Supporting Trans and Gender Diverse Youth with Disordered Eating

A discussion

July 25th 2023
Acknowledgement of Country

We recognize and pay our respect to Aboriginal and Torres Strait Islander peoples, their ancestors and the Elders past, present, and emerging from the different First Nations across this country.

We acknowledge the importance of connection to Land, culture, spirituality, ancestry, family and community for the wellbeing of all Aboriginal and Torres Strait Islander children and their families.
Acknowledgment of Privilege

"Nothing about us without us"

"It takes conscious effort to disrupt the habit of seeing others through our own assumptions”

“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.”

Presentation Overview

- Gender diversity and gender affirming care 101
- Epidemiology
- Eating disorders and gender diversity - a framework for understanding
- TGD lived experience perspectives on eating disorder care
- Assessment of eating disorders and gender diversity in young people
- Eating disorder treatment considerations
- Screening
- Medical considerations
- Case study
- Q&A
- Reading and Resources

This talk includes discussion of EDs, suicide and discrimination. If you need to have a break or leave early, please do. We are happy to be contacted afterwards if you would like.
Gender Diversity and Gender Affirming Care:
An introduction
Terminology: Sex and Gender

**Sex:** biological characteristics, including physical features and genetics; sex is assigned at birth; usually seen as binary (XX = female, XY = male) but it is not – some assigned males have XX chromosomes, some assigned females have Y chromosomes, and some people are intersex. 1 in 100 people are intersex.

**Sexuality:**
physical, sexual and/or emotional feelings, thoughts, attractions and behaviours towards other people – *sexuality is interpersonal*

**Gender:**
an individual's concept of themselves (*gender identity*) or socially constructed characteristics of the of a male or female in society (*gender role*) or – *gender identity is personal*

The challenge of conflation:
We use the terms ‘male’ and ‘female’ to describe both sex and gender.
<table>
<thead>
<tr>
<th><strong>Definitions and terminology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assigned male at birth (AMAB):</strong> A person who was thought to be male when born and initially raised as a boy.</td>
</tr>
<tr>
<td><strong>Assigned female at birth (AFAB):</strong> A person who was thought to be female when born and initially raised as a girl.</td>
</tr>
<tr>
<td><strong>Gender identity:</strong> A person’s innermost concept of self as male, female, a blend of both or neither. One’s gender identity can be the same or different from their sex assigned at birth.</td>
</tr>
<tr>
<td><strong>Cisgender:</strong> A term for someone whose gender identity aligns with their sex assigned at birth.</td>
</tr>
<tr>
<td><strong>Trans or transgender:</strong> A term for someone whose gender identity is not congruent with their sex assigned at birth.</td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Non-binary:</strong></td>
</tr>
<tr>
<td><strong>Gender fluid:</strong></td>
</tr>
<tr>
<td><strong>Gender diverse:</strong></td>
</tr>
<tr>
<td><strong>Gender expression:</strong></td>
</tr>
<tr>
<td><strong>Gender dysphoria:</strong></td>
</tr>
</tbody>
</table>
Ask the young person what terms they use (or don’t use)... check when they want you to use them, then do this consistently

“It’s good if they already know... but it’s polite to ask and you can tell them from your perspective”
9-year-old, Non-binary
2.3 - 3.7% of Australian young people identify as trans or gender diverse

A national, cross-sectional survey of 6,327 secondary school students in Years 10-12

2.3% reported being trans or gender diverse
What is gender affirming care?

The gender-affirming model of care affirms diversity in gender identity and assists individuals in defining, exploring, and actualizing their gender identity, allowing for exploration without judgments or assumptions.

This does not mean that all youth need to undergo medical transition; indeed, this is often not the case.

Gender-affirming care is highly individualized and focuses on the needs of each individual by including psychoeducation about gender and sexuality (appropriate to age and developmental level), parental and family support, social interventions, and gender-affirming medical interventions.

How do we provide gender affirming care to improve mental health outcomes?

- Listen
- Empathise
- Be self-aware
- Be non-judgemental
- Put the young person at the centre of decision making

Respond to the child or young person’s needs

- Preferred name
- Correct pronouns
- Social presentation
- Identity documents
- Pubertal suppression
- Menstrual suppression
- Hormone treatment
Gender affirmation

Refers to an interpersonal, interactive process whereby a person receives social recognition and support for their gender identity and expression.

Social affirmation

• Living life as one’s authentic gender and expressing it.
• Expressing gender in the ways that feel true to them (clothing, hair, name, pronouns, interests, activities, etc.)
• Binders, tuckers, padded bras, padded underwear
• Legal name and gender marker changes
Medical affirmation:

- Puberty blockers (GnRHa)
  - result in a pause in physical pubertal changes
  - Mechanism: blocking the release of the pituitary hormones (LH/FSH), so that the gonads are not stimulated to produce oestrogen or testosterone

- Androgen ‘blockers’: suppress the effects of androgen hormones

- Menstrual suppression

- Oestrogen/testosterone
Surgical affirmation:
• Top surgery: chest masculinising; breast augmentation
• Bottom surgery: labiaplasty, vaginoplasty, testicular implants, scrotoplasty; metoidioplasty; orchiectomy; hysterectomy
• Other: Chondrolaryngoplasty (aka tracheal shave), facial feminisation surgery
World Professional Association for Transgender Health
Standards of Care
- Version 8
- Published 2022
Australian Standards of Care and treatment guidelines

For trans and gender diverse children and adolescents

First published online in September 2017
A/Prof. Michelle Telfer, Dr Michelle Tollit
Dr Carmen Pace, Dr Ken Pang.
- Version 1.3, 2020

• Endorsed by the Australian Professional Association for Trans Health

• Published in MJA on 18 June 2018

• Subject of an editorial in The Lancet on 30 June 2018

Find it at https://www.rch.org.au/adolescent-medicine/gender-service/#resources
<table>
<thead>
<tr>
<th>Ten Things Transgender &amp; Gender Diverse Youth Want Their Doctors to Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turban et al (2017)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Gender and sexuality are totally different things</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Talking to strangers about this is uncomfortable</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Non-binary people exist</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Names, pronouns, and gender markers are important</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Don’t ask me about my genitals unless medically necessary</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Physical exams are uncomfortable for everyone, but especially for me</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Gender-affirming hormonal interventions can save my life</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Please train your staff as well. Many of us have had visits starting with the wrong tone, starting with check-in. This can make me shut down</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>If I am depressed or anxious, it’s likely not because I have issues with my gender identity, but because everyone else does</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Let me know that you are on my team</td>
</tr>
</tbody>
</table>

Gender Diversity is not a mental health disorder

Trans and gender diverse identities are a part of the human existence.

There is no treatment that is indicated or warranted for people with transgender identities.

Mental health issues may arise for trans and gender diverse people due to a lack of support, rejection, misunderstanding and discrimination, which can lead to bullying, exclusion, marginalization, institutional barriers, negative attitudes, and denial of their existence, or the validity of their experience.

Gender Dysphoria is a health condition that may benefit from support & medical intervention.
Strauss et. al. Trans Pathways (2017)
Trans youth living in Australia aged 14-25 years.
859 trans young people and 194 parents/guardians of trans youth
Co-occurrence with mental health conditions

- Depression: 74.6%
- Anxiety Disorder: 72.2%
- Eating Disorder: 22.7%
- Self harm: 80%
- Attempt suicide: 48%
Online survey of LGBTQ+ young people aged 14-21
6,418 respondents – largest survey

- 90% of trans young people experience high or very high psychological distress in the last 4 weeks
- 64% of trans young people had self-harmed
- 71% of trans young people had experienced suicidal ideation
- 14% had reported attempted suicide in the last 12 months
- 38% had reported attempted suicide in some time in their lives.
Transgender youth suffer high rates of harassment

- Verbal harassment: 70-84%
- Physical harassment: 20-33%
- Sexual harassment: 31-55%
- Unsafe/uncomfortable - education: 66-74%
- Misgendering: 52%
- Being ‘outed’: 54%

(Hill et. al. 2021)
Minority stress model (Meyer, 1993)

External factors (distal):
• Discrimination
• Prejudice
• Bullying
• Harassment
• Misgendering
• Exclusion

Internal (proximal) factors:
• Vigilance and anxiety about prejudice
• Concealment of identity/stealth

Deeply internal (proximal) factors:
• Internalized stigma
• Internalized transphobia

Community Connectedness
• Pride

Mental health symptoms, self-harm, suicidality, substance use, physical health symptoms
The role of any clinician – in all contexts

• Understand a trauma-informed approach
• First do no harm, create a safe space
  – Exploration and understanding can only occur in psychological safety/security
• Avoid paternalism, the “all-knowing adult stance”
• Listen

Be aware of:
• Experiences of bullying, discrimination, transphobia
• Misgendering and lack of social affirmation
• Minority stress
• Anxiety and trauma responses
ED & TNB youth

TGD young people have higher rates of disordered eating and diagnosed eating disorders.

- 15% of TGD individuals having experienced an ED within the last year, compared to 0.55–3.7% of cisgender men and 1.85–3.52% of cisgender women.

ED & TGD youth

- Prevalence of eating disorders in TGD youth vary across studies, with a range from 5-18% according to a scoping review.
- In a sample of youth (13-22 yrs) attending a gender clinic:
  - 63% engaged in intentional weight manipulation for gender-affirming purposes
  - 15% showed significant eating disorder psychopathology
  - 11% of those AFAM did so to suppress menstruation

Eating disorders are seen in higher rates across all TNB identities. AN, BN, ARFID, BED, OSFED are all seen.


TNB people with eating disorders have one of the highest rates of NSSI, SI & previous suicide attempt

- 74.8% of TNB individuals with an ED diagnosis reported non-suicidal self-injury
- 75.2% reported suicidal ideation
- 74.8% reported a previous suicide attempt (Duffy et al., 2019).

- TNB individuals with EDs have “the highest rates of past-year self-injury, suicidal ideation, and suicide attempts, which is 24 times higher than cisgender women with EDs and 21 times higher than transgender people without EDs.”

EDE-Q scores in TGD youth

Relationship Between Gender Identity/Expression and Disordered Eating

"Binging and purging helps me manage feelings of shame about being trans"

"Avoid Body"

"Dysphoria makes me dissociate and my ED helps me avoid connecting with my body so I can stay present"

"Manage Feelings"

"Puberty"

"Halt"

"Anorexia helped stunt my growth when I was younger. It was the only way I could stop my body changing while I waited for hormones"

"Self-Punishment"

"I used to self-harm. Restricting is just another way of punishing myself"

"Control"

"I can’t control how masculine my face looks but at least I can be thin"

"Gender Expression"

"I used to think that in order to be taken seriously as non-binary that you had to be thin"
Stigma vs. connectedness, its impact on eating

Survey of 923 trans youth (14-25 years) in Canada, looked at risk and protective factors for eating disordered behaviours:

• **Enacted stigma** (higher rates of harassment and discrimination) was linked to higher odds of reported past year binge eating, fasting & vomiting to lose weight.

• **Family connectedness**, school connectedness, caring friends and social support were linked to lower odds of past year disordered eating.

TGD youth experiences of ED care

In one study:

- 40% of TNB people did not disclose their gender identity during ED treatment due to fear of stigma and discrimination and previous negative experiences within ED therapy
- Of those who did disclose, participants reported that their gender identity was ignored or disregarded by their providers and experienced misgendering and other microaggressions

“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”


<table>
<thead>
<tr>
<th><strong>NOT HELPFUL</strong></th>
<th><strong>HELPFUL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of provider understanding, knowledge and experience in providing gender affirming care</td>
<td>1. Exploration of the function of disordered eating and relationship to gender-related distress. Referral to gender providers</td>
</tr>
<tr>
<td>2. Absence of concurrent treatment for gender-related distress/dysphoria</td>
<td>2. Focus on promoting body neutrality &amp; function rather then body positivity</td>
</tr>
<tr>
<td>3. Discordance between focus on body positivity in ED treatment &amp; gender affirming care</td>
<td>3. Centering trans &amp; gender-diverse voices in ED treatment</td>
</tr>
</tbody>
</table>

Duffy, M., Henkel, K., & Earnshaw, V. (2016); McGregor, K et al. (2023)
Helpful

“When my providers have been able to understand how my trans identity is connected to my eating disorder, we’ve been able to talk about finding alternative solutions and addressing body image holistically”

“We talked a lot about why I used my eating disorder to try to minimize gender dysphoria. My therapist encouraged me to get a binder to help me feel comfortable in my body without my ED”.

The head of the program flat out told me they weren’t equipped to deal with gender & recommended a workbook for me to do on my own. I felt extremely alone, like they didn’t care, and like I had to just shut down that part of me.” (White, nonbinary, 22)

“That being trans is/was what’s causing my eating disorders. They’re unrelated aside from contributing to my negative self/body image. They don’t work hand in hand. Anorexia wants to kill me, dysphoria wants me to live.” (White, genderqueer/fluid, 18)

“Constantly being referred to as a girl sucked. Especially in group—always started with “all right ladies let’s dive right in.”

TGD experiences of ED care

Clients who have therapists with greater queer and trans competency and knowledge of minority stress theory respond better to treatment

Summary - Relationship Between Gender Identity/Expression and Disordered Eating

• Do not assume that gender diversity explains, or is the cause of an eating disorder, but always explore the possible connections

• Eating disorders may present prior to an understanding or acceptance of one’s gender identity so be open to supporting this at ‘any and all’ stages

• Gender diversity may impact recovery as much or more than illness development
Summary - Why standard treatments for ED may not be effective for those with Gender Dysphoria

• It does not address the Gender Dysphoria

• It may worsen Gender Dysphoria e.g. with re-commencement of menses, increase in chest size, more stereotypically feminine body shape

• The treatment settings may not be comfortable for patients if their gender diversity is not acknowledged or affirmed

• There is emerging evidence that gender affirming medical treatment can lead to a reduction in disordered eating, where gender dysphoria is the motivating distress
ED Treatment Considerations: Assessment Phase

- Who constitutes family for the young person? What is the quality of & communication style within these relationships? Is the family aware of their YP’s gender diversity & does the YP feel supported and affirmed?

- Develop collaborative understanding of the relationship between disordered eating and gender-related distress/dysphoria. Explore internalised gender role expectations & how these might impact on self/body image. Identify goals for recovery.

- Provide concurrent treatment for disordered eating and gender dysphoria/gender-related distress. Establish a collaborative team of ED, Gender & Trauma-Informed treatment providers. Reflect carefully with team, young person & family about best treatment framework to address disordered eating and affirm gender identity.

- Discuss parameters to information sharing & limits to confidentiality.
Timeline: 13-yr-old Transfemale with AN

8 years of age
- Felt-sense of being in the wrong body
- Described as “emotional, like a girl”
- Friends mainly female
- Mum values thinness, active ED

12 years of age
- Pubertal development of peers
- Anxious ++ puberty
- Starts to restrict intake to prevent pubertal development

13 years of age
- Restriction increases, dx of AN
- Values thinness; sense of control over body, halts puberty
- Fearful of weight gain
- Anx about “coming out”
Treatment Considerations: Initial Phases

• FBT: Re-think agnostic approach & explore the relationship between disordered eating and gender-related distress/dysphoria. Address during Phase 1 alongside restoration of weight and physical health.

• CBT-E: Conduct historical review early-on in CBT-E and develop collaborative formulation illustrating precipitating and current maintaining factors to disordered eating.

• Collaboratively determine gender-affirming physical and psychological markers of recovery. This includes nutritional goals as well as metrics used to determine health.

• Explore young person’s sense of safety within their home/school environment. This includes access to toilets/locker rooms at school & fears about being misgendered following weight restoration.

• Evaluate family’s acceptance of their young person’s gender diversity & refer to support groups/family therapy (if needed). This might also include psychological support to address parental anxiety re: treatment tasks and weight restoration.
Treatment Considerations: Middle & Later Phases of Tx

• Assess for potential distress/gender dysphoria following weight restoration and resulting body changes, including return of menses. Refer to gender providers if not yet engaged.

• Collaboratively determine markers that indicate readiness to return to independent eating. Do not assume that body-related behaviours (e.g., body checking) are being driven by ED.

• Be mindful of young person’s access to gender-affirming facilities (toilets, locker rooms) & potential increase in gender dysphoria, when establishing movement-related goals

• Consider addressing negative body image from a “body neutral” or “body functionality” perspective. E.g., Idea of nourishing one’s mind to better advocate for oneself and/or gender-diverse peers.

• Conceptualise over-evaluation of weight, shape and appearance as a way of cultivating a sense of physical and psychological safety.
Screening for disordered eating should be incorporated into gender clinics

- **Questionnaires:**
  - EDE-QS “good measurement and construct validity in a transgender and gender diverse sample”
  - Single factor global score may be optimal in trans youth
  - However, is it really measuring the experience of trans youth?

- **Discussion:**
  - Ask about disordered eating, intake past 24 hrs, their relationship to physical activity, how they feel about their body in general


Asking about gender diversity should be part of an eating disorder assessment. Include asking about:

- Gender identity
- How a patient feels about their body in relationship to their gender
- What goals the patient has for their body

E.g. “Some people may change how they eat to make their body appear more masculine or feminine, has this ever been true for you?”

“What does the ideal body look like to you?”


Medical considerations – growth charts

• Not aware of any gender inclusive growth charts
• If possible, identify markers of progress collaboratively (not only weight)
• Use prior measurements, and other markers (HR, BP)
• May need to consult both the binary “female” and “male” growth charts
  – If on gender affirming hormones, use chart that matches their gender identity
• Be mindful of the significant limitations of BMI

When asking questions about bodies, avoid language that is inherently gendered, e.g. chest vs. breast.

If needing to discuss gendered body parts, you can say “in those with ovaries” instead of “your ovaries”.

Examinations can be stressful – always ask yourself if it is really needed and inform the person in advance. Explain what is involved.

Weighing (when needed)
- consider doing weighs in clothes (not a gown)
- allow gender affirming items to remain on e.g. binders
Medical considerations – bone mineral density

- Restrictive eating disorders, especially if more chronic, can result in low BMD
- Puberty blockers, can reduce BMD, especially if:
  - There is a baseline low BMD prior to starting
  - They are used for a long time, without any Oestrogen or Testosterone present
- Therefore, the benefits and risks of using blockers in those with restrictive eating disorders needs to be considered and discussed with the young person and family on an individual basis
- Optimize bone health for all – nutrition, Vit D, weight-bearing exercise (when appropriate)
- Of note, The International Society of Clinical Densitometry recommends that Z-scores be calculated based on the gender identity of the patient, rather than SAAB

Medical considerations – binders

- Binder use may reduce dysphoria
- Most adolescents will find a way to bind if they want to, and this may not always be safe (taping, bandages)
- Provide education on safe binding (or direct to resources)
- Ensure it is not too tight, ensure breaks, no use whilst asleep
- Those very unwell, in hospital, may need a break from binding. Discuss how to support this (clothing choice such as tighter singlets under loose tops)
- Regular check-ins and measurements may be needed if body shape is changing

https://www.transhub.org.au/binding
Medical considerations – menstrual suppression

• Discuss whether there is any dysphoria related to menstruation
• If so, discuss options for menstrual suppression
  – This can be discussed prior to the return of menses, in those with amenorrhea, to reduce anticipatory anxiety
• Most commonly used – Primolut (5mg BD)
• Avoid Depot Provera if BMD is low
Does gender-affirming care support recovery from an ED?

- Some preliminary evidence supports a reduction in ED symptomology in trans people receiving gender affirming care (mostly in adults)
- Very limited data tracking ED symptoms in trans adolescents receiving gender-affirming care
- Case report of 2 adolescents with AN and GD, which reported significant reduction in ED behaviours and cognitions, and weight restoration associated with puberty blocker use.
  - Both had articulated their main motivation of restriction being to prevent gendered pubertal changes
- Scoping review: “Among youth who accessed gender-affirming medical interventions (e.g., pubertal suppression, hormone therapy) body satisfaction and psychological well-being improved and disordered eating symptoms decreased or resolved for some youth

Case study – slides removed for distribution
Take home messages

❖ Eating disorder clinicians should proactively educate themselves on TNB terminology, history, and current issues within the queer and trans community. Such training is critical, as lack of knowledge may result in disaffirming care.

❖ Individual approaches to treatment that consider a range of experiences that confer ED risk should be paramount to avoid stereotypical conceptualizations that may not be relevant to TNB individuals’ lived experiences.

❖ Review your language, work environment, bathrooms, IT systems, clinical notes, group programs, educational materials: are they inclusive? If not – make changes.
Family and peer connectedness are important protective factors.

Support people to explore means to increase gender euphoria – hairstyles, clothes, speech training, laser hair removal, name & gender marker change etc.

Gender affirming care, including medical care, can and should be provided at all stages of eating disorder support.

Providing gender affirming care is everyone’s business.
Further reading


Resources/Supports

Organisations:
• RCH Gender Service: https://www.rch.org.au/adolescent-medicine/gender-service/
• Queerspace: https://www.queerspace.org.au/our-services/
• Safe Schools: http://www.safeschoolscoalition.org.au/
• Fighting Eating Disorders in Underrepresented Populations: A Trans+ & Intersex Collective: https://fedupcollective.org/

Peer Support Groups:
• BLOOM online Support Group, EDV (18+ years): https://events.humanitix.com/bloom-online-support-group-2023
• Alphabet Soup Westgarth: https://www.facebook.com/alphabetsouptrans/
• Support group list: https://monashhealth.org/services/gender-clinic/resources/trans-gender-diverse-and-non-binary-peer-support-groups/
Resources/Supports

Parent Support Organisations:

• Transcend https://transcend.org.au/
• Parents of Gender Diverse Children: https://www.pgdc.org.au/
• Village program - Queerspace
Questions?
References

• Cusack, C. E., Iampieri, A. O., & Galupo, M. P. (2022). “I’m still not sure if the eating disorder is a result of gender dysphoria”: Trans and nonbinary individuals’ descriptions of their eating and body concerns in relation to their gender. *Psychology of Sexual Orientation and Gender Diversity*.


Thank you