused mainly on the cisgender female population, as they were thought to be at highest risk. However, more recent literature observes transgender, and gender diverse (TGD) individuals face significantly higher rates of eating disorders (EDs), and face unique challenges when it comes to the recognition of illness and ability to find treatment (Diemer et. al., 2015, Duffy et. al., 2016, Gordon et. al., 2016, Kamody et. al., 2020, Nagata et. al., 2020, Peterson et. al., 2020, & Romano & Lipson, 2021, Testa et. al., 2017). The intersection of gender identity and body image may intensify challenges around treatment and diagnosis for these individuals. In addition, disordered eating behaviors (DEBs) can be magnified by societal stigmas, lack of social/family support, and lack of gender affirming resources (Nagata et. al., 2020). The goal of this research is to investigate ways in which transgender and gender diverse individuals engage in disordered eating behaviors, as well as exploring the relationship between gender dysphoria and disordered eating. There is an existing gap in knowledge between the fields of eating disorder treatment and transgender healthcare. This research aims to bridge the gap between the fields and provide recommendations to healthcare professionals when caring for TDG individuals.

Research on the Prevalence, Specific Nature and Treatments of Eating Disorders in Transgender and Gender- Diverse Adults and Adolescents

Through an extensive literature review, the primary goal of this research is to advocate for ways in which transgender people may struggle with disordered eating in addition to providing clinical recommendations when treating this population. While there are inconsistencies when it comes to specific rates, most research supports that transgender individual are at highest risk for developing an ED. For instance, the largest quantitative study

on eating disorders in the transgender community found that transgender people are over eight times more likely than heterosexual cisgender women to have been diagnosed with an eating disorder in the past year (Diemer et. al., 2015). Additionally, a recent study done in Canada found that 48% of transgender adolescents experience disordered eating behavior (Romito et. Al., 2021). A study done in 2020 found that, about 70% of TG and GNC adult participants reported dissatisfactory eating habits, and 62% reported basing their self-worth on the status of their weight. (Parker & Harriger, 2020).

Transgender youth with the diagnosis of gender dysphoria often report higher levels of body dissatisfaction, weight and shape concerns, and disorders eating compared to cisgender counterparts (Peterson, et.al., 2020). Gender dysphoria is the feeling of body and social distress when one's gender identity does not match their assigned sex at birth and is characterized by preoccupation with unwanted secondary sex characteristics (Parker & Harriger, 2020). Additional risk factors that increase vulnerability to clinical eating disorders in transgender adults include: not being on HRT, anxiety, perfectionism, low self-esteem, identification as a sexual minority, social distress, body surveillance, sexual objectification, sociocultural beauty standards (Peterson, et.al., 2020). The following studies reflect the prevalence of EDs in TGD individuals, the effects of dysphoria and gender affirming surgeries, and tools for assessing EDs.

Large Scale Quantitative Research Designs

In 2015, Diemer and colleagues conducted the largest quantitative study comparing the rates of eating disorders in gender and sexual minorities to their heterosexual cisgender counterparts. By using a large-scale database, the findings of this study can be used as a foundation to make further predictions and generalize the results to the general population of gender and sexual minorities. Although this study investigated both gender and sexual

minorities, the current research will be focusing on the results about gender minorities, that is, transgender and gender diverse individuals.

The participants in this study consisted of 289,024 college students from 229 different universities participating in the American College Health Association's National College Health Assessment (ACHA-NCHA) (Diemer, et.al., 2015). About 0.17% (n=479) participants identified as transgender (Diemer, et.al., 2015). In order to examine the relationships between gender, sexual minority and EDs, the study analyzed: the rates of self-reported eating disorders (SR-ED) in the past year, the past month's use of diet pills, laxatives and vomiting. They were assessed across seven groups: transgender, cisgender homosexual men, cisgender heterosexual men, cisgender men questioning their sexuality, cisgender homosexual women, cisgender heterosexual women, and cisgender women questioning their sexuality.

Table 1

Prevalence of self-reported past-year eating disorder diagnosis and past 30-day compensatory behaviors by gender identity and sexual orientation and results from logistic regression models

	Past-year eating disorder diagnosis (N = 4,384)		Past-month diet pill use (N = 10,085)		Past-month vomiting or laxative use (N = 8,054)	
	%	OR (95% CI)[a]	%	OR (95% CI)	%	OR (95% CI)
Transgender	15.82	**4.62 (3.41–6.26)**[A]	13.50	**2.05 (1.48–2.83)**[A]	15.01	**2.46 (1.83–3.30)**[A]
Cisgender sexual minority men	2.06	**1.45 (1.28–1.65)**[B]	4.16	.92 (.83–1.02)[B]	3.69	1.04 (.95–1.14)[B]
Cisgender unsure men	3.66	**1.54 (1.13–2.09)**[B]	4.68	.91 (.71–1.17)[BD]	3.58	.77 (.58–1.02)[C]
Cisgender heterosexual men	.55	**.27 (.24-.30)**[C]	1.88	**.39 (.37–.42)**[C]	.67	**.15 (.14–.17)**[D]
Cisgender sexual minority women	3.52	.89 (.73–1.08)[D]	5.11	**.74 (.65–.85)**[D]	5.24	**.72 (.62–.84)**[C]
Cisgender unsure women	2.97	**1.40 (1.14–1.73)**[B]	3.86	**.80 (.69–.98)**[BD]	5.41	**1.35 (1.14–1.61)**[E]
Cisgender heterosexual women	1.85	1.00 (referent)	4.29	1.00 (referent)	3.71	1.00 (referent)

Values in bold type are statistically significant ($p < .05$).
OR (95% CI) with different superscripts within columns differ significantly from one another ($p < .05$) in pairwise comparisons.
OR = odds ratio; CI = confidence interval.
[a] OR with 95% CI adjusted for age, race/ethnicity, binge drinking, cigarette use, stress, college athletic participation, and fraternity/sorority membership.

The Diemer study found that 1.52% of the sample reported being diagnosed with ED in the past year, 2.79% reported vomiting or laxative use and 3.49% reported the use of diet pills (Diemer, et.al., 2015). In contrast, 15.82% of transgender students reported being diagnosed with

ED in the past year, 13.50% reported vomiting or laxative use, and 15.01% reported the use of diet pills. This is consistent with previous research in that eating disorders are more prevalent among people with transgender identities. Refer to table 1 for specific results.

In a more recent correlational study, Romano and Lipson evaluated relationships among weight misperception, thin-ideal overvaluation and eating disorder symptoms in transgender and nonbinary (TNB) young adults (Romano & Lipson, 2021). Weight misperception refers to inconsistencies between one's self-assessed weight status and actual weight status. This is often associated with ED symptoms which include food restriction and compensatory behaviors (i.e. vomiting, over-exercise etc.,). The purpose of this study was to further understand the association between ED and perceptual and cognitive-affective body image constructs. TNB individuals may be drawn to maladaptive behaviors to reduce inconsistencies between one's actual and ideal bodily states by preventing the development of undesired body characteristics.

Participants in this study consisted of 3,371 adult students from 78 campuses who identified as trans men, trans women, or NB. The results showed 35.04% of participants had an ED, 10.46% self-reported a lifetime ED diagnosis, and the average positive mental health score was 37.98%.

A structural equation model (SEM) was used to examine whether positive mental health is linked with ED symptoms (Romano & Lipson, 2021). Participants with weight over perception and thin-ideal overvaluation were more likely to exhibit ED symptoms and had lower positive mental health than those who accurately perceive their weight status. Individuals with weight under perception were less likely to exhibit ED symptoms but was not linked with positive mental health. The findings in this study suggest that further assessment is needed for the design of prevention programs for this population.

Effects of Gender Affirming Treatments

While not all transgender people wish to undergo a medical transition, many of those who do, feel their life is threatened if they do not receive treatment in a timely manner (Testa, et.al., 2017). The importance of access to gender confirming medical interventions (GCMIs) is outlined in a quantitative study assessing GCMIs and ED symptoms in transgender individuals. Positive correlations were found between affirmation of gender and body satisfaction, which is negatively correlated with disordered eating.

Previous studies have found that both trans feminine and trans masculine individuals exhibit higher levels of disordered eating than cisgender individuals, but not as high as clinical ED patients (Testa, et.al., 2017). Trans feminine individuals may restrict eating to achieve thin ideals that align with societal standards of femininity, while trans masculine individuals may restrict eating in attempts to conceal hips and breasts or to induce amenorrhea. Not all trans people experience elevated dysphoria and the need to undergo GCMIs. However, GCMIs are often successful in reducing symptoms of gender dysphoria related to specific body parts. These interventions include, but are not limited to: hormone therapy, genital reconstruction, chest surgery, hysterectomy, and hair removal.

Elevated risk of disordered eating. may be attributed to body dissatisfaction and/or societal reactions to nonconforming gender expressions (being misgendered, incorrect pronoun use etc..,) (Testa, et.al., 2017). A recent study found that participants who identify on the transfeminine spectrum (TFS) often experienced dissatisfaction with sex-specific body characteristics while participants on the transmasculine spectrum (TMS) often experienced dissatisfaction with all body parts.

Body dissatisfaction may be attributed to the way one is perceived in society (Testa, et.al., 2017). Individuals whose physical features are not in line with society's perception of a particular gender are often at risk for negative social consequences. These negative consequences may result in excessive misgendering and external stressors that do not affirm one's gender, as well as discrimination and victimization. Visible gender nonconformity may elevate one's risk of gender minority stressors, which are associated with negative mental health and suicidality.

Testa et. al., examines EDs and GCMIs in individuals on the TFS and TMS and to assess the relationship between GCMIs and EDs, with body dissatisfaction and affirmation to one's gender (Testa, et.al., 2017). Data from this study was collected from the Trans Health Survey and used a convenience sample of transgender individuals who indicated a desire to access or have already accessed GCMIs. There were 442 participants meeting the criteria for the sample (154 TFS, 288 TMS). GCMIs measures include: genital surgery, chest surgery (removal or enhancement of breast tissue), hysterectomy, hair removal, and hormone therapy (testosterone, estrogen, or progesterone). Participants responded whether they have done this, consider doing it, or have no interest. Nonaffirmation to gender identity was measured using a six-item self-report, Body satisfaction was measured using a 9-item Body Areas Satisfaction Scale (BASS), and EDs were measures using the Eating Attitudes Test (EAT-26), a 26-item self-report measure of behaviors and thoughts related to ED diagnosis.

The results showed that 23 % of TFS and 22% of TMS experience clinical levels of EDs according to the EAT-26 (Testa, et.al., 2017). Younger TMS reported higher levels of EDS but there was no difference in age for TFS. Participants with lower SES reported higher levels of EDS. Utilization of GCMIs was indirectly associated with a lower ED rate through affirmation of gender and increased body satisfaction. Genital surgery, hormone therapy, and hair removal

for TFS, and genital surgery, chest surgery, hormone therapy, and hysterectomy for TMS was associated with lower levels of EDS through decreased nonaffirmation, leading to increased body satisfaction.

The findings of this study support Testa's hypothesis that GCMIs may reduce the nonaffirmation of gender, which increases body satisfaction, and decreases disordered eating. For TFS chest surgery and body satisfaction alone, lower ED levels (Testa, et.al., 2017). This suggests that affirmation from others is not always necessary to increase body satisfaction. These results do not reflect the entire transgender population, as this study was based on a convenience sample of trans individuals who desire or have had access to GCMIs. Demographic limitations should be considered for the results, as many participants were young and white.

The Eating Disorder Examination Questionnaire

Recent literature observes transgender and gender diverse individuals to be at higher risk for EDs and may face unique challenges when it comes to recognition of illness and ability to find treatment. Nagata et. al., evaluates possible patterns or differences of disordered eating behaviors in transgender individuals, using the Eating Disorder Examination Questionnaire (EDE-Q). The EDE-Q is a 28-item, self-report questionnaire that measures DEB and assess the range and severity through 4 subscales: restraint, eating concern, shape concerns, and weight concerns. The global score is interpreted as the mean of the 4 scales. The prevalence of binge eating, and compensatory behaviors were evaluated by the number of occurrences in the previous month. The EDE-Q was designed based on ED behaviors norms in cisgender populations. This study postulates that ED behavior norms are more complex in transgender individuals and highlights the need for more research on effective ways to measure EDs in transgender individuals.

Participants included 312 FTM and 172 MTF adults from an existing PRIDE survey database (Nagata, et. Al., 2020). The results found, significant positive correlations between BMI and all subscales (weight concern, eating concern, shape concern) except restraint (table 2). Global scores were also positively correlated with BMI in both transgender men and women. 10.6% of trans-masculine participants reported having an ED diagnosis (4.2% anorexia, 3.2% bulimia, 1.6% Binge-eating disorder, 5.1% unspecified), while 8.1% of trans-femme participants reported having an ED diagnosis (4.1% anorexia, 2.9% bulimia, 1.7% binge eating disorder, 1.8% not specified). Shape concerns are found to be the most prevalent EDE-Q subscale among transgender men (27%) and women (28%). Dietary restraint is the most prevalent DEB in transgender men (24%) and transgender women (28%), followed by binge eating (11% and 13%, respectively). For more statistical information, refer to table 2.

Table 2

Comparisons of eating attitudes and disordered eating behaviors in a subsample of transgender men 18–26 years old (n = 143) and transgender women 18–42 years old (n = 109) in The PRIDE Study to age-matched cisgender[ˆ] men from the Lavender et al. (2010) sample (N = 404) and cisgender[ˆ] women from Mond et al. (2006) sample (N = 5231).

Eating attitudes	Transgender men from The PRIDE Study	Cisgender[ˆ] men from Lavender et al. (2010)	t-Test	p	Transgender women from The PRIDE Study	Cisgender[ˆ] women from Mond et al. (2006)	t-Test	p
	Mean (standard deviation)				Mean (standard deviation)			
EDE-Q Restraint	1.28 (1.41)	1.04 (1.19)	1.97	.049	1.48 (1.51)	1.30 (1.40)	1.33	.184
EDE-Q EC	0.94 (1.28)	0.43 (0.77)	5.63	< .001	0.83 (1.08)	0.76 (1.06)	0.68	.497
EDE-Q WC	2.11 (1.71)	1.29 (1.27)	6.03	< .001	2.16 (1.61)	1.79 (1.51)	2.53	.011
EDE-Q SC	2.69 (1.67)	1.59 (1.38)	7.74	< .001	2.86 (1.67)	2.23 (1.65)	3.94	< .001
EDE-Q Global	1.76 (1.36)	1.09 (1.00)	6.23	< .001	1.83 (1.28)	1.09 (1.00)	2.56	.010

Disordered eating behaviors	Any occurrence (%)		Z-test	p	Any occurrence (%)		Z-test	p
Dietary restraint	30.8	24.0	1.40	.160	26.6	3.4	[*]	< .001
Objective binge episodes	9.8	25.0	3.84	.001	11.0	17.3	1.72	.085
Self-induced vomiting	2.1	3.2	[*]	.772	1.8	3.0	[*]	.773
Laxative misuse	–	2.7	–	–	0.9	1.8	[*]	.999
Excessive exercise	9.1	31.4	5.26	< .001	7.3	28.2	4.81	< .001

EDE-Q. Eating Disorder Examination-Questionnaire. Any occurrence was defined as ≥1 episode in the past 28 days. EDE-Q scores were compared using independent samples t-tests. Proportions of disordered eating behaviors were compared with Z-tests or Fisher's exact tests.

[ˆ] Cisgender is presumed here as comprehensive gender assessment was not performed in Lavender et al. or Mond et al.

[*] Fisher's exact test.

When contrasted to an age matched sample of cisgender men, transgender men showed greater EDE-Q scores regarding eating concern, weight concern, shape concern, and global

scores (Nagata, et. Al., 2020). Transgender men showed lower scores in objective binge eating, and excessive exercise. This sample of transgender men did not report laxative misuse and no variations were seen in dietary restraint or self-induced vomiting.

When contrasted to an age-matched sample of cisgender women, transgender women show greater EDE-Q scores regarding weight concern, shape concern, and global score (Nagata, et. Al., 2020). No significant differences were found in restraint and eating concern. In regard to core ED behaviors, transgender women more frequently engage in dietary restraint, while cisgender women more frequently engage in excessive exercise. No significant differences were found on binge eating, self-induced vomiting, and laxative misuse.

Consistent with previous literature (Diemer et.al., 2015, Testa et.al., 2017, Romano & Lipson, 2021 & Nagata, et. al., 2020)., Peterson et.al. shows the elevated risk of EDs in transgender populations through a qualitative analysis on the internal structure of the Eating Disorder Examination Questionnaire (EDE-Q) in treatment seeking transgender youth (Peterson, et.al., 2020). The aim of this study was to explore the performance of the EDE-Q in a sample of TG youth seeking hormone replacement therapy (HRT) through examining the internal structure of the EDE-Q and exploring how the results from the sample compare to cisgender populations in previous studies. It was hypothesized that characteristics of ED symptoms in TG youth may be specific to gender dysphoria, which calls for a more specialized way of measurement. EDs in TG youth can be more complex than in cisgender individuals, understanding whether the standard measure of EDs can be applied to TG youth is important to ensure proper treatment.

Participants in this study include a clinical sample of 249 TG youth and adults with gender dysphoria (Peterson, et.al., 2020). 28% of the sample reported being on HRT while 72% were not. The measures used in this study was the EDE-Q, using exploratory factor analysis

methods. Differences between TG men and TG women were examined and compared with previous EDE-Q studies. Results showed a negative association with age, and no differences between TG women and TG men on EDE-Q scores were found. 23.4% of participants reported objective binge-eating (OBE) episodes in the past month, and 3.9% reported self-induced vomiting (SIV) episodes. These rates of OBE and SIV are similar to a community sample of cisgender women, undergraduate cis men, and undergraduate cisgender women. The findings of this study show that certain sections of the EDE-Q are sufficient in capturing EDs in TG youth.

Understanding this demographic of eating disorders is important, as weight dissatisfaction in youth with gender dysphoria is associated with a history of suicide attempts (Peterson, et.al., 2020). Previous studies have also found that TG men in comparison to TG women are at higher risk of EDs. This study found that transgender men may use maladaptive attempts to attain a more masculine figure. This includes restricting food intake to reduce breast size, curves, and/or to suppress menses. Maladaptive eating behaviors in transgender women may be an internalized ideal to be thin and fit the feminine beauty standards. In addition, TG women may engage in binge eating to achieve more curves on the body.

It should also be noted that TG men and women experience significant rates of violence and maltreatment; 46% and 9% report experiencing verbal harassment and physical violence, respectively, in the prior year just for being TG. Enacted stigma (harassment, discrimination, violence) is linked to higher rates of binge eating, fasting, and purging in transgender youth (Peterson, et.al., 2020). Factors that may help deter transgender adolescents (TGA) from developing EDs include family and school connectedness, caring friends, and social support.

For the clinical implications of this study, it is recommended that ED behavior is routinely assessed in treatment seeking transgender youth (Peterson, et.al., 2020). In addition,

there is no evidence to suggest it is necessary to delay gender affirming medical interventions until the patient has recovered from the ED. In fact, medical support for gender dysphoria may mitigate the symptoms of EDs.

Particular Issues for Transmasculine Youth

Another study on transgender youth focused on disordered eating in trans-masculine youth through a developmental standpoint (Kamody, et. Al., 2020). This area of research is highly understudied, as EDs have historically been studied under the gaze of cisgender women. The belief that disordered eating is evident of over-control, or lack of control ideologies may not be true for all transgender individuals. Recent studies have found that both restrictive and overeating are seen in trans-masculine youth. Restrictive eating and compensatory behaviors such as vomiting or taking laxatives are often maladaptive ways to reduce breast/hip size or terminate menstruation. Similarly, overeating may be a maladaptive way to hide hips/breasts by obtaining more mass in the abdomen resulting in these parts to appear smaller in relation. Both these mechanisms can be used as an attempt to reject the developmentally female role.

Pubertal onset has been recognized to be a critical period for the development of EDs in cisgender populations. Recent data shows that trans masculine youth are at even higher risk of adopting unsafe weight management behaviors (Kamody, et. Al., 2020). Being assigned female at birth is a risk factor to ED as these behaviors may be used as an attempt to suppress the progression of female puberty. In addition, transgender youth who experience higher rates of harassment and discrimination are at higher risk of developing an ED.

The importance of recognizing the progression of EDs is highlighted. Eating disorders often begin as patterns of disordered eating, not yet meeting full diagnostic criteria (Kamody, et. Al.,

2020). Early intervention in this stage is crucial in preventing clinical level EDs. During the progression of an ED over time, rituals become ingrained and intensified, rendering treatment to be significantly more difficult. GCMIs may be an effective tool for reducing ED symptoms. In a cohort study, it was found that 6 months after HRT, decreased disordered eating and increased body satisfaction were identified.

Particular Issues for Transfeminine Women of Color

Research on transgender women of color is also a highly understudied and important area of research (Gordon et. Al., 2016). Eating disorders related to the "ideal female body" can often be manufactured by White western cultural beauty standards that rely on specific demographics which are unattainable for many. From the point of view of many feminist scholars, culture is "not simply contributory but *productive* of eating disorders". There are large amounts of research supporting the notion that gendered societal thinness ideals promote body dissatisfaction which leads to disordered eating. Transgender women are considerably influenced by gendered beauty standards, in addition to gender related social stressors discrimination, sexual objectification, harassment, victimization, violence, and inaccessible gender affirming care.

A 2016 qualitative study explores weight and shape control behaviors among low-income, ethnically diverse young transgender women at high risk or living with HIV, which is the first study to examine disordered eating in transgender women of color (Gordon et. Al., 2016). Semi structured interviews are used in this study as empirical research and calls up on two theoretical frameworks: the ecosocial theory and the gender affirmation framework.

The goal of this study is to examine the ways in which transgender women engage with weight and shape control behaviors and contexts that may exacerbate such behaviors (Gordon et.

Al., 2016). Research was conducted through semi structured interviews with 21 participants (TG women ages 18-31, with annual income < 10,000; ethnicity: Multiracial [n = 8], Black [n = 4], Latina [n = 4], White [n = 4], Asian [n = 1]). Interview guidelines were based on the two theoretical frameworks, as well as disordered eating behaviors in cisgender women and contextual influences on health-risk behaviors in TG women.

Many participants verbalized the desire for thinness in the beginning of their transition. Some participants described adopting unhealthy weight and shape control behaviors from their cisgender peers. In contrast to desire for thinness, many Latin and African American-identified participants express desire to be proportionately thick with a large hips and butt, but a flat stomach. This is influenced by cultural beauty standards in Latin communities.

Additionally, all (n = 21) participants report the experience of growing up around homophobia, transphobia, and weight stigmatization (n = 12) (Gordon et. Al., 2016). The stress of sexual orientation and gender identity development was inseparable from weight control. Many described the fear of familial rejection being linked to eating and weight control coping strategies. For instance, one participant recalls starting hormones without coming out to her father knowing because it was unsafe. When she saw her father, he told her she gained weight and needed to lose her “bitch tits”. Body scrutinizing language is a barrier family members should never cross. Pressures to obtain stricter standards than cisgender women were also described. For example, one participant recalls her family’s criticism of her behaviors not being feminine enough, which reflects a constant need to prove herself.

Of the 15 participants who had started HRT, 10 recalled their weight to be affected by increased appetite (Gordon et. Al., 2016). The interaction between western feminine beauty

standards and hormone related weight changes are taxing obstacles for many transgender women on hormones. Another challenging aspect of biology is pubertal onset. One participant recalls her body becoming too masculine as her cisgender peers' bodies were becoming more feminine. She needed to do something about it, so she began binging and purging while her dysphoria became louder as male puberty progressed.

Though many (n = 16) participants engaged in disordered eating behaviors, 5 experienced severe disordered eating (Gordon et. Al., 2016). Resiliency and autonomy played a role in many of the interviews. For example, many participants described critically evaluating media and marketing to protect themselves from desiring unrealistic femininity ideals. Many participants also struggle with internalized transphobia

Previous research has shown correlations between disordered eating and high levels of economic/housing instability, social marginalization, and psychological distress, all of which are evident in this sample size (Gordon et.al., 2016). This research highlights the vitality of gender affirmation in addition to the effects of sexual objectification, stigmatization, and discrimination on DEBs in relation to culturally objective feminine beauty standards, gender socialization, and biology.

Theories about what Causes Eating Disorders in Transgender Individuals

The Minority Stress Model and Risk Factors

Previous research has found that the LGBT community disproportionately suffers from mental illnesses which can be largely attributed to minority stress (Parker & Harriger, 2020). The minority stress model (MSM) is often used to interpret mental health disparities in minority

groups. Adaptations of the MSM for gender diverse individuals include three unique stressors. Distal stressors, interactive proximal stressors, and internalized proximal stressors. Distal stressors include external stressors such as exposure to violence, discrimination, interactive proximal stressors describe the interactions between external stressors and feeling the constant need to protect oneself from others, internalized proximal stressors describe the internalization of transphobia, stigmatization, and concealment of identity (Valentine & Shipherd, 2018). Features of minority stress can influence one's relationship with their body. The LGBT population demonstrates an increased risk for developing physical and mental health problems (Parker & Harriger, 2020). More specifically, researchers found that individuals from sexual and minority groups that experience higher levels of stigma are more likely to report symptoms of eating disorders. That is, 54% of LGBT+ adolescents have been diagnosed with clinical eating disorders and 21% suspected they have had and ED at some point in their life. Additionally, the LGBT population display more acute ED symptoms and higher rates of abuse. Positive correlations between stigma and eating disorders in sexual minority identities are illustrated, in addition to higher acuity of symptoms.

The Objectification Theory

The objectification theory refers to the cultural objectification of the female body and how cisgender females internalize outside perspectives and monitor their body to fit cultural beauty standards (Gordon et.al., 2016). This theory is a framework for understanding the experience of being female in a culture that sexually objectifies the female body. This objectification is often exacerbated in trans feminine individuals. This theory also applies to trans masculine individuals, as they may also experience objectification throughout their transition. It should also be noted that these standards are becoming even more unattainable through what is

seen on social media. Adolescents are increasingly vulnerable to these ideals as they are still developing and experiencing new changes in their body.

The Tripartite Influence Model

There are many factors that play into the effects of physical attractiveness on self-worth. The tripartite influence model is used to describe the internalization of unattainable beauty standards one learns through media, family, and peers (Romito et.al., 2021). This model is a recent theoretical approach that includes a test of direct (peer, parental, and media factors) and indirect relationships (internalization of societal appearance standards, appearance comparison processes) as primary components to body dissatisfaction and disordered eating.

The Ecosocial Theory

The ecosocial theory highlights the integration of one's lived social and material life into their body. This theory alludes to various "pathways of embodiment" that focuses on the disposition of health and illness across populations in lifetime and historical contexts (Gordon et. al., 2016). It also describes embodiment as an active arrangement between biological and social domains. This theory incentivizes researchers to focus on impacts of health inequities in addition to adverse experiences in personal, institutional, and structural levels.

The Gender Affirmation Framework

The gender affirmation framework is used in this research to understand high-risk behaviors among TG individuals (Gordon et. al., 2016). Gender affirmation is an interactive proceeding where one receives validation or support of their gender identity in social contexts. This

framework illustrates how high-risk health behaviors can be correlated to the deficits in access to gender affirmation, and intersections of racism, transphobia, sexism, and poverty.

Patient Experiences with Providers

While it is important to examine quantitative research to understand the rates in which EDs occur through, it is equally important to examine qualitative research and examine first hand accounts and lived experiences of transgender individuals. When it comes to mental health, lived experiences can often be seen as a liability rather than an asset to research and treatment. The following studies provide narratives of the lived experiences of transgender individuals struggling with EDs.

In a qualitative research experiment examining the lived experience of transgender individuals with eating disorders, various recommendations for more affirmative care were addressed. Findings in previous research suggest that transgender individuals experience eating disorders differently than cisgender individuals (Duffy, Henkel, & Earnshaw, 2016). Increased awareness among mental health professionals and researchers on the needs of transgender individuals and eating disorders is needed to increase the likely hood of informed treatment approaches. Therapists are often uneducated in gender diversity, which increases the risk of discrimination, stereotyping, insensitivity, and misunderstanding.

This study examined the treatment received by transgender individuals with eating disorders (Duffy, Henkel, & Earnshaw, 2016). Many Clinicians are often ill equipped to treat these clients, therefore increasing the risk of elevated eating disorders. Effective treatment for transgender and nonbinary individuals is crucial, as EDs have the highest rates of medical complications, hospitalizations, and mortality of all the psychiatric disorders. Previous research

has shown that both individuals who identify as transgender and individuals with eating disorders are at increased risk for self-harm and suicidality. Thus, the combination of disordered eating and transgender identity should be of significant concern to the mental health community.

The participants in this study were recruited by an online organization Trans Folx Fighting Eating Disorders (TFFED), and consisted of 84 transgender individuals (7% women, 36% men, 57% nonbinary) (Duffy, Henkel, & Earnshaw, 2016). Participants completed an online questionnaire addressing their psychiatric history, ED treatment history, and experience as a transgender individual. In the analysis of the response of the open-ended items, three major themes were found: The role of the body in ED treatment, negative experiences with clinicians, and recommendations for treatment centers and providers.

In the analysis of the role of the body, it was found that 32% of participants responded that their eating disorder has to do with their physical body, i.e., using starvation to eliminate curves, body fat, or menstruation (Duffy, Henkel, & Earnshaw, 2016). While 56% of participants felt their ED was unrelated to their physical body. Factors such as abuse, trauma, and anxiety play a larger role. 15% of participants expressed that their therapists did not understand that body image issues are more complex for transgender clients. The body discomfort of a trans person cannot be simply overcome by the positive body image approach. In fact, these approaches are not only ineffective but also highly invalidating and dismissive of their experience. Clinical approaches should be tailored to individual clients, as everyone experiences their gender identity and eating pathology differently.

In the analysis of negative experiences with clinicians, it was found that 40% of participants did not disclose their gender identity while in ED treatment (Duffy, Henkel, &

Earnshaw, 2016). This was often due to fear of stigma, discomfort, or discrimination since many treatment centers are only for women. 60% of participants disclosed their gender identity while in treatment, however 10% of clients' disclosures were ignored as if they were never told, and 11% were disregarded with persistent misgendering. A lack of specialized training is also reflected upon, 19% of participants found it difficult to find clinicians capable of working with gender diversity and EDs. There is a profound lack of gender awareness and competence among ED treatment providers.

The final analysis was the participants recommendations for treatment centers and providers to increase their competence with gender diversity and Eds (Duffy, Henkel, & Earnshaw, 2016). About 25% of participants indicated that they wish providers would ask questions rather than make assumptions about identity, beliefs, and behaviors. About 8% of participants reported feeling there is no appropriate treatment available to them, it is suggested that treatment programs facilitate access to care for the transgender community. 17% of participants expressed the need for clinicians to be more educated on the transgender population. Ongoing education around cultural competency and specialized counseling skills is recommended by participants, in addition to reading about first person narratives from transgender individuals. Clinicians who are trained to manage EDs and gender diversity issues can be very beneficial to clients who struggle with both.

Transgender Narrative of Lived Experience

While transgender adolescents experience these same sociocultural and biological factors, they are at increased risk for body dissatisfaction and disordered eating as they additionally experience unique gender and body related stressors (Romito et.al., 2021). A recent study done in Canada found that 48% of TGAs experience disordered eating behaviors. Prior to transition

TGAs may experience an overwhelming sense of dysphoria, or distress related to their gender. This may drive TGAs to transition socially and/or medically. However, transitioning often comes with anxiety related to passing as the correct gender, which may increase body dissatisfaction.

Although there are nine interviews, I will be touching upon the stories of two different gender identities and experiences. Casey and Tyler. Casey is 17 years old, transfeminine, assigned male at birth (AMAB) and uses she/her pronouns. Tyler is 17 years old, genderqueer, assigned female at birth (AFAB) and uses they/them pronouns.

Casey

In Casey's experience, she expressed the desire to be a girl to her mother, at age four. These feelings were repressed throughout childhood as she experienced bullying due to her feminine appearance (Romito et.al., 2021). While unaware of the dysphoric roots of her behaviors, she managed the body discomfort and social scrutiny, by allowing herself to present femininely while maintaining a masculine physique. She did this by restricting food to prevent weight gain. In addition to restricting, she reported binging to fill an emotional void and purging to compensate for the binging. At age 14, she came out as a transgender female, no longer able to "live to please others". After coming out, she dedicated much of her time into passing as female, which led to excessive internal body surveillance and engaging in body modification behaviors. For instance, in order to obtain an hourglass figure, she wore a corset for hours, so tight she could not breathe. She also began restricting her food. Once starting hormone replacement therapy (HRT), the anticipation of new changes allowed her to feel more control over her life. In addition to HRT, she went to psychotherapy, where she learned more effective ways of coping and felt the desire to take care of her body. During the time of the interview, she reported feeling

less of a need to engage in disordered eating and engages in a healthy amount of exercise. Once she was able to see a girl in the mirror she felt at home in her body.

Tyler

In Tyler's experience, they report having body concerns before transitioning, and felt they were ugly, as they are not white, thin, or have straight hair like their peers (Romito et.al., 2021). They express having a drive for thinness and need for control which lead to occasional restriction pre transition. During these times, they did not eat at school or at home because there were no "safe" options. Pre-transition body dissatisfaction was also manifested through various focal points and areas of their body they did not like. It wasn't until a few years later when they realized this dissatisfaction was gender incongruence. Tyler came out at age 15 to their dating partner and their school's GSA (Romito et.al., 2021). With support from their partner, they were able to get new clothes and alter their appearance. However, altering their appearance led to anxiety about standing out at school.

Once they got their license and could drive themself places, their eating got better as they did not have to rely on their parents to get food (Romito et.al., 2021). However, they still experienced periods of time where they would only "eat healthy" for the intention of losing weight. After coming out, their eating and weight control behaviors were exclusively related to gender and the obviousness of their curves.

Tyler was 17 at the time of the interview and felt trapped in their transition, since they had not come out to their parents yet (Romito et.al., 2021). In previous conversations with their mom, they found it difficult to tell if she would be supportive. They also expressed the desire to medically transition with top surgery, but that HRT felt too threatening due to societal

misconceptions of the nonbinary identity. At the time of the interview, Tyler expresses excitement towards further steps in their transition.

Three important themes were found throughout the case synthesis of these interviews: (1) Disordered eating behaviors (DEBs) aimed to align the body with one's gender identity, (2) DEBs related to broader mental health concerns, (3) the influence of developmental and social context (Romito et.al.,2021). The first theme is evident in all participants, as they all report engagement in at least one DEB to alter body shape or weight. For instance, Casey restricted her food to enhance the hourglass effects of a corset. In addition, Tyler desired to eat "healthy" to lose weight in attempts to minimize their feminine features. The second theme is evident is many participants as they report different mental health concerns influencing their DEBs, not just body dissatisfaction. Depression and anxiety are common contributors for many different reasons since everyone's relationship with their gender, eating behaviors, and mental health. Finally, the third theme highlights the impacts of developmental and social contexts. Dependence and seeking of validation/approval from family members is a common theme. Many participants report that their parents hinder their ability to pursue a medical transition. In contrast, the participants with supportive parents note how significant their support was and how much easier it made their transition.

Personal Narrative

In the following segment of the paper, I will describe my experience as a transmasculine individual with an eating disorder. To speak on what is relevant, I will use the interview questions found in the appendix of Romito et.al., as a guide to illustrate my narrative.

Throughout childhood, I was very insecure with my body shape and weight, despite always having an average BMI. Due to health concerns my height and weight were regularly monitored by an endocrinologist from ages 7-13, which drastically increased weight concerns. I was extremely concerned with my body and how others were perceiving it. In middle school, I spent months at a time hyper fixating on different body parts (nose, forehead, knees, chin, calves, thighs etc.,) and would mentally compare mine to everyone else's while internally surveilling myself on whichever body part I was hyper fixated with.

In addition to experiencing body and weight concerns at an early age, I was also beginning to unknowingly explore my gender, alternating between being a "girly-girl" and being a "tomboy" throughout childhood and early adolescence. I wasn't comfortable being either, but I thought those were my only options since I hadn't been exposed to transgender identities. Transphobia was so normalized at the time, I honestly didn't know trans people existed, I just thought it was an insult or "bad word" that I was too young to understand.

During puberty, I experienced a lot of discomfort around my chest and hips, and developed a severe social anxiety disorder, as well as depression, and engaged in self-harming behaviors. At age 15, I learned about transgender identities through someone in my life who came out as a trans man. After researching different gender identities, I knew I was not a girl, but I kept this identity a secret for a year out of fear of stigmatization and what others may think. Throughout that year, I had been begging my mom for a short haircut. After finally convincing her, I got a "pixie cut", but made a promise to myself I'd still be feminine for a while so no one would know.

After a few months, I started to dress a little androgenous but made sure to wear enough makeup to balance it. I was severely uncomfortable with my female presentation and needed to do something about it. I felt that my hips, breasts, and curves were too big to ever be perceived as male, so I thought I should lose some weight.

This is when I started to restrict. Reducing portion sizes quickly escalated to fully eliminating meals. Within a few months, 1500 calories a day became under 500. My diet consisted of a handful of "safe" foods. I had given myself so many rules and there were so many consequences of breaking the rules. I was constantly mad at myself for not being comfortable in a female body, but I didn't want to accept it. I was surveilling my body 24/7, and wondering what others were perceiving (imagining them to be seeing a large curvy woman, even though that was far from reality). I was hyper aware of all the feminine features on my body and the only way I thought I could get rid of them was to not eat. As hungry as I was, I was terrified of gaining weight because I equated that to being female, and I wanted nothing to do with that identity.

At this point, my body was weak, my bones were achy, and I could not carry my bag up the stairs in school without taking a break. For most of the time, my primary focus was to not pass out. I suppose this functioned as a numbing technique, as I didn't know how to "fix" my dysphoria. I was also addicted to knowing and having control of all the numbers (calories, weight, BMI, nutritional facts, steps I walked in a day). I had no energy and could not engage in any conversations. I was highly irritable, self-isolating, and engaging in extreme measures to avoid food/eating. This led to lying to friends and family about where I was during mealtimes and whether or not I ate. It truly felt like an addiction. In addition to the physical motivators to

restrict, another aspect was the anxiety, guilt and shame around how I'd be perceived if I came out- especially to my family.

At this time, I was in Junior year of high school and out as nonbinary (which later changed) to a few friends at school. It had been over six months of heavy restriction, without anyone noticing until one day my sister confronted me on my weight loss and androgenous appearance. I told her I need to go to therapy, as I was not comfortable confiding in her at the time. I soon got a therapist who specializes in eating disorders, but when I told her my gender identity, she did not feel equipped to help me, and gave me a referral to someone else. Shortly after speaking with the new therapist, she diagnosed me with anorexia nervosa and gender dysphoria. I soon began outpatient recovery that lasted for about six months.

Although this treatment did not diminish the dissatisfaction I had with my body, I was able to restore much of my weight and learn how to eat meals again. I knew it would not last long, thus I began compulsively walking and exercising. I could not stand to see the curves on my body. I knew the only thing that would help me maintain recovery is to start testosterone and get top surgery, but I needed permission from my parents. Luckily, my therapist was aware of the importance of medically transitioning for my mental health and encouraged me to come out to my family sooner than later so I can start testosterone and continue recovering. Although it was difficult to gauge whether my family would be supportive or not, I wrote a coming out letter to them, as I could no longer pretend to be a girl or bear the persistent societal misgendering.

By senior year of high school, I was out as a trans male using a new name and he/him pronouns to everyone in my life. Although gaining support was challenging for some members of the family, my parents knew how important it was for me to medically transition. I started

testosterone in December of 2017, which was crucial for my mental health. After being on testosterone for a few months, I was able to eat normal meals again, did not worry about calories and experienced significantly less depression. A year later, I received top surgery which completely relieved my chest dysphoria.

Currently I am graduating college, over four years on testosterone, 3 years post-op top surgery and have legally changed my name and gender. Although I am in a much better place since socially and medically transitioning, I still experience dysphoria, and tend to use food restriction as a coping mechanism. However, I have recently begun seeing a nutritionist again after a brief relapse in my ED due to a significant life event unrelated to gender identity. Through this treatment and therapy, I hope to soon rediscover a positive relationship with food and my body.

I would like to note that my experience finding a therapist who specializes in transgender care, and EDs was almost impossible. I went through three therapist consultations in two months, where none of them felt equipped to work with me. Although my current therapist does not specialize in EDs he gave me a referral to a nutritionist who is transgender and eating disorder informed. Locating access to quality transgender health care is a huge barrier to treatment, as I will later mention in the discussion. I would also like to point out that EDs can be a lifelong battle for both transgender and cisgender individuals, so it is important to periodically check in on those who have previously experienced an ED.

Recommendations

Policy Recommendations

There is a strong emphasis on the need for more formal training, standardized treatment, and research on the safety and medical outcomes in transgender health care (Rafferty, 2018). Regarding the transgender population, about 0.7% of youth 13-17 years identify as transgender. However, this is likely an underestimate, given the stigma and difficulty defining transgender in an all-inclusive way. Trans and gender diverse (TGD) adolescents have higher rates of depression, anxiety, eating disorders, self-harm, and suicide than their cisgender peers. 56% and 31% of TGD youth report previous suicidal ideation and suicide attempt, respectively, compared to 20% and 11% of cisgender youth. TGD youth also report disproportionately high rates of homelessness, physical violence, substance abuse, and high-risk sexual behaviors. There is no evidence suggesting TGD identities constitute a mental disorder. However, the development of mental illness can be multifactorial, stemming from internal conflict between one's identity, limited mental health services, discrimination, social rejection, etc. If pediatric health care providers were more equipped with transgender care, early signs can be detected sooner, and decrease the likelihood of developing mental health disorders.

The American Academy of Pediatrics (AAP) committee posits an emphasis on the need for more formal training, standardized treatment, and research on the safety and medical outcome of transgender adolescents (Rafferty, 2018). Disparities in transgender health care include inequitable laws and policies, discrimination from society, and a lack of quality health care access. Fear of discrimination outlines a lack of safety in clinical environments, insufficient access to physical and mental health services. Lack of stability with providers outlines low access to quality care which can further exacerbate any mental or physical illnesses. In addition, intersections of racism, transphobia and sexism are not well studied and often result in extreme

marginalization of trans women of color. As of 2018, only 18 states have gender discrimination laws in place.

The Gender affirming care model (GCAM) is a framework for clients to receive a supportive environment where they can raise questions and explore their identity without judgment (Rafferty, 2018). GCAM is recommended to operate through medical, mental health, and social services. The goal is to destigmatize transgender health, provide access to care, educate parents and families, and offer safe spaces for transgender youth are able to explore their gender. Research shows that using this model can result in fewer mental health problems, whether or not they conclude they are transgender.

In order to minimize discrimination, it is recommended by the AAP that: (1) youth questioning their gender have access to comprehensive, gender-affirming health care provided in a nondiscriminatory clinical setting, (2) family-based therapy and support is accessible to parents and siblings of TGD youth, (3) health records must display affirming name and gender while maintaining confidentiality, (4) insurance coverage of transgender emotional and physical needs, (5) that providers practice continuing education and integrate practices for TGD youth and families, (6) advocacy from pediatricians for educating and developing TGD inclusive places in schools and communities and for policies and legal matters to protect TGD youth from violence and discrimination, (7) equal opportunity for employment and workplace protection, and (8) that research is prioritize by medical practitioners and the federal government to improve quality of evidence-based care.

In addition to emphasizing the need for more formal training and research on transgender health care (TGHC), I would like to highlight the important of ED awareness/inclusion in TGHC as they may go hand in hand. The following section illustrates the clinical implications of EDs,

underrepresented information, misconceptions and why this may be a significant health concern for transgender individuals, given the prevalence

Clinical Implications of EDs, Misconceptions, and Presenting Signs and Symptoms

Unfortunately, all EDs can be associated with serious medical complications affecting every organ system of the body (*Eating disorders medical guide,* 2016). Thus, it is important for people undergoing ED recovery to have a support team of medical providers. For example, a therapist, nutritionist, and general practitioner. However, finding a trans competent provider in all three fields may be a significant barrier to recovery. Additionally, it is important to recognize EDs as serious disorders with life threatening physical and psychological complications affecting a wide range of systems in the body: cardiorespiratory, oral and dental, gastrointestinal, endocrine, neuropsychiatric, and dermatologic.

EDs do not discriminate, as they can affect individuals of all ages, genders, ethnicities, socioeconomic backgrounds, and a variety of different body shapes, weights, and sizes (*Eating disorders medical guide,* 2016). A common misconception is that people give themselves eating disorders and that it is something one can easily get over if they tried. Many people suffering from EDs do not receive the compassion or understanding they deserve, which can further exacerbate the ED.

In addition, it is common for individuals with EDs to not recognize the seriousness of their illness which can lead to ambivalence around changing their eating or other weight control behaviors (*Eating disorders medical guide,* 2016). Therefore, it is important to consider screening clients with elevated dysphoria or body dissatisfaction for ED as a form of early intervention.

It is also important to recognize that weight is not the only clinical marker of an ED. In fact, less than 6% of those with EDs are diagnosed underweight *(Eating disorders medical guide,* 2016*)*. People at any weight can have an ED, may be malnourished and/or engage in unhealthy weight control practices. This is one of one of the biggest misconceptions. Part of the diagnostic criteria in the DSM 5 for anorexia is being underweight or having a significantly low BMI. This criterion fails to recognize the fact that one can be malnourished at any weight. DSM-5 diagnostic criterion also does not include atypical cases. For instance, I was in denial about having anorexia for a while since I thought the only way for it to be valid was if I was underweight. This also led me to believe I was undeserving of treatment because according to my BMI it wasn't "critical enough".

All instances of rapid weight loss or gain in otherwise healthy individuals should be investigated for the possibility of an ED (*Eating disorders medical guide,* 2016). The medical consequences of EDs can go unrecognized even by an experienced clinician. Therefore, it is important to check in on your client's relationship with food and if they are receiving enough nourishment for their body. If your client suffers from trauma, persistent invalidation, gender dysphoria, lack of support from family etc., it is suggested to consider the possibility that your client may use food control to manage these thoughts. This may look like screening your client for an ED, even if they don't "look" like they do or talk about it as a pressing concern.

Finally, this research highlights the importance of early intervention. Clinicians may do this by periodically checking in with clients on their relationship with food and their body. It is important for clinicians to be trained in recognizing early patterns and symptoms of a progressing ED. If any potential red flags come up, it is recommended to dive further into the topic, and if needed refer them to more specialized care.

Clinical Recommendations

The following section is a list of recommendations to mental health providers with reflective quotes on behalf of case studies, quantitative, qualitative, and personal research. I would like to highlight important considerations to make for clinicians who specialize in eating disorders and clinicians who specialize in gender affirming care. Recommendations and consideration include: (1) trust your client, (2) body related anxiety is valid for TGD individuals considering the discrimination they may face, (3) gender dysphoria and body dysmorphia are not the same, (4) ensure a safe, trauma-informed environment, (5) Investigate the function of the ED (6) Always ask your client's preferred name and pronouns.

The first recommendation is to trust that your client is the expert of their own lived experience. There is not much research on the most effective way to treat TG individuals with an ED. Although transition does not guarantee full recovery, recovery often does not occur without the transition. Often, transgender people must choose between prioritizing recovery and treatment. Unfortunately, clinicians do not always trust their TG client to know what they need for their body when it comes to recovery and transition.

Remember not to assume that one TG person's ED developed for the same reasons as another's. Additionally, trust your client if they express, they are transgender. For example:

> There needs to be better understanding that people develop disorders for different reasons. Many of my doctors told me I was trying to cover for my eating disorder by claiming that I was transgender, which couldn't have been farther from the truth. I have an eating disorder in addition to being a trans person, they are not necessarily related, though there are parts of them that interact. (Duffy, Henkel, & Earnshaw, 2016, p. 143)

Often in the early stages of transitioning or throughout transitioning, many transgender people struggle to “pass” and face persistent misgendering. Attempting to control body shape with food is a sincere concern in TGD individuals. It is important not to reinforce these concerns in therapy, as it is important to trust and validate one’s ED in addition to affirming their gender.

The second recommendation highlights the importance of investigating the function of one’s EDs. There is often an expectation that all trans people have suffered from mental health disorders or have been oppressed for extensive periods of time for their identity to be valid or “make sense”. Sometimes, EDs can function to validate one’s trans identity which can bring up many fears in recovery. It is important to consider what may function as a validation to one’s identity to begin rerouting these beliefs. There is a common mentality that if nothing is wrong, they didn’t suffer enough to know they are trans and conversely if “too much” is wrong, they can’t know they’re trans because they haven’t worked through their trauma. It’s as if there must be evidence of a struggle prior to transition for one’s identity to “make sense”. These notions are highly invalidating as there is no “correct” way to construct, reveal or develop one’s identity.

> now my body is just for me and how do I relate to my gender now… I guess the answer is I relate to my gender by starving myself because I feel more gender affirmed… The only thing left of my gender is my eating disorder (Brownstone et. Al., 2021, p. 8).

This quotation sheds light on how their ED functions to validate their gender identity. During the covid-19 pandemic, social isolation resulted in not having to “perform” gender. This led to a loss of external validation of gender which influenced old habits if disordered eating in order to validate and affirm their gender. This raises the question: How can one become less reliant on external validation? How do we support and teach self-affirmation/validation skills in transgender individuals?

The third recommendation is to recognize that the fears and anxieties a TGD person may feel are valid responses to the constant discrimination/ stigmatization they face. For instance, fearing to lose the ability to pass if one loses/gains weight may not be a cognitive distortion. (Duffy, Henkel, & Earnshaw, 2016). Transgender individuals share:

> I had no visible breast tissue at all and was thus able to have a more “androgynous” body without needing to come out to myself or transition. I have also known trans women who intentionally over-ate because it made them curvier (Duffy, Henkel, & Earnshaw, 2016, p. 140).

For example, being able to pass as one’s gender is a form of protection that can lower the risk of discrimination, harassment etc.,. Traditional ED treatments may be harmful for transgender individuals. “I am worried that the issues around my trans-specific body discomfort will be ignored or downplayed in favor of the traditional ‘learn to love your body’ approach to treatment” (Duffy, Henkel, & Earnshaw, 2016, Pg 140). For instance, the positive body image approach can be harmful for transgender individuals, as there may be valid reasons to want to alter one’s body due to the incongruence one feels between gender identity and sex. A transgender person cannot simply overcome their ED and dysphoria by “embracing their body”.

The fourth recommendation is to understand that gender dysphoria and body dysmorphia are not the same. This distinction is significant for ED treatment providers to be aware of. Body dysmorphia is categorized by obsessive body checking and preoccupation with one’s appearance or perceived flaw, sometimes to the point of surgical modification. This is also classified as a form of OCD that can result in an ED. Gender dysphoria is an incongruence between one’s sex and gender. One of the biggest differentiating factors is that gender dysphoria often results in preoccupation with unwanted secondary sex characteristics. Although being transgender is not a

mental illness, the inclusion of gender dysphoria in the DSM serves a variety of purposes. Some transgender people feel like their dysphoria is a disorder, impairing daily life functioning. While others, simply seek diagnosis for insurance coverage purposes to medically transition. Requiring the diagnosis of gender dysphoria can be seen as a barrier to treatment for HRT.

> I can't help but … wonder how my life might have been different … if anyone who saw me in the course of my treatment had been able to recognize my gender dysphoria and inform me that there were ways of addressing my extreme discomfort with my post-pubertal body other than starving myself (Duffy, Henkel, & Earnshaw, 2016 p. 144)

> I wish general practitioners were more knowledgeable on gender dysphoria and EDs. When my pediatrician noticed I lost weight, I told her it was because of anxiety. I feel like if she was more attuned to ED symptoms and/or gender diversity she could have asked more questions, which could have been a step to early intervention (Schepis, 2022).

These quotations highlight the importance of increased awareness on gender dysphoria in ED treatment.

The fifth recommendation is to ensure a safe environment, which is important in all clinical settings. More importantly, being trauma informed can significantly help the relationship with your client. There are six principles of trauma informed care: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and culture, historic and gender issues. Transgender people have faced invalidation both historically and individually, which can be traumatizing along with the many other possibly traumatic hardships a TGD individual may face. Making sure to provide an affirming and validating

environment is crucial for your client's recovery, as many have struggled for many years to accept their identity.

> In spite of my identification, "professionals" tend to fall back on essentialist notions: "you are a man." I am simply not interested in educating professionals about my gender or identity; it's the one space where I do not have the energy left to do so (Duffy, Henkel, & Earnshaw, 2016 p.143).

> I have stopped telling therapists, doctors, and groups that I don't identify as a woman. It makes them uncomfortable and alienates me. Lying is easier (Duffy, Henkel, & Earnshaw, 2016 p. 141).

> It's difficult in general for me to find therapy and help that understands me being trans, being a rape survivor, and having an eating disorder. I tend to find any help I seek for one, or any combination of those, fails in at least one of those areas (Duffy, Henkel, & Earnshaw, 2016 p. 142).

These quotes reflect a common theme of ignorance among providers when it comes to TGD identities. Unfortunately, there is not enough education on gender affirming care in the field of psychology, as this is an understudied and underfunded field.

Finally, the last recommendation is to always ask your client's preferred name and pronouns, as medical records do not always reflect these. It would also be helpful to advocate the gender of your client with their other providers if given consent.

> It would be reassuring to see programs which include some sort of reference to their inclusivity of transgender/gender-diverse people. It is nerve-wracking to look for treatment options and wonder whether a program which works with women means that it

> works with all women, or only with cis women. (Duffy, Henkel, & Earnshaw, 2016, p. 143).

Providing a safe space for clients to express their gender is crucial when caring for this population. Incorporating preferred name options to legal documents and forms is an easy way of doing this. Additionally, it is recommended to use gender neutral language when caring for patients. Disclosure of gender identity should be respected and remain confidential.

Limitations

There are several limitations to this research. For example, many of the studies reviewed contain a limited sample size which is not representative of entire populations (Kamody et. al., 2020, Gordon et. Al., 2016, Testa et. Al., 2017, Nagata et. Al., 2020, Peterson et. Al., 2020, Duffy, Henkel, & Earnshaw, 2016). Additionally, the demographic and location of each study should be considered as many studied were predominantly White sample sizes. Multiple studies include self-selected participants. Therefore, all-inclusive samples were not gathered. Another limitation of studies on transgender individuals is the probability of a trans person to be out as transgender and/or willing to participate.

Furthermore, all studies were cross-sectional. It would be beneficial for future research to conduct longitudinal studies on the effect of EDs in transgender individuals over time. Future research should examine more racially and socioeconomically diverse sample sizes in addition to including distinctions between transgender men, women, and nonbinary identities (Duffy, Henkel, & Earnshaw, 2016).

The current study is also limited in information as there were time constraints to this research. It would have been beneficial to examine the ways in which the Covid-19 pandemic

has influence EDs in TGD individuals. Additionally, this research would benefit from the inclusion of a qualitative comparison study of EDs in cisgender populations.

Discussion

Through an extensive literature review, the primary goal of this research is to advocate for ways in which transgender people may struggle with disordered eating in addition to providing clinical recommendations when treating this population. The intersection between gender identity and body image may intensify challenges around treatment and diagnosis for these individuals. In addition, disordered eating behaviors (DEBs) can be magnified by societal stigmas, lack of social/family support, and lack of gender affirming resources (Nagata et. al., 2020). This research illustrates the disparities in healthcare when it comes to treating transgender individuals who experience disordered eating.

This research fails to address the many barriers to receiving care. For instance, one’s weight can be a barrier to gender affirming surgeries. In order to be eligible to receive certain surgeries, one's weight must be in a certain BMI range, which excludes candidates who possibly need it most. For instance, TGD individuals with EDs who may be significantly overweight may not be able to receive gender affirming and possibly lifesaving treatment due to a lack of experience operating on large-bodied individuals. Another significant barrier includes limited health insurance coverage for therapy and surgeries. The diagnosis of gender dysphoria is required to receive insurance coverage. In addition, there is a lack of gender affirming care providers which may be due to lack of awareness, limited resources, and educational gatekeeping.

“Expertness” can be seen as a barrier in healthcare. The idea of being an expert in one’s profession is a form of educational gatekeeping where one can only obtain information if they

have earned the credentials. There is little communication between the eating disorder and transgender healthcare fields. Becoming an expert in one field often limits one's time and resources to obtain dual expertise, which is necessary for the targeted population. Another barrier to treatments is the cost of both ED treatment and GCMIs. Insurance does not always cover treatment and 25% of trans people are uninsured, so insurance is not always an option.

There are several root causes to the barriers in treatment. There is a narrow criterion for EDs and an oversimplified way of understanding EDs, which is often stereotyped. Additionally, poverty, discrimination and minority stress can result in heightened fear and trauma when navigating society. It should also be considered that given the current political climate, GCMIs may become more inaccessible and possibly illegal. Anti-trans bills in Texas, Florida, Alabama, and multiple other states are floating around and soon to be passed. The new laws will make it illegal for children to be transgender, considering it child abuse.

This discussion and research raise many questions for future research to unpack. What are some ways to effectively advocate for transgender rights? What does early intervention look like and what are some ways to identify early stages of an ED? How can dual certification in gender affirming care and ED treatment be implemented into education curriculums and programs?

Reference List

Bowman, Mary Katharine, "The Lived Experience of Transgender Individuals with Eating Disorders" (2018). College of Science and Health Theses and Dissertations. 255.

Brownstone, L. M., Kelly, D. A., Maloul, E. K., Dinneen, J. L., Palazzolo, L. A., Raque, T. L., & Greene, A. K. (2021). “It’s just not comfortable to exist in a body”: Transgender/gender nonbinary individuals’ experiences of body and eating distress during the COVID-19 pandemic. Psychology of Sexual Orientation and Gender Diversity. Advance online publication. http://dx.doi.org/10.1037/sgd0000519

Diemer, E. W., Grant, J. D., Munn-Chernoff, M. A., Patterson, D. A., & Duncan, A. E. (2015). Gender Identity, Sexual Orientation, and Eating-Related Pathology in a National Sample

of College Students. *Journal of Adolescent Health*, *57*(2), 144–149. https://doi.org/10.1016/j.jadohealth.2015.03.003

Duffy, M. E., Henkel, K. E., & Earnshaw, V. A. (2016). Transgender clients' experiences of eating disorder treatment. Journal of LGBT Issues in Counseling,10(3), 136-149. doi:10.1080/15538605.2016.117780

Eating disorders medical guide - AED report 2016. (n.d.). Retrieved May 14, 2022, from https://www.massgeneral.org/assets/MGH/pdf/psychiatry/eating-disorders-medical-guide-aed-report.pdf

Gordon, A. R., Austin, S. B., Krieger, N., Hughto, J. M. W., & Reisner, S. L. (2016, August 1). "I have to constantly prove to myself, to people, that I fit the bill": Perspectives on weight and shape control behaviors among low-income, ethnically diverse young transgender women. Social Science & Medicine. Retrieved March 6, 2022, from https://www.sciencedirect.com/science/article/abs/pii/S0277953616303999?via%3Dihub

Harrison, C. (2019, December 12). *Food psych #150: Disordered eating & gender identity with Sand Chang*. Christy Harrison - Intuitive Eating Dietitian, Anti-Diet Author, & Certified Eating Disorders Specialist. Retrieved December 11, 2021, from https://christyharrison.com/foodpsych/5/eating-disorder-recovery-gender-identity-with-sand-chang.

Kamody, R. C., Yonkers, K., Pluhar, E. I., & Olezeski, C. L. (2020). Disordered eating among trans-masculine youth: Considerations through a developmental lens. *LGBT Health*, *7*(4), 170–173. https://doi.org/10.1089/lgbt.2019.0354

Murray, S. B. (2016, November 10). *Gender identity and eating disorders: The need to delineate novel pathways for eating disorder symptomatology*. Journal of Adolescent Health. Retrieved February 27, 2022, from https://www.sciencedirect.com/science/article/pii/S1054139X16304001?via%3Dihub

Nagata, J. M., Murray, S. B., Compte, E. J., Pak, E. H., Schauer, R., Flentje, A., Capriotti, M. R., Lubensky, M. E., Lunn, M. R., & Obedin-Maliver, J. (2020). Community norms for the Eating Disorder Examination Questionnaire (EDE-Q) among transgender men and women. *Eating Behaviors*, *37*, 101381. https://doi.org/10.1016/j.eatbeh.2020.101381

Parker, L.L., Harriger, J.A. Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. *J Eat Disord* **8,** 51 (2020). https://doi.org/10.1186/s40337-020-00327-y

Peterson, C. M., Toland, M. D., Matthews, A., Mathews, S., Thompson, F., & Conard, L. A. E. (2020). Exploring the Eating Disorder Examination Questionnaire in treatment seeking transgender youth. *Psychology of Sexual Orientation and Gender Diversity, 7*(3), 304–315. https://doi.org/10.1037/sgd0000386

Rafferty J; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COMMITTEE ON ADOLESCENCE; SECTION ON LESBIAN, GAY,

BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics. 2018 Oct;142(4):e20182162. doi: 10.1542/peds.2018-2162. Epub 2018 Sep 17. PMID: 30224363.

Romano, K. A., & Lipson, S. K. (2021, September 9). Weight Misperception and Thin-Ideal Overvaluation Relative to the Positive Functioning and Eating Disorder Pathology of Transgender and Nonbinary Young Adults. Psychology of Sexual Orientation and Gender Diversity. Advance online publication. http://dx.doi.org/10.1037/sgd0000524

Romito, M., Salk, R. H., Roberts, S. R., Thoma, B. C., Levine, M. D., & Choukas-Bradley, S. (2021). Exploring transgender adolescents' body image concerns and disordered eating: Semi-structured interviews with Nine gender minority youth. *Body Image*, *37*, 50–62. https://doi.org/10.1016/j.bodyim.2021.01.008

Rafferty J, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, AAP COMMITTEE ON ADOLESCENCE, AAP SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and GenderDiverse Children and Adolescents. Pediatrics. 2018;142(4): e20182162

Testa, R. J., Rider, G. N., Haug, N. A., & Balsam, K. F. (2017). Gender confirming medical interventions and eating disorder symptoms among transgender individuals. *Health Psychology, 36*(10), 927–936. https://doi.org/10.1037/hea0000497

Valentine, S. E., & Shipherd, J. C. (2018, March 28). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. Clinical Psychology Review. Retrieved December 7, 2021, from https://www.sciencedirect.com/science/article/pii/S0272735817304208?via%3Dihub.