SPECIAL ISSUE ARTICLE

Gender-Affirmative Eating Disorder Care: Clinical Considerations for Transgender and Gender Expansive Children and Youth

Ben Geilhufe, MA, LPCC; Oliver Tripp, BA; Scout Silverstein, BS; Lindsay Birchfield, MS, RD; and Marcella Raimondo, PhD, MPH

ABSTRACT

Transgender and gender expansive (TGE) children and youth suffer staggering rates of discrimination and are at higher risk of developing eating disorder symptoms and behaviors than cisgender youth. This article presents an overview of current research on identified risk factors for the development of eating disorders for TGE children and youth; provides clinical considerations for professionals in providing gender-affirming, collaborative eating disorder care; outlines specific concepts for staff training and for developing gender-affirming systems of care including policies and practices; and identifies numerous resources for TGE children and youth and their families. The clinical considerations and suggested practices reflect current research and clinical practice. Both the gender-affirmative clinical field and the eating disorder field are constantly evolving, and the recommendations and resources will need ongoing updates to reflect developments in these fields. **[*Pediatr Ann*. 2021;50(9):e371-e378.]**

> Almost every day, it seems like we're bombarded with a new law or article attacking our basic humanity for the crime of daring to live as a trans person. Listening to folks debate whether or not you are allowed to participate in social institutions that most take for granted can be an incredibly dehumanizing experience and there can be a lot of anger and/or pain that comes with that. For better or for worse, one coping mechanism when dealing with these negative emotions is to return to patterns of disordered eating.[1]

This article uses the terms transgender and gender expansive (TGE) to describe any individual whose gender identity differs from their designated sex at birth, including those who identify as transgender, nonbinary, gender diverse, agender, third gender, metagender, genderqueeer, and many more (see **Table 1** for educational resources on key concepts and foundational information in gender care, including definitions of the terms above). This includes endosex and intersex people: research reports that more than 25% of intersex individuals identify as nonbinary and about 7.9% identify as transwomen and transmen, respectively.[2] Language is imperfect and there is no term or acronym that is inherently inclusive of all genders.

TGE children and youth often endure high levels of bullying, discrimination, trauma, and abuse as well as high rates of body dissatisfaction.[3,4] The 2015 US National Transgender Discrimination Survey reported that 77% of TGE children and youth experienced mistreatment in school, including verbal harassment, physical assault, and harsher discipline.[5] One-third of people reported discrimination in health care settings within the past year alone, including providers refusing to use accurate name and pronouns and outright refusal of services due to transgender identity.[5] Fifty percent of TGE respondents reported having to teach their medical providers about transgender care.[5]

A growing body of research identifies stigma and discrimination and body dissatisfaction as significant risk factors in developing eating disorder (ED) behaviors for TGE children and youth.[6,7] In addition, TGE 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.[8]

TGE children and youth may develop disordered eating behaviors for many reasons. Multiple studies identify that they may engage in ED behaviors to combat or prevent the development of secondary sex characteristics during puberty or to shape their body to align more closely with their gender identity.[4,8-13] Other reasons include lack of access to gender-affirming health care providers due to geographical, financial, or other factors; navigating pressures from cisnormative (expectation that a person's gender identity aligns with their designated sex at birth), Western, gendered body ideals; and heightened social stigma, especially for youth who face higher levels of gender-based discrimination due to visibly nonconforming gen-

SLACK INCORPORATED
Copyrighted Material

der expressions.[6,7,11,13] TGE individuals may also develop ED behaviors as coping mechanisms to navigate emotional distress and minority stress, or the stress experienced by minoritized individuals due to discrimination and prejudice. This stress is further compounded for people with multiple marginalized identities including TGE children and youth who are disabled, fat, neurodivergent (divergent in neurocognitive function, including autism, attention-deficit/hyperactivity disorder, and more), and BIPOC (Black, Indigenous, person of color).[3,9,11] These factors are not exhaustive as existing research is based on a primarily affluent, White sample population.[3,9]

Providers are ill-equipped to support TGE patients in treatment, largely due to a lack of training in gender-affirmative clinical care.[14] Patients report negative experiences with providers, fear of disclosing their gender identity, and ineffective or harmful treatment practices.[10,12] In a study on transgender adolescents' experiences in ED treatment specifically, 40% of patients chose not to disclose their gender identity to their providers, 10% did disclose but were ignored, and 19% of participants reported that it was extremely difficult or impossible to find providers who specialized in both ED treatment and gender-affirming care.[10] A staggering 0% of participants had a positive experience in ED treatment.[10]

Family acceptance and support is a primary indicator of physical and mental health for TGE children and youth.[15] TGE children and youth with family support are less likely to experience mental health symptoms, and far less likely to attempt suicide; only 4% with affirming family reported suicide attempts versus 57% without affirming family.[16] In fact, family support acts as a protective factor specifically against the development of EDs, even when youth are experiencing high levels of gender-based harassment and discrimination. One study identified that TGE children and youth experiencing significant discrimination and no protective factors had a 71% probability of reporting binge eating, compared to a 40% probability with family support.[5]

The Gender Affirmative Care Model (GACM) is the American Academy of Pediatrics' (AAP) suggested treatment approach for TGE children and youth.[17,18] The GACM states that gender variations are not disorders, that gender presentations are diverse and vary across cultures, and that mental health issues most prevalently develop from stigma and discrimination, rather than from the youth's intrinsic gender experience.[18] The AAP, multiple other organizations, and current research identifies that therapies that attempt to change a youth's gender experience or expression are ineffective and harmful.[17] One of the primary clinical goals of the GACM is to facilitate gender health—the opportunity to live in the gender that feels most authentic with freedom from rejection.[18] Providers must seek training and consultation to equip themselves to support TGE children and youth and their families with gender exploration through the GACM.

CLINICAL CONSIDERATIONS

> I have been regularly misgendered over the course of my treatment. It's kind of par for the course by now, but it's still really upsetting. Even my therapist doesn't really understand how to use my pronouns, and has referred to me as "girl" and "daughter," despite the fact I've come out to her.[10]

Ben Geilhufe, MA, LPCC, is the Director of Community-Based Clinical Programs, University of California, San Francisco Child and Adolescent Gender Center; an Adjunct Faculty, Santa Clara University; and a Private Practice Clinician. Oliver Tripp, BA, is a Research Team Member, Fighting Eating Disorders in Underrepresented Populations (FEDUP); and a Graduate Teaching Associate, San Francisco State University. Scout Silverstein, BS, is an Administrator and Research Team Member, FEDUP. Lindsay Birchfield, MS, RD, is an Outpatient Dietitian, Center for Discovery; and an Adjunct Faculty, Sage College. Marcella Raimondo, PhD, MPH, is a Clinical Psychologist, Kaiser Permanente Oakland Adult Eating Disorders Clinic; and a Private Practice Clinician.

Ben Geilhufe (he, him, his) is a transmasculine, queer, White clinician, educator, and trainer who supports youth of all genders in navigating disordered eating, eating disorders, and relationship with body. Oliver Tripp (they, them, theirs) is a transgender non-binary, queer, White team member at FEDUP. Scout Silverstein (they, themme, theirs) is a White, transgender, and intersex person who collaborates on academic research and administers training to health care providers about how gender-diverse experiences intersect with the risk for developing an eating disorder. Lindsay Birchfield (they, them, theirs) is a White, transmasculine, registered dietitian in a straight size body who has worked in various levels of hospitalized care for eating disorders. Marcella Raimondo (she, her, hers) is a cisgender, queer, woman of color psychologist who specializes in eating disorders and provides trainings on eating disorders and social justice.

Address correspondence to Ben Geilhufe, MA, LPCC, PO Box 808, Felton CA, 95018; email: bgeilhufe@gmail.com.

Disclosure: The authors have no relevant financial relationships to disclose.

Acknowledgment: The authors thank Vaughn Darst MS, RD (Center for Discovery), Micah Hammond MA, LPCC (The Lotus Collaborative), Diane Ehrensaft PhD (Mental Health, Child and Adolescent Gender Center), Vivian Underhill, BA (University of California, Santa Cruz, Feminist Studies), and Jen Hastings, MAT, MD (University of California San Francisco), for providing feedback on the manuscript.

doi:10.3928/19382359-20210820-01

Copyright © SLACK Incorporated

There is currently no clear guidance for supporting TGE children and youth in ED treatment, which has historically centered thin, White, heterosexual, able-bodied, cisgender women.[19] The following presents suggested practices to support TGE children and youth in ED treatment, based on clinical experience and the limited body of research.

Affirming Approaches to ED Treatment

Concurrent treatment of both gender distress and/or dysphoria and ED symptoms with a collaborative team of gender providers and ED providers is crucial. Only addressing ED symptoms in treatment may increase patient distress and is likely to make treatment ineffective.[12] Access to gender-affirming medical care for patients with dysphoria can increase body satisfaction and decrease the prevalence and severity of ED behaviors.[6,11] All treatment must be trauma-informed due to the significant rates of harassment and discrimination faced by TGE children and youth. Establish collaborative care teams to create a patient-centered treatment plan that addresses both gender dysphoria and ED symptoms. All youth presenting with ED symptoms should be assessed for gender distress.[12]

For family members to be an effective component of treatment for TGE children and youth, their understanding of, and biases toward, gender diversity must be addressed. Include clinical goals facilitating family acceptance of the youth's gender experience, as acceptance leads to a decrease in mental health symptoms and suicide attempts.[5] Ensure that parents and caregivers access the support they need to accurately hear their child's gender experience, support their child's gender health, and process their own emotional responses. Facilitate referrals including family therapy, support groups, psychoeducation, and community building (see **Figure 1** for example resources).

TABLE 1.

Resources for Education, Training, and Program Development

Education and training resources

- *Fighting Eating Disorders in Underrepresented Populations: A Trans+ & Intersex Collective*
  https://fedupcollective.org/
- *Fenway Institute: The National LGBTQIA+ Health Education Center*
  https://www.lgbtqiahealtheducation.org/
- *The Transgender Training Toolkit. A Facilitator's Guide to Increasing Knowledge, Decreasing Prejudice & Building Skills*
  http://www.teachingtransgender.org/
- *ProjectHEALTH: TransLine*
  http://project-health.org/transline/
- *Gender Education Network*
  https://gendereducationnetwork.com/
- *World Professional Association for Transgender Health Global Education Initiative*
  https://www.wpath.org/gei
- *Gender Spectrum*
  https://www.genderspectrum.org

Gender-inclusive practices and policies

- *The National LGBTQIA+ Health Education Center: Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients*
  https://www.lgbthealtheducation.org/publication/focus-forms-policy-creating-inclusive-environment-lgbt-patients/
- *Gender Spectrum: Establishing Trust with Youth Seeking Gender Affirmative Medical Care*
  https://static1.squarespace.com/static/5ac6a3e825bf0250fa23d6cb/t/5b329131575d1ff01744b94d/1530040625617/Establishing+Trust+with+Youth+Seeking+Gender+Affirmative+Medical+Care.pdf
- *American Medical Association: Creating an LGBTQ-Friendly Practice*
  https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice?utm_source=twitter&utm_medium=social_ama&utm_term=2624946319&utm_campaign=PE&utm_effort=FBB001
- *University of California, San Francisco Transgender Care and Treatment Guidelines*
  https://transcare.ucsf.edu/guidelines

Careful assessment of the function of ED behaviors is a critical component of care for TGE children and youth. For example, providers often attribute a patient's desire for body modification as a symptom of body dysmorphia, rather than assessing for other potential triggers including gender dysphoria and/or seeking physical alignment with gender identity.[12] Furthermore, many neurodivergent TGE children and youth may develop food restriction or food avoidance due to sensory sensitivities or physical discomfort upon eating and digestion.[20] Assess the function of the ED behavior to adequately support the patient.

ED treatment is often inaccessible for many TGE children and youth and their families and finding gender-affirming referral resources for all levels of treat-

SLACK INCORPORATED Copyright © SLACK Incorporated

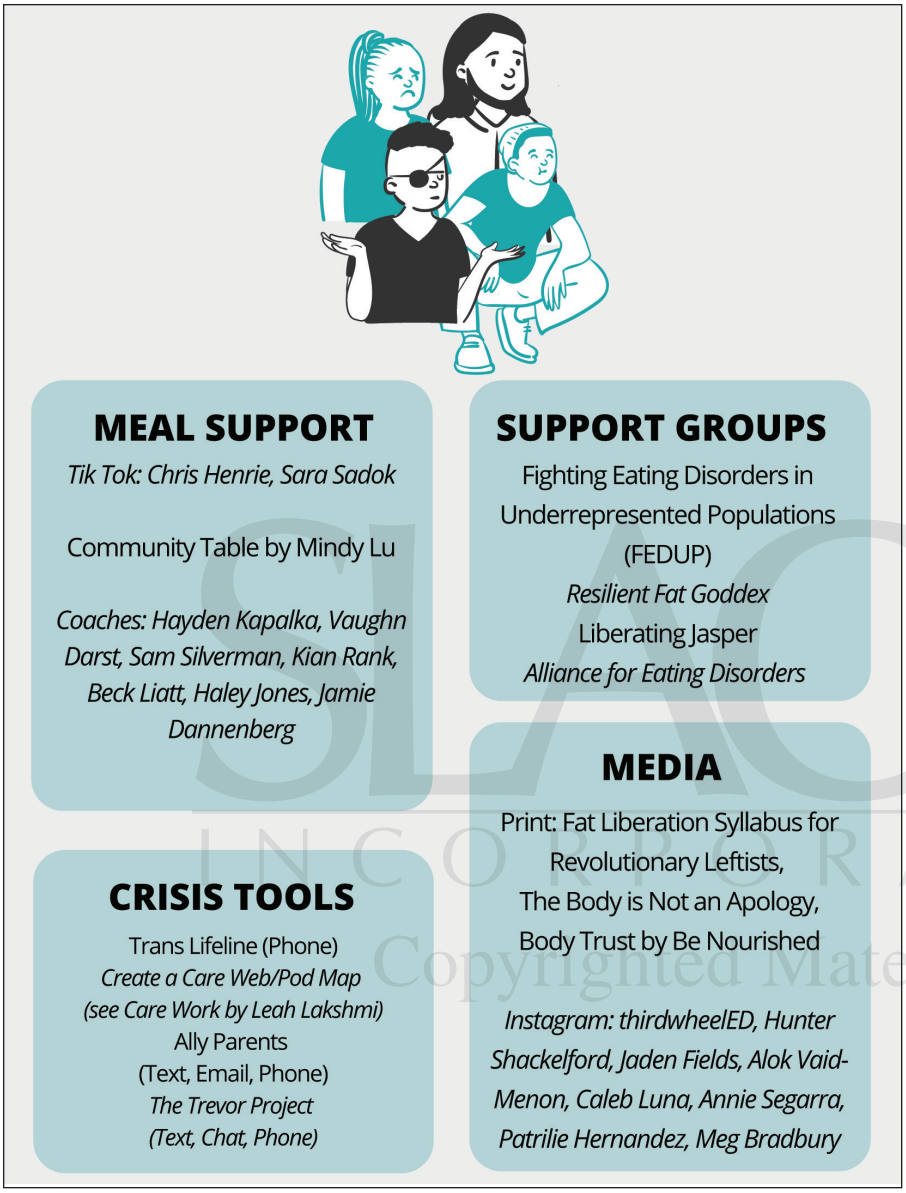


Figure 1. Resources for transgender and gender expansive children and youth with eating disorders. Image created via sourced information from Scout Silverstein, BS, and Fighting Eating Disorders in Underrepresented Populations (personal communication, 2020).

ment (outpatient, intensive outpatient, partial hospitalization, and residential facilities) can be difficult. Higher levels of ED treatment are expensive and time-consuming.[21] Treatment can be largely unavailable to people who need to work, attend school, or lack insurance coverage. Many treatment programs are not equipped to support gender exploration or to administer gender-affirmative hormone therapies (GAHT) or puberty blockers, and restrooms and sleeping spaces are often segregated into "male" or "female" categories. All of these issues can be barriers to care for TGE children and youth. These barriers are much more severe for patients with multiple marginalized identities and can compound experiences of minority stress, dissatisfaction in treatment, and avoidance of treatment.[2,10] Professionals often misunderstand resistance to treatment as a lack of motivation when the resistance is really due to the facility's inability (or unwillingness) to accommodate the person's needs. Treatment facilities and individual providers need to reevaluate the measures by which they assess motivation to engage in treatment, taking into account structural barriers to care and minority stress.

Due to the significant lack of individual providers and ED treatment programs with experience in gender-affirming clinical care, it is important that a primary care provider assess each potential referral option for gender awareness. See **Figure 2** for example questions that can be used when assessing referrals. This list can also serve as a self-assessment for providers.

Considerations for Puberty, Dysphoria, and GAHT

Some TGE children and youth may experience dysphoria upon puberty and may develop ED behaviors to mitigate physical changes. Consistently assess for distress in response to puberty and support the family in exploring the applicability of gender-affirmative medical interventions if clinically indicated, like puberty blockers and GAHT. Collaborate closely with patients taking GAHT to explore their experience of resulting body changes (both desired and undesired) and how those changes may impact ED symptoms and behaviors.

Historically, the return of menses after amenorrhea has been used as an indicator of medical stabilization in ED treatment. However, some TGE adolescents may experience dysphoria related to menstruation—whether it be the presence of it (for bodies that menstruate) or the absence of it (for bodies that do not). Assess for potential distress and/or dysphoria upon the return of menses in patients who menstruate. If medical rehabilitation restores men-

SLACK INCORPORATED Copyrighted Material

Copyright © SLACK Incorporated

ses and distress is present, birth controls, hormone blockers, and/or progesterone-releasing intrauterine devices can suppress menstruation.[22] Note that not all patients with a vagina or a uterus menstruate, nor do all patients who identify as women. Do not assume a patient's anatomy based on their gender marker. See **Table 1** for resources that discuss gender-inclusive intake practices.

Nutrition Practices in ED Treatment

Traditional nutrition care practices in ED treatment include using sex-based growth charts, weight formulas, and caloric equations to monitor patient health. These reference points are dependent on the assumption that all bodies fit into cisgender "male" and "female" categories. To date, gender-inclusive growth charts, weight formulas, and caloric equations do not exist. This calls into question the efficacy of current weight restoration practices and highlights how they do not support patients of all genders.

Providers often use body mass index (BMI), a scale developed using the bodies of White, cisgender men, to determine levels of care and nutrition protocols. The scale is outdated, discriminatory, and has a limited ability to assess levels of body mass across age, gender, and race.[23,24] There are currently no evidence-based recommendations for the use of BMI with TGE children and youth, including patients taking puberty blockers and/or GAHT.[25,26] BMI may also be used as a gatekeeping metric for gender-affirming medical interventions. Barred access to gender-affirming medical intervention can increase distress and/or dysphoria and subsequently exacerbate ED symptoms and behaviors.[27]

In the absence of gender inclusive tools, it is important to collaborate with the patient to identify the best approach for their body for nutrition and weight rehabilitation. This may require creative approaches that include consulting both

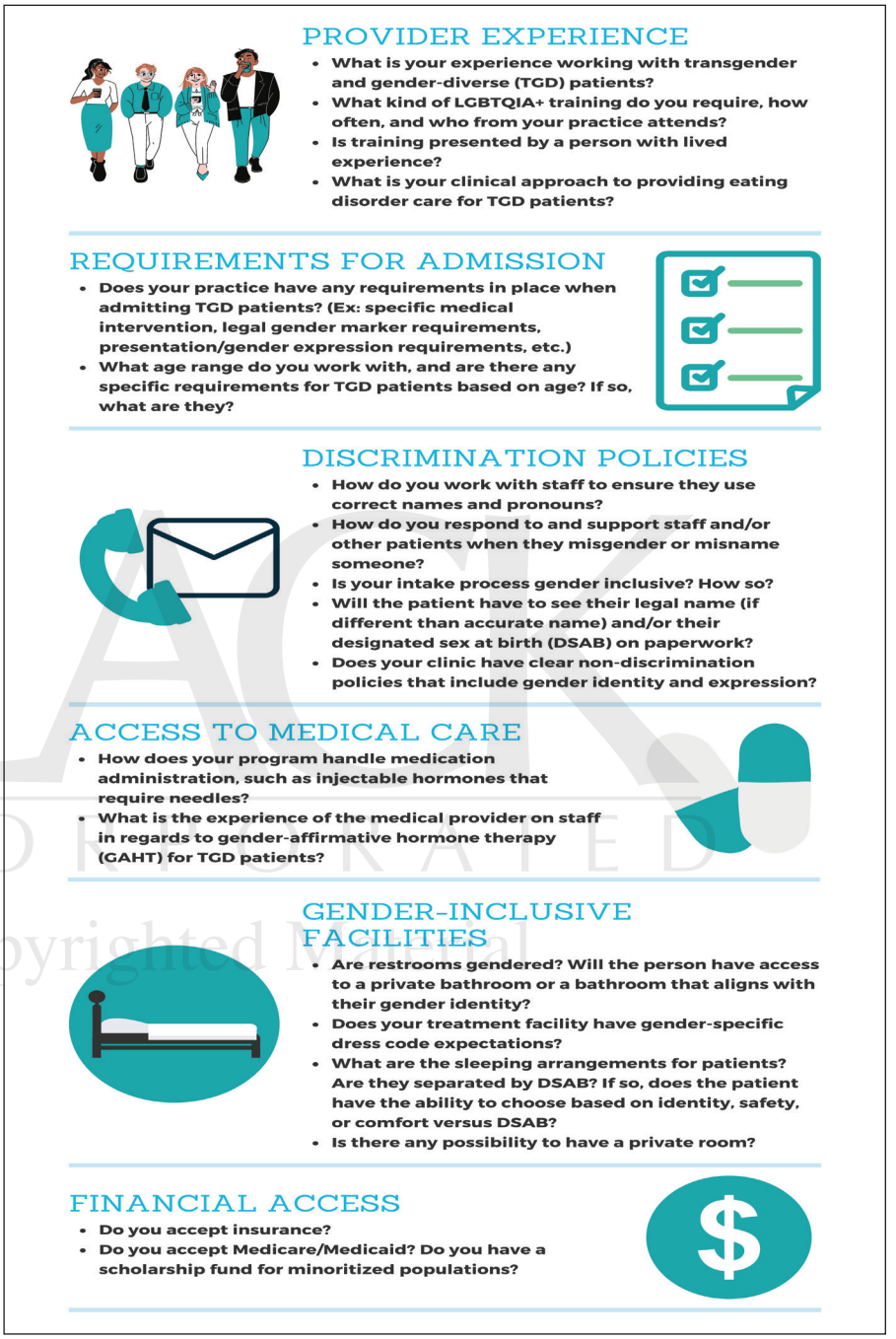
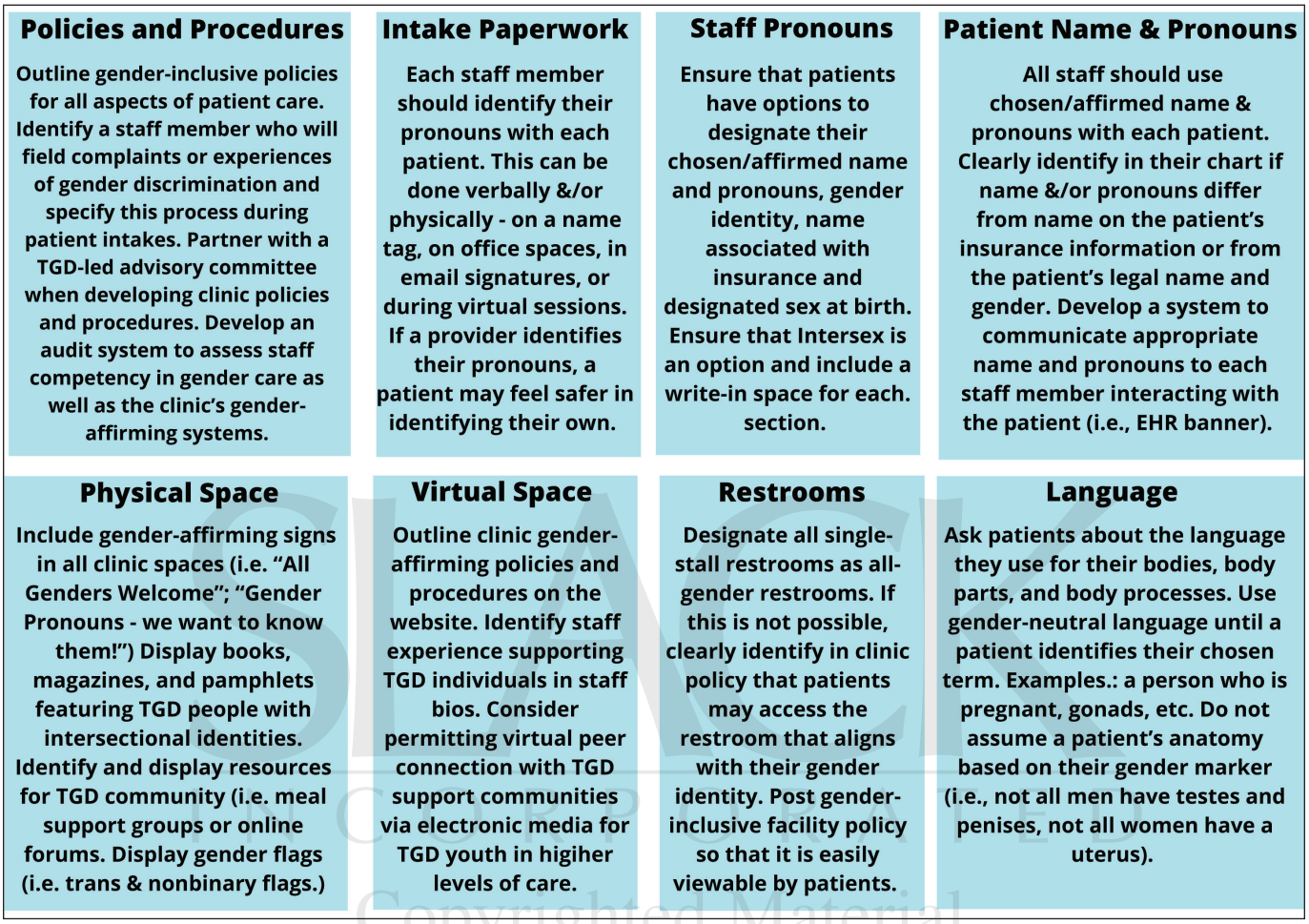


Figure 2. Making referrals: assessment questions for gender-affirming eating disorder care. Image created via sourced information from Ben Geilhufe, MA, LPCC, and Micah Hammond, LPCC (personal communication, 2019) and Scout Silverstein, BS, and Fighting Eating Disorders in Underrepresented Populations (personal communication, 2020).

binary sex "male" and "female" growth charts and weight formulas to determine averages that affirm a patient's gender while providing medical stability.[28] This is a rapidly evolving area of clinical care and further research and clinical practice are needed to establish best practices for using growth charts with TGE patients.

When identifying movement goals, be aware that many TGE children and youth

SLACK INCORPORATED Copyrighted Material



SLACK Incorporated Copyrighted Material

Figure 3. Examples of system-wide gender-affirming care. EHR, electronic health record; TGD, transgender and gender diverse. Image created via sourced information from Ben Geilhufe, MA, LPCC, Oliver Tripp, BA, Scout Silverstein, BS, Lindsay Birchfield, MS, RD, and Marcella Raimondo, PhD, MPH (personal communication, 2021).

do not feel safe using binary gendered locker rooms and are often denied access to gendered organized sports teams. Movement may exacerbate dysphoria or serve as a coping mechanism and a means to mitigate the physical effects of puberty.[29] Work closely with the patient to identify movement goals that are inclusive, affirming, and address both the patient's gender and nutrition-related needs.

STAFF TRAINING, DEVELOPING GENDER-AFFIRMING SYSTEMS OF CARE, AND FINDING RESOURCES

> For some binary and nonbinary people, there is no desire to pass, beyond the necessary need to do so at times to survive. . . .This challenges cisnormative ideas of what it means to beautiful. But challenging what beauty means has never been an easy task. I can't count the number of times I've been called a 'monster,' an 'it,' ugly, etc. I can, however, count the number of times I have been seen as desirable. I needed something to hold on to, to give me the ability to say I am desirable and worthy and loveable, setting the stage for my then disordered eating to morph into an eating disorder.[30]

TGE children and youth are often not adequately supported in ED treatment. To address this, it is imperative that all providers (1) seek training in the GACM, including an exploration of potential provider biases; (2) develop gender-affirming systems in all settings; and (3) identify gender-affirmative ED resources and community support.

Staff Training in the GACM

The cisnormative assumption that a cisgender identity is normal and a transgender identity is abnormal is a significant contributing factor to provider bias and a barrier to competent care for TGE patients.[31,32] Gender diversity has been documented in cultures across the globe and throughout history.[33,34] However, individuals who express or identify their authentic identity outside of the

Copyright © SLACK Incorporated

gender binary—the inaccurate belief that there are only two genders and that these genders correspond with physical sex characteristics (ie, any body with testes is a man, any body with ovaries is a woman)—are often discriminated against and pathologized.[33,34] Few treatment centers have intentionally developed gender-inclusive policies, practices, and facilities. This lack of structural, clinical, and procedural support creates stigma and increases the likelihood of discrimination for TGE patients.[32] To shift this dynamic, providers must critically examine their own biases and beliefs around cisnormativity and how these biases impact their clinical services. Providers must also explore how their treatment centers uphold the structural prioritization of cisgender bodies by focusing on the medical needs of cisgender bodies, rather than adapting services for bodies of all genders.

Training and interacting with TGE patients have been documented to increase provider competence and confidence.[35,36] Researchers, clinicians and advocates recommend ongoing gender-affirmative care training for all providers and staff, including front office staff, medical assistants, medical providers, behavioral health staff, registered dietitians, laboratory technicians, and insurance billers. Training should include cultural sensitivity (gender-affirming language and terminology, history of gender diversity and cross-cultural perspective of gender diversity); stigma, discrimination, and health care disparities; an exploration of provider biases; legal considerations like gender marker and name changes; and specific clinical training in the GACM for each provider type (ie, mental health training, medical training). Gender-affirmative clinical training includes medical considerations like hormone therapies and surgeries; navigating insurance coverage and denials; supporting the whole family system; and other specific medical and behavioral health considerations.

Develop Gender-Affirming Systems in All Clinic Settings

Implementing gender-affirming systems of care in all clinic settings is instrumental in decreasing health care disparities for TGE individuals. A few examples of systems-wide gender-affirming care can be found in **Figure 3**.

Identify Gender-Affirmative ED Resources and Community Support

Gender-affirmative ED resources, including meal support groups, psychoeducation, family and caregiver support, crisis tools, and peer connection/coaching, help TGE children and youth in building community through shared physical and virtual spaces. Assist patients, parents, and other family members in accessing these resources. Examples of resources for TGE children and youth are included in **Figure 1**. A few examples of resources specifically for family members and caregivers include Trans Family Support Services, Gender Spectrum, and Trans Youth Equality Foundation. This list is by no means exhaustive and the authors do not endorse each resource for every patient. Have patients explore resources to find a fit for their needs.

CONCLUSION

TGE children and youth are at higher risk of developing EDs than their cisgender peers and are often not supported in ED treatment. It is essential that providers seek training in the GACM and develop gender-inclusive treatment policies and practices. Collaborative, trauma-informed and patient-centered care teams with both gender providers and eating disorder providers can support the patient in navigating gender diversity and ED symptoms concurrently. Identifying the limitations of sex-based care practices (such as growth charts and BMI) and exploring gender-affirmative approaches to ED care is essential. Gender-affirming community resources facilitate connection, build narratives of body liberation, and decrease isolation. More research and clinical experience in the intersection of the gender-affirmative clinical field and the ED field is needed to better support TGE children and youth with EDs and their families.

REFERENCES

1. Knudsen L. Navigating eating disorder recovery while visibly trans. National Eating Disorders Association. Accessed August 20, 2021. https://www.nationaleatingdisorders.org/blog/navigating-eating-disorder-recovery-while-visibly-trans
2. Rosenwohl-Mack A, Tamar-Mattis S, Baratz AB, et al. A national study on the physical and mental health of intersex adults in the U.S. *PLoS One*. 2020;15(10):e0240088. https://doi.org/10.1371/journal.pone.0240088 PMID:33035248
3. Mensinger JL, Granche JL, Cox SA, Henretty JR. Sexual and gender minority individuals report higher rates of abuse and more severe eating disorder symptoms than cisgender heterosexual individuals at admission to eating disorder treatment. *Int J Eat Disord*. 2020;53(4):541-554. https://doi.org/10.1002/eat.23257 PMID:32167198
4. Jones BA, Haycraft E, Murjan S, Arcelus J. Body dissatisfaction and disordered eating in trans people: a systematic review of the literature. *Int Rev Psychiatry*. 2016;28(1):81-94. https://doi.org/10.3109/09540261.2015.1089217 PMID:26618239
5. James S, Herman J, Rankin S, Keisling M, Mottet L, Anafi M. The report of the 2015 U.S. Transgender Survey. Accessed August 20, 2021. http://hdl.handle.net/20.500.11990/1299
6. Watson RJ, Veale JF, Saewyc EM. Disordered eating behaviors among transgender youth: probability profiles from risk and protective factors. *Int J Eat Disord*. 2017;50(5):515-522. https://doi.org/10.1002/eat.22627 PMID:27862124
7. Testa RJ, Rider GN, Haug NA, Balsam KF. Gender confirming medical interventions and eating disorder symptoms among transgender individuals. *Health Psychol*. 2017;36(10):927-936. https://doi.org/10.1037/hea0000497 PMID:28368143
8. Duffy ME, Henkel KE, Joiner TE. Preva-

SLACK INCORPORATED Copyrighted Material

lence of self-injurious thoughts and behaviors in transgender individuals with eating disorders: a national study. *J Adolesc Health*. 2019;64(4):461-466. https://doi.org/10.1016/j.jadohealth.2018.07.016 PMID:30314865

9. Diemer EW, Grant JD, Munn-Chernoff MA, Patterson DA, Duncan AE. Gender identity, sexual orientation, and eating-related pathology in a national sample of college students. *J Adolesc Health*. 2015;57(2):144-149. https://doi.org/10.1016/j.jadohealth.2015.03.003 PMID:25937471
10. Duffy ME, Henkel KE, Earnshaw VA. Transgender clients' experiences of eating disorder treatment. *J LGBT Issues Couns*. 2016;10(3):136-149. https://doi.org/10.1080/15538605.2016.1177806
11. Gordon AR, Austin SB, Krieger N, White Hughto JM, Reisner SL. "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. *Soc Sci Med*. 2016;165:141-149. https://doi.org/10.1016/j.socscimed.2016.07.038 PMID:27518756
12. Coelho JS, Suen J, Clark BA, Marshall SK, Geller J, Lam PY. Eating disorder diagnoses and symptom presentation in transgender youth: a scoping review. *Curr Psychiatry Rep*. 2019;21(11):107. https://doi.org/10.1007/s11920-019-1097-x PMID:31617014
13. Diemer EW, White Hughto JM, Gordon AR, Guss C, Austin SB, Reisner SL. Beyond the binary: differences in eating disorder prevalence by gender identity in a transgender sample. *Transgend Health*. 2018;3(1):17-23. https://doi.org/10.1089/trgh.2017.0043 PMID:29359198
14. Rider GN, McMorris BJ, Gower AL, Coleman E, Brown C, Eisenberg ME. Perspectives from nurses and physicians on training needs and comfort working with transgender and gender-diverse youth. *J Pediatr Health Care*. 2019;33(4):379-385. https://doi.org/10.1016/j.pedhc.2018.11.003 PMID:30827755
15. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*. 2009;123(1):346-352. https://doi.org/10.1542/peds.2007-3524 PMID:19117902
16. Travers R, Bauer G, Pyne J, Bradley K, Gale L, Papadimitriou M; Trans PULSE; Children's Aid Society of Toronto; Delisle Youth Services. Impacts of strong parental support for trans youth: a report prepared for Children's Aid Society of Toronto and Delisle Youth Services. Accessed August 20, 2021. https://transpulseproject.ca/research/impacts-of-strong-parental-support-for-trans-youth/
17. 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;142(4):e20182162. https://doi.org/10.1542/peds.2018-2162 PMID:30224363
18. Hidalgo MA, Ehrensaft D, Tishelman AC, et al. The gender affirmative model: what we know and what we aim to learn. *Hum Development*. 2013;56(5):285-290. https://doi.org/10.1159/000355235
19. Riobueno-Naylor A. *"Not Just a White Woman's Disease": Radicalizing Eating Disorder Knowledge*. Wellesley College; 2018. https://doi.org/10.13140/RG.2.2.13414.57920
20. Gratton F. *Supporting Transgender Autistic Youth and Adults: A Guide for Professionals and Families*. Jessica Kingsley Publishers; 2019.
21. Le LKD, Hay P, Mihalopoulos C. A systematic review of cost-effectiveness studies of prevention and treatment for eating disorders. *Aust N Z J Psychiatry*. 2018;52(4):328-338. https://doi.org/10.1177/0004867417739690 PMID:29113456
22. Gaudiani JL. *Sick Enough: A Guide to the Medical Complications of Eating Disorders*. CRC Press; 2018. https://doi.org/10.4324/9781351184731
23. Ahima RS, Lazar MA. Physiology. The health risk of obesity—better metrics imperative. *Science*. 2013;341(6148):856-858. https://doi.org/10.1126/science.1241244 PMID:23970691
24. Nuttall FQ. Body mass index: obesity, BMI, and health. *Nutr Today*. 2015;50(3):117-128. https://doi.org/10.1097/NT.0000000000000092 PMID:27340299
25. Kidd KM, Sequeira GM, Dhar CP, Montano GT, Witchel SF, Rofey D. Gendered body mass index percentile charts and transgender youth: making the case to change charts. *Transgend Health*. 2019;4(1):297-299. https://doi.org/10.1089/trgh.2019.0016 PMID:31663036
26. Brownstone LM, DeRieux J, Kelly DA, Sumlin LJ, Gaudiani JL. Body mass index requirements for gender-affirming surgeries are not empirically based. *Transgend Health*. 2021;6(3):121-124. https://doi.org/10.1089/trgh.2020.0068
27. Martinson TG, Ramachandran S, Lindner R, Reisman T, Safer JD. High body mass index is a significant barrier to gender-confirmation surgery for transgender and gender-nonbinary individuals. *Endocr Pract*. 2020;26(1):6-15. https://doi.org/10.4158/EP-2019-0345 PMID:31461357
28. Donaldson AA, Hall A, Neukirch J, et al. Multidisciplinary care considerations for gender nonconforming adolescents with eating disorders: a case series. *Int J Eat Disord*. 2018;51(5):475-479. https://doi.org/10.1002/eat.22868 PMID:29740834
29. Hayden L. Nurturing healthy transitions: nutrition, exercise, and body image for transgender and gender diverse youth. In: Evans YN, Docter AD, eds. *Adolescent Nutrition.* Springer International Publishing; 2020:795-820. https://doi.org/10.1007/978-3-030-45103-5_26
30. Zamantakis AS. 4 ways to make space for nonbinary people when discussing eating disorders. The Body is Not An Apology. Accessed August 20, 2021. https://thebodyisnotanapology.com/magazine/my-journey-to-eating-disorder-treatment-as-neither-a-man-or-woman/
31. Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. "I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people. *J Assoc Nurses AIDS Care: JANAC*. 2009;20(5):348-361. https://doi.org/10.1016/j.jana.2009.07.004 PMID:19732694
32. Kcomt L, Gorey KM, Barrett BJ, McCabe SE. Healthcare avoidance due to anticipated discrimination among transgender people: a call to create trans-affirmative environments. *SSM Popul Health*. 2020;11(100608):100608. https://doi.org/10.1016/j.ssmph.2020.100608 PMID:32529022
33. Binaohan B. *Decolonizing Trans/Gender 101*. Biyuti Publishing; 2014.
34. Lugones M. The coloniality of gender. In: Harcourt W, ed. *The Palgrave Handbook of Gender and Development: Critical Engagements in Feminist Theory and Practice*. Palgrave Macmillan; 2016:13-33. https://doi.org/10.1007/978-1-137-38273-3_2
35. Eisenberg ME, McMorris BJ, Rider GN, Gower AL, Coleman E. "It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States. *Health Soc Care Community*. 2020;28(3):1082-1089. https://doi.org/10.1111/hsc.12941 PMID:31917883
36. Thomas DD, Safer JD. A simple intervention raised resident-physician willingness to assist transgender patients seeking hormone therapy. *Endocr Pract*. 2015;21(10):1134-1142. https://doi.org/10.4158/EP15777.OR PMID:26151424

SLACK CONTENT Copyright Material

Copyright © SLACK Incorporated