THE STATUS OF EATING DISORDER PREVALENCE AND QUALITY OF EATING DISORDER TREATMENT AMONG TRANSGENDER AND GENDER EXPANSIVE PATIENTS IN THE UNITED STATES – A MIXED METHODS STUDY

A Dissertation Presented

By

KATARINA A. FERRUCCI

Submitted to the Faculty of the University of Massachusetts Graduate School of Biomedical Sciences, Worcester in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

11.08.22

CLINICAL AND POPULATION HEALTH RESEARCH
THE STATUS OF EATING DISORDER PREVALENCE AND QUALITY OF EATING DISORDER TREATMENT AMONG TRANSGENDER AND GENDER EXPANSIVE PATIENTS IN THE UNITED STATES – A MIXED METHODS STUDY

A Dissertation Presented

By

KATARINA A. FERRUCCI

This work was undertaken in the Graduate School of Biomedical Sciences
Clinical and Population Health Research

Under the mentorship of
Bill M. Jesdale Ph.D., Thesis Advisor
Catherine Dubé Ed.D., Member of Committee
Kate L. Lapane Ph.D., Member of Committee
Kathleen Mazor Ph.D., Member of Committee
Tiffany Brown Ph.D., External Member of Committee
Stephenie Lemon Ph.D., Chair of Committee

Mary Ellen Lane, Ph.D.,
Dean of Graduate School of Biomedical Sciences

November 8th, 2022
TABLE OF CONTENTS

ACKNOWLEDGEMENTS ................................................................................................................... iv

ABSTRACT ........................................................................................................................................... v

CHAPTER I: INTRODUCTION .............................................................................................................. 1

CHAPTER II: PREVALENCE OF DIAGNOSED EATING DISORDERS IN US TRANSGENDER ADULTS AND YOUTH IN INSURANCE CLAIMS .............. 10

CHAPTER III: CLINICIAN PERCEPTIONS OF BARRIERS AND FACILITATORS TO CARE IN EATING DISORDER TREATMENT FOR TRANSGENDER AND GENDER DIVERSE PATIENTS: A QUALITATIVE STUDY ......................................................... 29

CHAPTER IV: EATING DISORDER SPECIALIST VIEWS ON GENDER COMPETENCY AND EDUCATION FOR TREATING GENDER MINORITY PATIENTS ........................................................................................................ 59

CHAPTER V: DISCUSSION AND CONCLUSIONS ............................................................................. 92

REFERENCES ......................................................................................................................................... 99
Acknowledgements

I would like to thank William Jesdale, Kate Lapane, and Catherine Dubé who contributed their time and expertise to help me develop as a researcher through this dissertation. Their subject matter expertise and contributions to these papers extend far beyond contributions to the literature and will aid me indefinitely as I move forward as a researcher. Special acknowledgements also go out to Emily McPhillips who spent much of her spare time helping me to code transcripts for Chapters 3 and 4.
ABSTRACT

Background: This dissertation sought to fill gaps in our understanding of eating disorder (ED) prevalence and clinician gender competency. It examined 1) clinically validated estimates of ED prevalence among gender minority (GM) individuals, 2) clinician awareness of barriers to care for these populations, and 3) clinician educational histories.

Methods: International Classification of Disease (ICD-10) codes and procedure codes (HCPCS) in the 2018 IBM® MarketScan® Commercial Database were leveraged to identify a cohort of GM individuals with EDs for producing prevalence estimates of EDs.

Individual interviews were conducted with mental health clinicians across the US to gather clinician narratives detailing perceived barriers to care, as well as their individual experiences receiving education on gender identity.

Results: 2.43% of people identifiable as transgender with evidence of a gender affirming medical intervention had a record of an ED. EDs were most common among GM youth. Clinicians highlighted 14 barriers and facilitators to care for GM patients. Clinicians reported scant gender education in their graduate curricula. Most clinicians identified educational resources to best support their GM patients, despite minimal gender competency.

Conclusions: Exploration of clinically validated prevalence estimates in those not receiving affirming medical care is necessitated. Findings supported clinician awareness of barriers and facilitators to ED treatment that GM patients face, regardless of gender competency. A lack of standardized education among clinicians was the primary barrier to their understanding of how to best care for GM patients. These findings reinforce the need for better education in gender-related competencies among clinicians.
CHAPTER I: INTRODUCTION
Introduction

In the United States, 9% of people will be diagnosed with an eating disorder in their lifetime (Deloitte Access Economics, 2020). Prevalence estimates of eating disorder diagnoses among gender minority individuals, or those whose gender identity differs from their sex assigned at birth (i.e., transwoman, transman, non-binary) (Table 1, Terminology), have primarily been produced using self-reports, and consequentially has resulted in a wide range of estimates. A 2018 Trevor Project Survey found that 71% (straight respondents) of gender minority individuals had ever been diagnosed with an eating disorder (The Trevor Project and National Eating Disorders Association, 2018). Other studies have reported prevalence estimates of 7.4% (Diemer et al., 2018), 15.8% of transgender college students (Diemer et al., 2015), 17.6% transgender college students (Duffy et al., 2019), and 10.5% and 8.1% of transgender men and transgender women respectively (Nagata et al., 2020).

<table>
<thead>
<tr>
<th>Table 1. Terminology used in this dissertation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
</tr>
<tr>
<td><strong>Transgender</strong></td>
</tr>
<tr>
<td><strong>Cisgender</strong></td>
</tr>
<tr>
<td><strong>Gender Minority Individual</strong></td>
</tr>
<tr>
<td><strong>Clinician</strong></td>
</tr>
</tbody>
</table>

Nearly one and a half million adults (Flores et al., 2020) and ~150,000 youth 13-17 (Conron, 2020) identify as a gender minority. Eating disorders have the highest rate of mortality of all mental health conditions and are associated with high risk for suicidality (Bulik et al., 2008; Chesney et al., 2014). Considering these estimates, the additional burden of instances of discriminatory care, experiences of dismissal of and disregard for their gender identity, and receipt of care that conflicts with their gender identity or exacerbates their gender dysphoria are alarming (Duffy et al., 2016; Hartman-Munick et al., 2021).

Many gender minority individuals report experiences of gender dysphoria. Gender dysphoria refers to the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or physical sex-related characteristics (Mayo Clinic, 2019). Many, but not all, gender minority individuals will pursue gender affirming care or medical intervention that helps their physical primary and/or secondary sex characteristics align with the gender they identify with. Gender affirming medical intervention has been shown to reduce eating disorder symptomology (Ristori et al., 2019).

In efforts to have their gender medically affirmed, through hormone therapies, sex reassignment surgeries, and/or other aesthetically affirming procedures or therapies, many gender minority individuals face barriers to both standard medical and gender affirming care, and may endure discrimination from health care clinicians (Forbes-Roberts et al., 2018; Hines et al., 2019). Often social barriers and financial barriers to receiving medically affirming care cannot be managed and some may feel the need to resort to unsafe methods, including disordered eating.

---


behaviors (Guss et al., 2017) to affirm their gender identity and suppress secondary sex characteristics (i.e., breasts, menstruation) (Turan et al., 2015) which can place them at greater risk for developing eating disorders (Diemer et al., 2015, Gordon et al., 2016).

**Risk Factors for Eating Disorders Among Gender Minorities**

Manipulating one’s body through disordered eating behaviors is not limited to gender minority individuals. For many cisgender women and men, sociocultural stereotypes may lead individuals to pursue alternative means to enhance musculature (Badnes-Ribera et al., 2019) or to achieve thin- or fitspiration (Griffiths et al., 2018) ideals. Like their cisgender counterparts, gender minority individuals may develop eating disorders for a number of other reasons, including but not limited to trauma (as a result of sexual assault, abuse, or violence), bullying (Bishop et al., 2020), and body dissatisfaction (Jones et al., 2016; Milano et al., 2020). For gender minority individuals, these risk factors may be exacerbated by intersecting identities, minority stress, and discrimination. Intersectional identity and higher weight may lead individuals to develop maladaptive coping mechanisms in response to minority related stress (Beccia et al., 2021). Instances of stigmatization and discrimination may also contribute to development of these behaviors among marginalized groups (Diemer et al., 2015; Mason et al., 2019; Goldhammer et al., 2019).

**Disparities in Eating Disorder Care**

*Disparities in treatment services*

Eating disorder services are rarely tailored to the needs of gender minority populations. Some authors have acknowledged many screeners and treatments (i.e., Fairburn et al., 1994; Cooper et al., 1989) for eating disorders that have been both designed and validated among samples of White women (Smith et al., 2017; Murray et al., 2017). The typecast of the skinny, white,
affluent girl (SWAG) has been credited for this outcome (Sonneville & Lipson, 2018). This stereotype has long been what many within and outside of the field recognized as the type of individual who is most likely to suffer from an eating disorder. In part, this can be attributed to the exorbitant costs associated with seeking out eating disorder treatment and that those from affluent backgrounds are more likely to be able to afford care (Sonneville & Lipson, 2018), thus they are occupying many treatment spaces.

Many residential facilities and hospital floors have been either exclusively accessible to women or are sex segregated, which has been acknowledged as a barrier to care for all gender minority individuals (Hartman-Munick et al., 2021; Duffy et al., 2016). Additionally, those who are non-affluent, non-White, and non-female are less likely to perceive themselves as in need to treatment for their eating disorder (Sonneville & Lipson, 2018). Despite the gender, racial, and financial impacts of the SWAG stereotype, progress has been made in diversifying research seeking to develop and validate screeners and treatment approaches for many diverse groups, including gender minority individuals (Halbeisen et al., 2022). However, the scope of utilization of these new tools is unknown.

**Stigmas in Eating Disorder Care Towards Gender Minorities**

While improvements to incorporate the needs and experiences of diverse populations are being integrated into research to develop inclusive and competent treatment approaches, prevention methodologies, and screening materials, gender minority individuals are reporting unsatisfactory experiences in their interactions with mental health clinicians as they seek care for their eating disorders (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022). Patients have reported incidents of both explicit discrimination and microaggressions from mental health professionals such as refusing to acknowledge their identity, blaming their identity for their
eating disorder, being forced to receive care on a floor or wing that doesn’t align with their identity, misgendering, and assuming they desired surgical intervention and harassing about their “true gender” (Duffy et al., 2016). Clinician encounters also resulted in clear displays of a lack of knowledge of various gender minority identities. Consequentially, clinicians were not able to understand the intersecting experiences of gender identity, racial or ethnic identity, physical abuse or sexual trauma, and their eating disorder (Duffy et al., 2016).

**Theoretical Implications**

As a result of their minority status, gender minority individuals may face exacerbated health risks, especially mental health risks, due to chronic stress driven by stigmatization (Meyer, 1995). Previously, minority stress theory has been used to explain differences in disordered eating behaviors among sexual minority individuals and women generally (Bayer et al., 2017; Calzo et al., 2017). Minority stress as it affects gender minority individuals and increased risk for disordered eating has been attributed to dehumanization through objectification (Brewster et al., 2019). Gender minority individuals may resort to disordered eating behaviors due to stress caused by their minority status and their internalization of standards of beauty or performance of gender. Discrimination and stigma may exacerbate symptomology or increase risk for these individuals to develop an eating disorder or body dissatisfaction (Gordon et al., 2018).

In this research, the impact of minority stress is both expected to play a role in prevalence of disordered eating among gender minority individuals, as well as explain the barriers that they may face as patients. Clinicians who lack the gender competency to sensitively work with gender minority patients may risk contributing to the severity of their eating disorder, increase distress in patients, and slow their progress in treatment. Particularly, if they also reject gender minority individuals. It is hypothesized that clinicians with minimal self-described competency, and/or a
high degree of rejection of this patient population, will be more likely than clinicians with great competency and/or high degree of acceptance to report struggles with delivering care that their gender minority patients benefit from.

Further, the clinician’s relationship with gender minority patients and its impact on health outcomes and healthcare experiences may be affected by clinicians’ awareness of the barriers to acceptance and support that their patients face at the hands of institutions, other relationships, and their social environments. Stigmatization that leads to minority stress can occur at multiple levels: including structural, interpersonal, and individual. The theory that describes the roles and interactions between these levels of an individual and the world around them is Social Ecological Theory (Dahlberg, 2002). Gender minority patients have stated that clinicians have been responsible for the barriers to care that they face (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022). However, other barriers such as but not limited to economic inequality, policies and laws that permit discrimination against gender minority individuals in healthcare spaces and their communities, and belief systems are known to impact how gender minority individuals receive healthcare and experience various health outcomes (Hughto et al., 2015). A clinician’s relationship with patients can improve or worsen these additional barriers or improve or worsen because of these barriers. Moreover, the clinician-patient relationship exists among a number of interacting factors that contribute to and contextualize patient experience and wellbeing.

**Clinician Education**

Patients have called attention to the lack of gender competency they have witnessed among clinicians in their encounters with them (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022), as have clinicians—regarding their own minimal competency in this area (Ferrucci et al., 2022). While graduate programs specializing in counselling for sexual and gender minority
individuals exist, few other programs place emphasis on gender affirming practice beyond what is briefly taught in general diversity courses or lessons (Austin & Craig, 2015). It is common knowledge among those in the field of mental health counseling that eating disorder treatment expertise is learned on the job. New clinicians gain knowledge from more experienced counselors, in addition to what they may have learned through continuing education requirements and attending conferences. Those opting to specialize in eating disorder treatment must go out of their way to obtain competency in working with specific populations or to connect with clinicians with expertise in changing methodologies in care that better serve these groups. Otherwise, new clinicians are potentially limiting their learning to knowledge passed to them from established clinicians, who may be maintaining the same problematic approaches to care.

A recent survey of 512 clinicians with eating disorder expertise found that only 0.6% of clinicians self-reported as non-binary or genderqueer. Ninety percent identified as women and 73% identified as White (Jennings Mathis et al., 2020). Approximately 21% of mental health clinicians identify as racial and ethnic minorities in the United States (Zippia, 2021). Furthermore, the ability to find clinicians with lived experience in certain identity groups is limited as, based on these demographics, about 80% are practicing with the learned knowledge of others’ lived experiences. Consequentially, patients have struggled to find clinicians who are educated on the barriers and risks they face or who understand their experiences firsthand (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022).

**Dissertation Aims and Hypotheses**

This dissertation seeks to 1) produce clinically validated estimates of eating disorder prevalence among gender minority individuals, receiving gender affirming care and 2) qualitatively identify clinicians’ perceptions of barriers to care and areas for improvements to
clinician education and care experience for gender minority patients in eating with eating disorders.

The specific aims of this dissertation are to:

Aim 1: Produce clinically validated prevalence estimates of eating disorders among gender minority individuals in the United States

Hypothesis: Gender minority patients with evidence of gender-affirming medical interventions in claims data will have lower prevalence of eating disorders relative to those reported in extant self-report prevalence studies.

Aim 2: Explore clinician awareness of barriers and facilitators to accessing and receiving care among gender minority patients with eating disorders.

Aim 3: Investigate the formal, workplace-required, and self-led gender-based educational experiences of mental health clinicians in the U.S. and how their education impacts their self-perceived ability to deliver eating disorder treatment to gender minority patients.
CHAPTER II: PREVALENCE OF DIAGNOSED EATING DISORDERS IN US TRANSGENDER ADULTS AND YOUTH IN INSURANCE CLAIMS

Abstract
Objective: We estimated the prevalence of diagnosed eating disorders, overall and by select demographics, among commercially insured individuals identified as transgender in a national claims database.

Methods: From the 2018 IBM® MarketScan® Commercial Database, there were 10,415 people identifiable as transgender based on International Classification of Disease (ICD-10) codes and procedure codes specific to gender-affirming care, from inpatient and outpatient claims. Eating disorders were identified from ICD-10 codes and included anorexia nervosa, bulimia nervosa, binge eating disorder, eating disorder not otherwise specified, avoidant restrictive feeding and intake disorder, and other specified feeding and eating disorders. We estimated the prevalence of specific eating disorders diagnoses by selecting patient characteristics.

Results: Of individuals receiving some form of gender-affirming care, 2.43% (95% confidence interval: 2.14%–2.74%) were diagnosed with an eating disorder: 0.84% anorexia nervosa, 0.36% bulimia nervosa, 0.36% binge eating disorder, 0.15% avoidant restrictive feeding and intake disorder, 0.41% other specified feeding and eating disorders, and 1.37% with an unspecified eating disorder. Among transgender-identifiable patients aged 12–15 years, 5.60% had an eating disorder diagnosis, whereas 0.52% had an eating disorder diagnosis in patients aged 45–64 years.

Discussion: In patients identifiable as transgender who received gender-affirming care, the prevalence of diagnosed eating disorders was low compared to extant self-reported data for eating disorder diagnosis in transgender individuals. Among this population, eating disorders were highest in adolescents and young adults. Clinically verified prevalence estimates for eating disorder diagnoses in transgender people with a history of gender-affirming care warrant further investigation.

Introduction
In the United States, 1.4 million adults and ~150,000 youth aged 13–17 years identify as transgender (Conron, 2020; Flores et al., 2020). Transgender is a broad term that can be used to describe people whose gender identity is different from the gender assigned at birth. Some transgender people identify as neither a man nor a woman, or as a combination of male and female, and may use one or several terms to describe their gender identity. Often these individuals are referred to as gender diverse (National Center for Transgender Equality, 2018). Transgender and gender diverse individuals are more likely than cisgender individuals to develop a range of chronic physical and mental health conditions in their lifetime (Cicero et al., 2020; Dragon et al., 2017). This population additionally may face stigmatization based on others’ perceptions of their outward appearance, particularly among those who may physically present as what is perceived by an onlooker as visibly transgender (i.e., assumed to not be cisgender based on the onlooker’s ideas of what appearance constitutes identifying with a particular gender).

Both groups may experience social incongruence between their gender identity and others' perceptions of their gender conformity. Incongruence that is internalized and affects well-being is referred to as gender dysphoria (Zucker et al., 2016). This incongruence, a discomfort with one's physical body and a lack of body satisfaction, can increase vulnerability for the development of eating disorders (Diemer et al., 2018; Gordon et al., 2016; Grossman & D'Augelli, 2007). Those with eating disorders are characterized as having an excessive preoccupation with food, eating, and body image (American Psychological Association, 2021). People with eating disorders are at an elevated risk for suicide, hospitalization, and poor health outcomes—including but not limited to cardiac arrhythmias, dehydration and electrolyte disorders, gastrointestinal issues, nutritional deficiencies, anemia, and amenorrhea (Bulik et al., 2008; Casiero & Frishman, 2006; Sato & Fukudo, 2015). In a multiyear, longitudinal study, Franko et al. (2013) reported a standardized
mortality ratio of 7.7 in the first 10 years, among a sample of 246 (assumed cisgender) women with diagnosed anorexia nervosa and bulimia nervosa. While all eating disorders are associated with a high all-cause and suicide mortality, anorexia nervosa has the highest mortality rate among them (Arcelus et al., 2011; Chesney et al., 2014; Franko et al., 2013).

Despite a common desire among members of transgender and gender diverse populations to have their gender medically affirmed through hormone therapies and/or surgeries, many face barriers to both general and gender-affirming care and may endure discrimination from health care clinicians (Forbes-Roberts, 2018; Hines et al., 2019). Many transgender and gender diverse people resort to unsafe methods, including disordered eating behaviors (Guss et al., 2017) to align their body with their gender identity and suppress secondary sex characteristics (Turan et al., 2015) largely through restrictive eating and overexercise, placing them at greater risk for developing eating disorders (Diemer et al., 2015; Gordon et al., 2016). About 75% of transgender and gender diverse college students with eating disorders reported attempted suicide in the last 12 months (Duffy et al., 2019), whereas ~42% of cisgender patients with eating disorders have attempted suicide (Suokas et al., 2014). Considering high all-cause and suicide mortality among cisgender individuals and transgender individuals, eating disorders pose a tremendous threat to the lives of those who suffer from them.

The current understanding of eating disorder prevalence in transgender populations is primarily based on medium-sized self-report studies from transgender youth and young, college-age adults (White et al., 2011). Two studies that used data from the American College Health Association–National College Health Assessment II have reported similar prevalence of self-reported past-year eating disorder diagnosis among two samples of self-identifying transgender and gender diverse students; Diemer et al. (2015) reported 15.8% (n = 479) of transgender students
and Duffy et al. (2019) reported 17.6% (n = 678) of transgender students. Diemer et al. (2015) additionally found transgender students to be 4.6 times as likely to be diagnosed with an eating disorder as cisgender students. At the community level, one study leveraged self-report data from a cross-sectional study of transgender individuals over the age of 18 years (n = 452) and found that 7.4% had ever been diagnosed with anorexia nervosa or bulimia nervosa (Diemer et al., 2018). Among these individuals, 55% self-reported having accessed gender-affirming medical services, which have been shown to reduce eating disorder symptomology (Ålgars et al., 2012; Jones et al., 2018; Testa et al., 2017; Uniacke et al., 2021).

Most eating disorder literature in the general population has focused on youth and college-age adults; to our knowledge, estimates of eating disorders among older transgender individuals do not exist. Jaworski et al. (2019) analyzed the International Classification of Disease (ICD)-10 codes for anorexia nervosa, atypical anorexia nervosa, bulimia nervosa, and atypical bulimia nervosa in a sample of (assumed cisgender) Polish men who received care through the National Health Fund between 2010 and 2017 and found that eating disorder prevalence dropped significantly among those older than 20 years of age. Another study that examined the prevalence of eating disorders among a nationally representative sample of (assumed cisgender) US adults found that the average age of onset for anorexia nervosa, bulimia nervosa, and binge eating disorder ranged from 19 to 25 years, and the average current age of the same individuals with these conditions ranged from 39 to 45 (Udo & Grilo, 2018). In the same study, hazard ratios for all three conditions were inversely associated with age, relative to those 60 years and older, such that those between 18 and 29 years old were 3.86–5.81 times as likely to be diagnosed with an eating disorder as those 60 years of age and older, those 30–44 years were 2.77–5.45 times as likely and those 45–59 years were 2.37–2.52 times as likely. While eating disorders in assumed cisgender aging
populations are much less common than in assumed cisgender youth, as evidenced here, they may persist into middle age and are as equally detrimental to the health of older adults as they are to others. Thus, we advocate that it is important to produce clinically validated estimates of the prevalence of eating disorder diagnoses across all age groups in this population, as prior self-report studies have revealed that high numbers of transgender youth and adults reported past year eating disorder diagnoses.

In addition to a paucity of estimates among an older cohort of transgender adults, clinically validated eating disorder prevalence estimates among large samples of transgender individuals do not exist. Within the United States, records of medical billing claims (i.e., billing for medical procedures and services provided to patients) are consolidated in several databases (Commercial, Medicaid, & Medicare Supplemental and Coordination of Benefits), which may be made accessible to researchers and institutions seeking to examine a range of health outcomes, cost of care, and care utilization among other areas of interest. While gender identity is not routinely recorded in these datasets, methods to identify transgender individuals through diagnostic and procedure codes have been developed (Dragon et al., 2017; Ewald et al., 2019; Proctor et al., 2016; Progovac et al., 2018). In this study, we have adapted these methods to provide estimates of the prevalence of specific eating disorder diagnoses and describe patient-level characteristics associated with having any diagnosed eating disorder among commercially insured transgender people receiving gender-affirming medical interventions.

Methods
Participants

We used the IBM® MarketScan® Commercial Database (2018). This data resource provides nationwide patient-level data for a commercially insured population (health insurance provided to employees of a company, as well as their spouses and/or dependents, which are most often their children; Butler, 2021). The data resource allows linkages of medical billing claims across different settings and services (e.g., inpatient, outpatient, emergency room visits, and prescription medications). Because these data are de-identified, this study was not considered human participants research by the Institutional Review Board at the University of Massachusetts Chan Medical School.

Sample of Transgender Individuals

We identified 11,169 individuals with evidence of receipt of gender affirming care in inpatient (i.e., records that summarize information about a hospital admission, including up to 15 diagnosis codes and 15 procedure codes), and outpatient (up to 4 diagnosis codes and 1 procedure code) databases within the 2018 IBM® MarketScan® Commercial Database. This was the most recent year available to the research team. In accordance with prior literature, we used ICD-10 diagnosis codes for gender identity disorder: F64.0, F64.1, F64.2, F64.8, and F64.9 and/or history of sex reassignment: Z87.890, as well as Procedure Coding System (ICD10-PCS) and Healthcare Common Procedure Coding System (HCPCS) procedure codes for male to female bottom surgery: 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 55970 and female to male bottom surgery: 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1, 55980 (Dragon et al., 2017; Ewald et al., 2019; Proctor et al., 2016; Progovac et al., 2018). We excluded patients who lacked continuous coverage throughout 2018 and those who either lacked mental health coverage or whose mental health claims were not visible to the research team (n = 313). The remaining 10,415 patients comprised
the final transgender sample. Individuals without continuous coverage were excluded because insured individuals are identified in the IBM® MarketScan® Commercial Database with an insurance enrollee identification number that may change when they change employers or when an abrupt change in status (such as disability) intervenes. Additionally, not all insurance plans cover mental health utilization on parity with physical health. Our choice to include only those with continuous coverage was in an effort to capture as many people with complete information as possible given these limitations.

Measures

Operational definition of eating disorders

Using all data included in the inpatient, inpatient services, and outpatient databases from 2018, we used ICD-10 diagnostic codes for eating disorders in any diagnosis field for anorexia nervosa (F50.0X), bulimia nervosa (F50.2X), binge eating disorder (F50.81), avoidant/restrictive food intake disorder (F50.82), other specified eating disorders (F50.89), and an overall eating disorders category that includes eating disorders (broadly), unspecified eating disorders, and eating disorder unspecified (F50.X, F50.8X not including F50.81, F50.82, F50.89, F50.9X) (based on 5th ed.; DSM-5; American Psychiatric Association, 2013).

Covariates

Covariates included age, region of medical service within the United States, relationship to plan-holder, sex reported on claims, and type of insurance coverage. Our sample included all patients aged 64 years and younger, grouped into six age groups: <11, 12-15, 16-18, 19-24, 25-44, and 45-64 years to reflect a relatively small number of informative age groups. Patients were categorized based on their relationship to plan holder (i.e., the plan holder, their spouse, or a child/dependent of the plan holder). Sex categories, female and male, were maintained from the
variable’s original format and reflect a mixture of sex at birth and current gender. Categories for the US region of service were also maintained from the region variable, in five categories: Northeast, North Central, South, West, or unknown. Race/ethnicity, education, and income are not available in the IBM® MarketScan® Commercial Database. Other demographics that were available, namely plan holder employment type (salary/hourly), unionization status, and employer industrial sector were not analyzed in this analysis due to excessive missingness and/or lack of relevance to the topic at hand.

Statistical analysis

Analyses were conducted using SAS 9.4 (Cary, NC, 2011). Descriptive statistics for patient characteristics were calculated. Characteristics of transgender people receiving gender-affirming medical interventions were stratified by age and presence of any eating disorder and proportions were generated with 95% confidence intervals (CI).

Results

Descriptive statistics

Our sample consisted of 10,415 transgender-identified individuals. Almost sixty percent of the sample was described as female on claims (59.2%, which may be sex at birth or current gender), 63% were younger than 24 years old. Nearly one third (32.2%) were identified as being the primary plan holder, 62.6% were the child of a plan holder, 5.2% the spouses of the plan holder (Table 1).

Eating disorder prevalence
Among individuals identifiable as transgender from claims, we found that unspecified feeding and eating disorders (1.37%, 95% CI [1.16-1.62]) were the most commonly diagnosed eating disorders, followed by anorexia nervosa (0.84%, 95% CI [0.67-1.03]), other specified feeding and eating disorders (0.41%, 95% CI [0.30-0.56]), bulimia nervosa (0.36%, 95% CI [0.26-0.50]), binge eating disorder (0.36%, 95% CI [0.25-0.49]), and avoidant restrictive feeding and intake disorder (0.15%, 95% CI [0.09-0.25]) (Table 2). The median age of individuals with diagnosed eating disorders ranged from 15 for avoidant restrictive feeding and intake disorder to 22 for binge eating disorder.

Those diagnosed with any eating disorder were more likely to be young, reported as female on claims; the proportion diagnosed with eating disorders was similar across all US geographic regions (Table 3). Figure 1 displays the prevalence of any diagnosed eating disorder for these patients identifiable as transgender, within 5-year age groups.

**Discussion**

Our study is the first to provide contemporary national estimates of clinically diagnosed eating disorders among US transgender individuals. Using national claims data from individuals, covering a diversity of insurers, clinicians, and commercially insured individuals, we found that 2.43% of transgender individuals had a diagnosis of an eating disorder in 2018. The prevalence of any eating disorder was highest among those younger than 24 years of age, and among patients coded as female on claims.

Our estimate of the prevalence of clinically diagnosed eating disorders is lower than previous reports of any eating disorder among transgender individuals. Prior studies have reported that that 7.4-17.6% of transgender individuals self-reported eating disorders (Diemer et
al., 2015; Diemer et al., 2018; Duffy et al., 2019). We found that the highest prevalence of eating disorders was in those aged 12–15 years (5.60%) and 16-18 years (3.93%). These findings are consistent with general population age trends that highlight a greater prevalence of onset of disordered eating among those between the ages of 15-21 (Hudson et al., 2007; Keski-Rahkonen et al., 2007; Isomaa et al., 2009). We additionally found that 0.84% of our sample was clinically diagnosed with anorexia nervosa and 0.36% with bulimia nervosa. These estimates are lower than previous reports. In a survey of almost 500 transgender adults, Nagata et al. (2020) found that 4.1% of transgender women and 4.2% of transgender men reported being told by a clinician that they had anorexia nervosa, closely followed by 2.9% and 3.2% with bulimia nervosa.

The discrepancy between our prevalence estimates based on clinically diagnosed eating disorders and estimates based on self-reported eating disorders may be explained by low rates of clinical diagnosis generally; only 1 in 10 people living with eating disorders receive clinical treatment (Noordenbos, 2002). This may be because there are low levels of interaction with and potentially barriers to accessing care clinicians, perhaps especially for transgender individuals (Duffy et al., 2016). In the general population, low levels of diagnosis may be attributed to weight stigma (Hatzenbuehler et al., 2009), financial barriers and cost of care (Deloitte Access Economics, 2020; Evans et al., 2011), barriers caused by disparities and discrimination in healthcare settings due to racial, sexual and gender identity (Marques et al., 2011; Strother et al., 2012; Duffy et al., 2016). Within the sample we investigated, all individuals had received gender affirming care. Prior studies have shown that affirmation of gender identity can lead to a decrease in or lower disordered eating symptomology (Jones et al., 2018; Testa et al., 2017; Uniacke et al., 2021) and increased body image satisfaction (Owen-Smith et al., 2018). As such, the occurrence of eating disorders in this medically affirmed population is likely to be lower than
in a general population of transgender people. Nevertheless, eating disorders may persist well beyond physical symptom remission and there is not yet consensus in the field regarding what qualifies as full recovery (Steinhausen, 2002; Vall & Wade, 2015). Those with eating disorders or those in recovery may take on new disordered eating behaviors; undergoing diagnostic cross-over, especially on the path of recovery from one disorder (Eddy et al., 2008; Mortimer, 2019). Thus, the extent to which treatment of eating disorders provides attentive care that positively affirms their gender identity warrants further investigation.

Cross-sectional surveys of gender minority people tend to have a higher average age of transgender respondents than what was observed in the current study. Cross-sectional studies of transgender people are largely comprised of individuals over 25 years of age (Herman et al., 2017). Our study provides a rare look at the prevalence of clinically diagnosed eating disorders among older transgender adults as well as transgender youth. For transgender people, eating disorders may be a means to affirm their gender identity through the suppression of secondary sex characteristics (Ålgars, Santtila, & Sandnabba, 2010), coping with stress related to gender identity (Cohelo et al., 2019), body uneasiness (Bandini et al., 2013), objectification, and minority stress (Brewster, Velez, Breslow, & Geiger, 2019). Eating disorders, like in their cisgender peers, may serve as a path to rapidly attaining a socially desirable figure, gain social capital with peers of the gender they identify with, or attain a sense of control over one’s body and appearance when they lack a sense of control over the impact of puberty on their body (McGuire et al., 2016; Ålgars, Santtila, & Sandnabba, 2010, Murray et al., 2013). Non-conformity to cisgender norms as a by-product of seeking to affirm one’s gender presentation, can render transgender individuals vulnerable to scrutiny from family, peers, and strangers (Bradford, Reisner, Honnold, & Xavier, 2013; Fuller & Riggs, 2018). With societal pressures on
young people to look a certain way and the added pressures that they may face from adults and peers if they are not cisgender, feeling comfortable about one’s body or appearance may be challenging, particularly for those experiencing gender dysphoria (Duffy, Henkel, & Earnshaw, 2016; Gordon et al., 2016; Nagata, Ganson, & Austin, 2020). Considering this, it is not surprising that most of our sample diagnosed with an eating disorder are in their teens (Ristori et al., 2019); when young people are coming into who they are as an individual.

Despite the use of a national claims data resource, our data were limited to those identifiable as transgender in claims data, likely reflective of receipt of gender-affirming care. Considering barriers to receiving gender-affirming care, it is not appropriate to generalize these findings to transgender people who are not receiving gender-affirming care. We have used a validated approach to identifying transgender individuals in claims data. Yet, the possibility of misclassification of individuals who prefer another gender identity than “transgender”, such as non-binary, gender queer, or two spirit among various other identities remains.

There are several explanations for why our estimates are lower than expected. First, in this claims dataset, diagnoses of eating disorders are likely driven by the receipt of health care for eating disorders, and thus under-reported relative to the actual prevalence in this population (Tkacz & Brady, 2021; Deloitte Access Economics, 2020). Clinicians may lack awareness of eating disorders among transgender individuals and fail to recognize these disorders, may prioritize treatment for gender dysphoria above disordered eating behaviors or may blame gender dysphoria as the cause of an eating disorder when it is being caused by trauma, issues with food texture, or bullying among a number of reasons. Patients receiving gender affirming care may be reluctant to disclose disordered eating behaviors either due to lack of time with clinicians or
because of required mental health assessments before insurers authorize gender-affirming surgery.

Limitations

While we have produced findings that provide us insight regarding the scope of individuals with eating disorders who receive affirming medical care, overall and stratified by age, our cross-sectional analysis is limited to a single recent year of data and may not reflect the age of diagnosis with eating disorders for gender minority individuals, merely their prevalence. Further, despite identifying a sample based on receipt of gender affirming care, we did not consider procedure codes for mammoplasty, orchiectomy, puberty blockers, and hormone replacement therapy, as these are all commonly used in the treatment of cisgender individuals. We recognize that in doing so, these findings must be interpreted within the context of those who have received particular types of gender affirming care. Additionally, we restricted our eligibility criteria to include only those with continuous health insurance coverage in 2018. Future research may lengthen the study period. This database does not collect information on race/ethnicity or socioeconomic status and thus individuals in this database are representative only of those insured by their employers, and these findings do not pertain to individuals who are covered under Medicare (i.e., older adults 65 years and older) and Medicaid (i.e., individuals with notably low income and disabled individuals). Lastly, females historically have been reported as the most affected by eating disorders and have been the focus of eating disorder treatment generally (Cohelo et al., 2019). Sex reported on claims in this study may be the sex of the individual at birth or the individual’s gender identity, and there is likely to be variation in coding practices between care sites. Thus, we caution against interpreting findings by sex.
Conclusion

In this population of individuals identifiable as transgender from claims data indicating receipt of gender-affirming care, 2.43% were diagnosed with one or more eating disorders. This proportion is low compared to the self-reported prevalence of eating disorders from other sources. While we suspect diagnostic biases to be at play, our data do not allow us to explore this issue further. The health of transgender individuals is understudied, and these claims data provide new insights about those receiving affirming care.

Nevertheless, we believe that the occurrence of eating disorders in transgender populations is likely undercounted, particularly in adolescent and young adult populations. Young, gender minority adults may be hindered in their ability to access care (Duffy et al., 2016) or may avoid disclosing gender identity to clinicians due to fear of exile from family members and/or community, as well as fear of discrimination and microaggressions from clinicians. Despite this population of transgender individuals already having received care, more research is needed to understand potential issues around identifying eating disorders and ensuring that those providing care for eating disorders are aware of issues specific to mental wellness for transgender individuals. As with all clinicians, those treating eating disorders should 1) be educated around providing gender affirming care, 2) allow gender minority patients in their practice to identify themselves (i.e., gender identity, pronouns, preferred name) and use those identity markers, 3) affirm the gender identity of their gender minority patients, 4) develop treatment plans cognizant of their patients’ developing gender identities, and 5) seek resources to help them develop these skills, such as attending gender minority focused grand rounds at local universities and medical centers, educational trainings for providing treatment and affirming care to gender minority patients through local, state, and national transgender and gender diverse run
mental health and advocacy organizations, 6) educate themselves on state level healthcare
policies pertaining to gender minority individuals, and 7) network with peers who openly
advocate for and provide gender inclusive mental health care.
### Table 1: Demographic characteristics of transgender people identified in a database of those with commercial insurance, 2018

<table>
<thead>
<tr>
<th></th>
<th>N=10,415</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex reported on claims</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>40.8</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>59.2</td>
<td></td>
</tr>
<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;11</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>12 to 15</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>16 to 18</td>
<td>18.1</td>
<td></td>
</tr>
<tr>
<td>19 to 24</td>
<td>31.6</td>
<td></td>
</tr>
<tr>
<td>25 to 44</td>
<td>26.0</td>
<td></td>
</tr>
<tr>
<td>45 to 64</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td><strong>Plan Type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic/ major medical/ comprehensive</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Preferred clinician organization</td>
<td>49.9</td>
<td></td>
</tr>
<tr>
<td>High-deductible/consumer-driven</td>
<td>20.3</td>
<td></td>
</tr>
<tr>
<td>All other health plans†</td>
<td>25.8</td>
<td></td>
</tr>
<tr>
<td>missing</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship to Plan Holder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>32.2</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>Child/other</td>
<td>62.6</td>
<td></td>
</tr>
<tr>
<td><strong>US Region of Service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>21.4</td>
<td></td>
</tr>
<tr>
<td>North Central</td>
<td>24.1</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>31.3</td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>22.8</td>
<td></td>
</tr>
<tr>
<td>missing</td>
<td>0.4</td>
<td></td>
</tr>
</tbody>
</table>

† All other health plans include: exclusive clinician organization, health maintenance organization, point-of-service.
TABLE 2:

Table 2. Proportion and measures of the age distribution of specific eating disorder diagnoses among claims-identified transgender individuals, 2018

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Number of patients</th>
<th>Proportion % (95% confidence interval)</th>
<th>Median age (25th – 75th percentile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia nervosa</td>
<td>87</td>
<td>0.84 (0.67-1.03)</td>
<td>17 (16-20)</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>38</td>
<td>0.36 (0.26-0.50)</td>
<td>19 (16-23)</td>
</tr>
<tr>
<td>Binge eating disorder</td>
<td>37</td>
<td>0.36 (0.25-0.49)</td>
<td>22 (17-25)</td>
</tr>
<tr>
<td>Avoidant restrictive feeding and intake disorder</td>
<td>16</td>
<td>0.15 (0.09-0.25)</td>
<td>15 (14-20)</td>
</tr>
<tr>
<td>Other specified feeding and eating disorders</td>
<td>43</td>
<td>0.41 (0.30-0.56)</td>
<td>18 (15-22)</td>
</tr>
<tr>
<td>Unspecified feeding and eating disorders</td>
<td>143</td>
<td>1.37 (1.16-1.62)</td>
<td>17 (15-20)</td>
</tr>
<tr>
<td>Any eating disorder</td>
<td>253</td>
<td>2.43 (2.14-2.74)</td>
<td>18 (15-22)</td>
</tr>
</tbody>
</table>

TABLE 3:

Table 3. Prevalence of any eating disorder diagnosis across claims-identified transgender individuals

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Number of patients with any eating disorder</th>
<th>Prevalence estimate (95% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (on claims)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (n=4,252)</td>
<td>73</td>
<td>1.72 (1.35-2.15)</td>
</tr>
<tr>
<td>Female (n=6,163)</td>
<td>180</td>
<td>2.92 (2.51-3.37)</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-11 (n=256)</td>
<td>1</td>
<td>0.39 (0.01-2.16)</td>
</tr>
<tr>
<td>12-15 (n=1,125)</td>
<td>63</td>
<td>5.60 (4.33-7.11)</td>
</tr>
<tr>
<td>16-18 (n=1,883)</td>
<td>74</td>
<td>3.93 (3.10-4.91)</td>
</tr>
<tr>
<td>19-24 (n=3,287)</td>
<td>77</td>
<td>2.34 (1.85-2.92)</td>
</tr>
<tr>
<td>25-44 (n=2,709)</td>
<td>32</td>
<td>1.18 (0.81-1.66)</td>
</tr>
<tr>
<td>45-64 (n=1,156)</td>
<td>6</td>
<td>0.52 (0.19-1.13)</td>
</tr>
<tr>
<td>Region of Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast (n=2,229)</td>
<td>63</td>
<td>2.83 (2.18-3.60)</td>
</tr>
<tr>
<td>North central (n=2,509)</td>
<td>69</td>
<td>2.75 (2.15-3.47)</td>
</tr>
<tr>
<td>South (n=2,377)</td>
<td>65</td>
<td>2.00 (1.54-2.54)</td>
</tr>
<tr>
<td>West (n=2,377)</td>
<td>54</td>
<td>2.27 (1.71-2.95)</td>
</tr>
</tbody>
</table>
FIGURE 1:

Figure 1. Prevalence and 95% confidence interval for any diagnosed eating disorder among patients identifiable as transgender in the IBM® MarketScan® 2018 database, by 5-year age groups.

Point estimates for any diagnosed eating disorder shown as black diamonds. 95% confidence intervals shown as vertical lines. The upper confidence limit for the 11 patients aged 1 to 4 is truncated from 28.5%
CHAPTER III: CLINICIAN PERCEPTIONS OF BARRIERS AND FACILITATORS TO CARE IN EATING DISORDER TREATMENT FOR TRANSGENDER AND GENDER DIVERSE PATIENTS: A QUALITATIVE STUDY
Abstract

Background: The prevalence of eating disorders is higher in transgender and non-binary compared to cisgender people. Gender diverse people who seek eating disorder treatment often report struggling to find affirming and inclusive treatment from healthcare clinicians. We sought to understand eating disorder care clinicians’ perceptions of facilitators of and barriers to effective eating disorder treatment for transgender and gender diverse patients.

Methods: In 2022, nineteen US-based licensed mental health clinicians who specialized in eating disorder treatment participated in semi-structured interviews. We used inductive thematic analysis to identify themes around perceptions and knowledge of facilitators and barriers to care for transgender and gender diverse patients diagnosed with eating disorders.

Results: Two broad themes were identified: 1) factors affecting access to care; and 2) factors affecting care while in treatment. Within the first theme, the following subthemes were found: stigmatization, family support, financial factors, gendered clinics, scarcity of gender-competent care, and religious communities. Within the second theme, prominent subthemes included discrimination and microaggressions, clinician lived experience and education, other patients and parents, institutions of higher education, family-centered care, gendered-centered care, and traditional therapeutic techniques.

Conclusion: Many barriers and facilitators have potential to be improved upon, especially those caused by clinicians’ lack of knowledge or attitudes towards gender minority patients in treatment. Future research is needed to identify how clinician-driven barriers manifest and how they can be improved upon to better patient care experiences.

Keywords: transgender, gender diverse, eating disorders, treatment, clinician
Introduction

In the United States, 14.4 million people have had an eating disorder (ED) in their lifetime (Economics, D. A., 2020). Self-reported history of EDs has been found to occur among 7.4-17.6% of transgender individuals generally (Diemer et al., 2015; Duffy et al., 2016; Diemer et al., 2018) and among 4.32% of transgender individuals who have received gender affirming medical intervention (Ferrucci et al., 2022). Transgender and gender diverse people (gender minorities) are those whose gender identity differs from the gender they were assigned at birth. Some gender diverse people identify as neither a man nor a woman, or as a combination of male and female, and may use one or several terms (i.e., non-binary, gender fluid, demi-girl, demi-boy) to describe their gender identity (National Center for Transgender Equality, 2018). The prevalence of EDs among transgender people is greater than among people whose gender identity aligns with gender assigned at birth (cisgender) (Diemer et al., 2015).

Gender minority individuals often struggle to find healthcare that is both affirming and inclusive (Seelman et al., 2017; Roberts et al., 2014; Poteat et al., 2013; Shirres et al., 2015). Some delay healthcare visits due to fear of discrimination. Depression and suicide attempts are much higher among those who delay healthcare visits out of fear of discrimination relative to those who don’t (Seelman et al., 2017). Those seeking mental health care might be plagued with added stressors. A study using the 2015 United States Transgender Survey reported that nearly 25% of gender minority respondents had to educate their clinician on gender identity (Kattari et al., 2020). Further, 18.8% of transgender women, 21.1% of transgender men, 72.5% of nonbinary, assigned female at birth, and 65.6% of nonbinary, assigned male at birth did not feel respected by their clinician after identifying themselves as transgender (Kattari et al., 2020). Despite these
challenges, more than half develop relationships with health care clinicians with whom they are very satisfied (Ferrucci et al., 2021)

Qualitative studies reporting the narratives of gender minority patients seeking and receiving treatment for an ED are consistent with reports based on overall engagement with the health care system. Many describe instances of having received discriminatory comments and microaggressions from clinicians and other members of the care team. Patients emphasize experiencing fear and anxiety due to uncertainty about how inclusive a clinician may be especially when attending appointments with specialists (e.g., nutritionist, internists, dentists) whom they were referred to by their primary ED care clinician (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022). In response to the need to improve care provided to gender minority patients, the American Psychological Association developed clinician standards of care for gender competent treatment (American Psychological Association, 2015). Yet, analyses of patient narratives derived from two different projects led by FEDUp (Fighting Eating Disorders in Underrepresented Populations) reveal these standards of care may not have diffused into clinical practice (Duffy et al., 2016, Hartman-Munick et al., 2021). Transgender patients seeking and receiving eating disorder treatment felt that the clinicians with whom they engaged were generally unfamiliar with specific needs of transgender patients related to body image and the role of the body in traditionally structured ED treatment. Some clinicians were seen as blaming the ED entirely on the patients wanting to affirm their gender identity (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022) and others accused patients of coming out as a means of attention seeking (Cusack et al., 2022). Most disturbingly, some clinicians suggested that symptoms of a transgender patient’s ED may lessen if the patient accepted the gender they were assigned at birth (Duffy et al., 2016; Hartman-Munick et al., 2021).
Gender minority patients have clearly identified where clinicians may fail them throughout their ED treatment. The current analysis explores clinician awareness of facilitators of and barriers to inclusive care for gender minority patients with EDs. Clinician perspectives on these facilitators and barriers lend further insight into effective means to better address the unique health care needs of gender minority patients in the ED care setting. Through individual interviews with mental health clinicians caring for patients with EDs, we sought to learn more about clinician perceptions of the barriers and facilitators to successful ED treatment for transgender and gender diverse patients and to elicit clinician perspectives of the experiences of these vulnerable patients.

Conceptual Model

We evaluated clinician perceptions and perspectives using deductive analysis guided by the Social-Ecological Model (Dahlberg, 2002). This model is built on the premise that health outcomes and healthcare experiences are the result of mutual interactions between individuals, groups, and their immediate and extended social environments. This model is particularly helpful in allowing those who seek to develop effective policies and health promotion measures and provide a richer understanding of the patient-clinician interactions, clinic settings, the regulatory and policy environment, and broader social structural factors they seek to change (Sallis et al., 2015).

Methods

We conducted a series of individual semi-structured interviews with 19 ED care clinicians in the United States. Interviews addressed a range of topics related to their familiarity with transgender and gender diverse populations, perceptions of facilitators, and barriers to care, and opportunities for intervention and improvement of the delivery of ED care to transgender and
gender diverse populations. The current analysis focuses on clinician perceptions of gender minority patients’ experiences and challenges with eating disorder treatment.

Setting and Participants

We contacted potential participants from all US states and territories using email solicitation, social media messaging, and snowball sampling. We sought to recruit professionals with experience in a range of ED treatment settings and approaches to care and to capture a diverse sample. Eligible clinicians were older than 18 years, licensed to provide mental health treatment, and had at least one year of experience in their current role.

Procedures

We identified mental health clinicians who specialized in ED treatment from the Psychology Today website (Psychology Today) All listed with a link to their website or an email address were contacted via email until sufficient representation was achieved for race, gender, and age. Additionally, clinicians were recruited via social media (Instagram) and personal academic networks (an ED interest email newsletter). Recruitment lasted 2 months. Potential participants who expressed interest in response to the recruitment messages sent via email or social media direct messaging were asked to complete a screening survey. Those who met our inclusion criteria were invited to participate and were sent the link to a background/demographic questionnaire. To improve the diversity of the pool of participants, we also asked participants to identify potential respondents from their own networks who represented geographic and philosophic approaches to eating disorder care different from their own.

Web surveys and questionnaire responses for demographic and clinician attitude and education data were collected and managed using REDCap electronic data capture tools (Harris et
al., 2009; Harris et al., 2019) hosted at the University of Massachusetts Chan Medical School. REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies. Participants provided consent electronically and confirmed being 18 years of age or older before completing the study background and demographics questionnaire. Questionnaires were completed before interviews; however, participants were told during the consent process that their survey responses would not be reviewed until after the interview when data analysis began. To ensure the anonymity of participants, each was assigned a participant ID. Participant names and email addresses linked to participant IDs were stored separately from participant data. All data were maintained on a secure research drive at the University of Massachusetts Chan Medical School.

Participants each met once with the interviewer (KF), via Zoom. KF is a cisgender female doctoral candidate with qualitative research experience. Semi-structured interviews were conducted using an interview protocol based on findings from Duffy et al. (2016) and Hartman-Munick et al. (2021) (See Appendix A). Interviews were conducted in English and lasted 45-60 minutes. Elements of consent were verbally reviewed with participants prior to the start of each interview using an IRB approved Fact Sheet. Zoom audio recordings were downloaded onto secure University of Massachusetts Chan Medical School laptops connected to a secure verified network and transferred to a secure network drive for storage. Zoom video recordings and chat records were permanently deleted.

Data analysis

Interviews were transcribed from Zoom audio files using Otter.ai. Transcripts were cleaned, deidentified, and verified by KF and EM. Final transcripts were independently coded by two researchers (KF and EM), who both identify as cisgender females. Coders met weekly to
review coding discrepancies and new themes as they were identified. We used NVivo (QSR International Pty Ltd., 2020) for coding and employed inductive thematic analysis (Braun & Clarke, 2012) to identify themes. Interrater reliability was calculated and found 94.3% agreement between coders.

**Results**

**Characteristics of participant**

Table 1 shows the characteristics of the 19 study participants. Participants were predominantly from the South, but geographic diversity was obtained, as was diversity in age, race/ethnicity, gender identity, and practice setting.

**Gender identity and ED risk**

Many clinicians discussed the increased risk for developing an ED among gender minority individuals (particularly youth) relative to cisgender individuals. Additionally, most clinicians noted that those undergoing puberty may use disordered eating behaviors to mitigate the impact of puberty on their bodies and consequently reduce dysphoria. Use of disordered eating for this purpose was perceived among many clinicians as a risk factor for more moderate to severe ED among gender minority youth. Higher risk was also attributed to gender dysphoria, limited accessibility of gender affirming care in the US, experiences of trauma, physical violence, stigmatization, and bullying.

**Factors affecting access to care**

Clinicians cited the following barriers to ED treatment in US mental health settings: stigmatization, family, financial factors, gendered clinics, scarcity of gender competent care, and religious communities. Quotes supporting these findings can be found in Table 2.
**Stigmatization**

Most felt that gender minority patients’ fear of stigmatization or trauma triggered from prior experiences could prevent them from seeking treatment. Clinicians recognized themselves, patient peers, as well as the family of patient peers, and patients’ own family members as having roles in shaming, silencing, or rejecting gender minority individuals. A few clinicians acknowledged their historical role as gatekeepers in accessing gender affirming care, which they felt has contributed to gender minority patients’ distrust when seeking out psychological services, including ED treatment.

**Family support**

Clinicians perceived a lack of family support as an important negative factor in gender minority children seeking ED treatment. According to several clinicians, it was not uncommon for unsupportive parents to limit their children to treatment facilities and clinicians who adhered to parental values and beliefs around gender identity, particularly in religious communities. Some clinicians observed that patients with unsupportive family members delayed seeking care or coming out until they were living independently as adults, to avoid familial and community conflict as youth. They speculated that, as a result, gender related distress and ED symptomology were likely prolonged. Many families, however, were described as supportive, which allowed patients to easily access care. According to most clinicians, many parents who, in one way or another, receive education around gender identity and eating disorders may be less likely to hinder their child’s ability to continue in or pursue care with affirming clinicians.
Financial factors

It was noted that many clinicians and clinics treating EDs do not accept insurance. Cost of care was viewed as a great impediment for patients who may need to choose between costly gender affirming medical intervention or ED treatment when their safety and wellbeing may require both. Several observed that most patients could rarely afford both types of care.

Clinicians associated lack of financial support for ED treatment with lack of gender affirmation from family. A few participants reflected on instances where young gender minority individuals were kicked out of their homes, having to support themselves with low-income jobs often without health insurance. A common concern was that those with insurance may find that ED care is not covered due to incongruence between gender assigned at birth and their current gender identity.

Gendered clinics – cis female only

Many clinicians highlighted that female-only residential treatment facilities, may be unappealing to gender minority patients even if they are welcomed by staff. Patients may try to seek care elsewhere, but other mixed gender facilities may be less financially feasible to access due to 1) distance from the patient or 2) because facilities have staff who are discriminatory or not gender competent.

Scarcity of gender competent care

Several clinicians noted their gender minority patients struggled to identify safe clinicians located outside of their city or state (i.e., mental health clinicians and other healthcare specialists). This struggle was thought by many to be exacerbated by a scarcity of gender-competent ED treatment professionals. Accessing affirming or competent ED care was generally felt to be more
difficult for those living 1) where care in general is scarce (patients may need to travel to access it) and 2) in states with more conservative political leanings which was believed to be a barrier as patients may be unsure of whether a clinician’s political ideology facilitates discrimination towards gender minority individuals.

**Religious communities**

A few clinicians were familiar with the struggles of gender minority individuals living in communities with large religious populations. Clinicians who disclosed that they work or have worked in these communities (n = 4) explained that gender minority clients seeking care were often hindered by spiritual leaders and religious family members, more so if care affirmed gender identities that were not felt to be compliant with religious doctrine. Two of the four clinicians conveyed that it was not uncommon for gender minority patients to avoid care or struggle throughout care because they feel their identity conflicted with their religious values. Some participants felt that clinicians in religious communities are often not prepared to help patients grapple with seemingly conflicting identity and spirituality.

**Factors affecting care while in treatment**

Clinicians cited the following factors affecting gender minority patients’ care while in ED treatment: discrimination and microaggressions, clinician lived experience and education, other patients and parents, systems of higher education, family-centered care, gender-centered care, and traditional therapeutic techniques. Quotes supporting these findings can be found in Table 3.

**Discrimination and microaggressions**

Clinicians considered lack of acceptance and validation or microaggressions from other clinicians, peers in treatment, and family as barriers to successful treatment and sources of trauma
for gender minority patients. Discrimination from clinicians was broadly associated with being older, having restrictive religious or political beliefs, limited knowledge around gender identity, and stigmas around gender identity. Some interview participants spent time preparing gender minority patients to cope with other clinicians, usually specialists outside of their practice, whose beliefs were unknown or were known to be discriminatory but were the only option for these patients.

Clinician lived experience and education

Many clinicians perceived the mental health community broadly as well as those providing ED treatment to be poorly trained to work closely with gender minority patients. Some clinicians discussed how patients are frequently burdened with educating clinicians about gender identity generally and as it applies to their eating disorder. A handful of clinicians recognized that while patients are excellent first-hand resources, they should not have to take on the task of bringing clinicians up to speed on how to provide gender informed treatment. Some clinicians discussed the benefits of programs that had staff who reflected the gender, racial, and ethnic identities of patients; stating that programs with diverse staff were more effective in their ability to provide a safe, informed, and relatable space for patients with similar identities.

Other patients and parents

Among clinicians who offered it, group therapy was often deemed an inclusive space for gender minority patients, particularly when practices/clinics had established rules for interpersonal respect in that setting. Use of telehealth platforms for group therapy raised some concerns about potential harm, such as inadvertently exposing patients’ personal beliefs (i.e. posters, signs, flags – in video background), which otherwise may have never surfaced in an in-person clinic session. Several clinicians felt that instances such as these had reduced comfort for gender minority
patients. Additionally, numerous clinicians noted that it was not uncommon for a roommate’s parents, unsatisfied with their child’s roommate’s gender identity, to either remove their child from treatment at that clinic or have them relocated to another room. It was also mentioned by a handful of clinicians that some parents of other patients had made bigoted comments about gender minority patients.

*Institutions of higher education*

One clinician felt that despite the counselling center at their religious university making efforts to provide safe and inclusive care, the broader university culture often counteracted much of that work. Of clinicians who acknowledged having experience working in college counseling centers (n = 5), three reported feeling that they were often a patient’s only source of affirmation, and that patients with limited support outside of the clinical setting may struggle to excel in their recovery. Additionally, two noted that gender minority patients may require several sessions before feeling safe and ready to be transparent with their clinician. This may limit progress patients and clinicians can make with ED recovery, as students are typically only on campus for 2-4 years and may only be allotted a fixed number of sessions per year.

Additionally, counseling center clinicians’ efforts to make materials more inclusive were sometimes slowed by institutional procedures, policy or culture and influenced by donors, politicians, or personal beliefs of institutional leadership.

*Family-centered care*

Clinicians had a range of experiences with families of their gender minority patients; some with many supportive parental encounters and others reporting few to no encounters with supportive family. The role of the family is often central to ED treatment, primarily for youth. This
was mentioned often. Nearly all clinicians described family-centered care as most effective when parents affirmed their child’s identity. Families who made efforts to self-educate or who were open to being educated by clinicians were viewed as great sources of support in their child’s ED recovery. Conversely, clinicians recalled instances of unsupportive parents extracting their children from ED treatment if their child’s identity was being affirmed by clinicians. Unsupportive parents reportedly exhibited counterproductive behaviors while their children were receiving care, having persisted in efforts to invalidate their child’s identity by using their old name (deadnaming) or misgendering them. Several clinicians feared accidentally outing patients, while trying to affirm their identity and tiptoeing around difficult or toxic family members.

Gender-centered care

In some female-only facilities, where transmasculine patients (female transitioning/ed to male) were receiving care, clinicians expressed concern for: 1) patients not feeling included in therapeutic programming due to their gender identity, 2) therapeutic focus on the cisgender female body, 3) clinician unfamiliarity with working with patients identifying as male or non-binary, and 4) a lack of neutral facilities (i.e. restrooms) – all of which may cause distress for gender minority patients in recovery. Some clinicians looked negatively upon instances where gender minority patients were placed in care wings for the gender they were assigned at birth, rather than their current gender identity.

Traditional therapeutic techniques

A lack of knowledge around therapies that accommodate ED patients with gender dysphoria was discussed by many clinicians. Most clinicians felt available ED treatments were not designed with transgender or gender diverse bodies in mind; many felt unprepared to navigate providing non-triggering treatments to gender minority patients, especially to those undergoing
medical transition. Consequently, patients communicated feelings of distress to clinicians about traditional approaches to care such as observing their body in a mirror, engaging in body-positive and body acceptance talk, and exposure therapies such as residential facility field trips to practice body acceptance in retail clothing stores. Clinicians reported instances of gender minority patients feeling triggered around body-centric activities, especially in gendered settings such as fitting rooms or clinic restrooms. Several clinicians noted that their clinic or other clinics had made changes to their facilities to provide focused programming for gender minority individuals (i.e. Intensive Outpatient Program, Partial Hospitalization Program). According to these clinicians, patient response was overwhelmingly positive, and programming was well utilized by members of these populations.

**Discussion**

Clinician perceptions in the current study were in line with findings from previous studies of patient perspectives, focused on clinician and systemic influences, which have hindered patients from productive and safe eating disorder treatment. Our analysis generated two overarching themes: 1) barriers to accessing care/finding clinician and 2) barriers to receiving therapeutic and safe care. Many barriers to accessing care and barriers to receipt of effective and safe care were similar but had differing impacts.

In our study the role of family in eating disorder treatment and in the lives of gender minority patients was prominent. Clinicians in the current study noted the need to consider how the attitudes of their patient’s families towards their gender identity can impact success in treatment; a barrier not discussed in patient studies. The role of family in eating disorder treatment may cause unease, particularly among those who are not yet out to their families or clinicians. Many gender minority patients don’t come out at all throughout treatment to avoid mistreatment,
discrimination, or other burdens imposed on them by clinicians while they are seeking help for their eating disorder (Duffy et al., 2016). Clinicians in our study noted that patients may wait to come out until they are living independently for similar reasons. Previous studies with patient participants have largely explored care experiences in those older than 18 years (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022); our study allowed clinicians to reflect on the experiences of patients of all ages, including the experiences of younger patients, ranging from middle school to college, who are more impacted by the role of family, and adult patients who are more independent and less impacted. Research to better understand how family centered therapeutic styles may serve as barriers to care for gender minority youth is warranted.

Clinicians in our study honed in on unique roles that patients’ social contexts and communities have on their ability to access and receive quality eating disorder care. The use of religion to justify denial of care disproportionately impacted gender minority individuals—under Conscience Clauses. The language of Conscience Clauses affords clinicians the right to refuse to provide care to transgender individuals if they feel that 1) they would need to discuss gender affirming medical intervention in any way or 2) if a condition is so much as tangentially associated with the patient’s gender identity (Religious refusals in health care, 2018). A 2016 Center for American Progress survey found that 29% of transgender individuals were refused the ability to even see a health care clinician, because of clinician attitudes towards gender minority individuals (Mirza & Rooney, 2018). Twelve percent managed to see a health care clinician but the clinician, because of their religious beliefs, refused to provide affirming care to the patient.

Institutions of higher learning can have direct roles in selecting what care is available to their students who use on-campus health services. According to clinicians, influence from upper leadership on campuses has resulted in an inability to use inclusive messaging to welcome gender
minority patients or to provide certain types of healthcare for these individuals. Gender minority individuals entering college counseling centers for care are more likely to have more severe mental health concerns than their cisgender peers (Platt, 2020). Limiting or denying access to safe, affirming eating disorder care can delay a patient from entering care for their eating disorder or other treatment for other mental health conditions. Gender minority college students are 4-6 times as likely as cisgender college students to be diagnosed with an eating disorder (Diemer et al., 2015). Additionally, eating disorders increase risk for suicide and suicidal ideation, especially among gender minority individuals (Duffy et al., 2019). Risk for suicide or suicidal ideation can be exacerbated if patients are unable to access affirming care or are subjected to transphobia (Turban et al., 2020; Pellicane & Ciesla, 2022). For these reasons, the barriers that clinicians identified in these care settings serve as cause for concern. Improving access to affirming care and accommodating the needs of gender minority students on college campuses is imperative.

Clinicians in our study who worked on religious affiliated campuses and within religious communities mentioned methods of accessing care through ecclesiastical leaders as a means of getting eating disorder treatment. Despite access to care via sponsorship from ecclesiastic sources, transgender patients were hesitant to do so. The religious affiliations for campus clinicians in this study did not support receipt of gender affirming care and clinicians noted that this had detrimental effects on their gender minority patients. Religiosity has been shown to be associated with negative attitudes towards gender minority individuals (Elischberger et al., 2018; Norton et al., 2013). Religiosity of a community in which a gender minority individual lives or practices their faith has been identified as a barrier for them in seeking to access health care generally (Johnson et al., 2020). However, there is a paucity of research exploring how access to care through religious pathways has impacted ED outcomes and experiences for gender minority individuals.
Study participants were particularly aware of the ways in which discrimination manifested and impacted patients. In prior studies, avoidance of treatment due to misgendering, or continued use of an old name (i.e., deadnaming), and/or clinicians using incorrect pronouns were noted as major barriers that prevented gender minority patients from receiving care for their eating disorder (Anzani et al., 2019). Twenty three percent of gender minority patients receiving any type of healthcare have reported being misgendered or deadnamed by a clinician (Mirza & Rooney, 2018). Our participants confirmed that it was not only difficult for patients to find affirming clinicians, but it was difficult for clinicians themselves to identify other safe clinicians for referrals. Gender minority patients have expressed frustration with the uncertainty of safety or acceptance when seeking out a clinician for eating disorder treatment—preferring that clinicians clearly identify themselves as allies of transgender and non-binary patients (Hartman-Munick et al., 2021). Although many clinicians may claim to be accepting, both patients and clinicians have found that clinicians who self-identify as allies are not always living up to that expectation (Hartman-Munick et al., 2021; Cusack et al., 2022). Clinicians and patients who identify as transgender or non-binary have expressed that those who have lived experience may be best suited to work with patients with similar gender identities; these shared experiences likely serve as a source of comfort to patients who may not wish to be so transparent with cisgender clinicians (Hartman-Munick et al., 2021; Cusack et al., 2022). Many patients have expressed greater feelings of comfort working with gender minority clinicians (Cusack et al., 2022). Patients have attributed these feelings of comfort to gender minority clinicians having a higher likelihood of affirming a patient and greater gender-competency by way of personal experience (Cusack et al., 2022).

In treatment spaces, both clinicians and patients called attention to the ineffectiveness of traditional ED treatment approaches and the detrimental effects they have on gender dysphoria for
many gender minority patients. Patients from prior research felt like the use of body positive approaches, such as radical body acceptance, make them feel like they are “pushing themselves to be in their body” (Hartman-Munick et al., 2021). Clinicians in our study elaborated further, noting that their gender minority ED patients have a difficult time with exposure therapies and discussions around anatomies of cisgendered bodies. Gender minority patients have expressed discomfort with gendered care settings that exclude the body experiences of transgender and non-binary individuals (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022). The ability to use names and pronouns to involve gender in ED treatment by clinicians is necessary, but not sufficient. Patients report that clinicians blame their ED for causing gender dysphoria and others blame the dysphoria for causing their ED (Cusack et al., 2022). Most clinicians in this study recognized that dysphoria is not always the cause of ED for every gender minority patient; their ED may result from trauma, poor body image, or anxiety. Patients have asked for care needs to be tailored to the individual such that clinicians inquire about gender identity and how it is affecting the patient individually, not as a member of a homogenous group (Cusack et al., 2022).

Strengths and Limitations

This study focused on the views of clinicians, who may have a full picture of care experiences across multiple patients of varying ages, races and ethnicities, experiences in medical and social transition, support systems, and financial circumstances. Individual interviews allowed for extensive discussion of clinician perspectives and experiences. Their views expand on patient perspectives in other studies; specifically, views on clinician comfort and ability to treat gender minority individuals with body-centric mental health conditions, as well as the dominant disparities in this field of care. This study provided responses from nineteen clinicians of differing
ages, race/ethnicities, clinical experiences, clinical settings, and geographic locations. Our sample was representative of clinician demographics in the United States (Zippia, 2021).

Validity in qualitative research can be impacted by reactivity, researcher bias, and selection bias. We sought to include clinicians from a wide range of belief systems and attitudes towards gender minority individuals. Yet, participants may become aware of researcher preconceptions on the subject matter and feel compelled to alter responses. We made efforts to reduce participant reactivity prior to the start of each interview by having the interviewer explicitly convey that all 1) perspectives, 2) beliefs, 3) maintained knowledge and 4) lack of knowledge on the subject matter were critical and equally important to researchers in this study.

The lead author (K.F.), who served as the interviewer and as a coder, had extensive prior knowledge of barriers and facilitators to care for gender minority individuals in U.S. mental health and primary care settings. Prior content area knowledge may have biased how codes were constructed and populated. To reduce the impact of researcher bias, we employed a second coder (E.M.) with limited prior knowledge of the subject matter and population. Both K.F. and E.M. identify as cisgender females, which may have limited the scope through which data could be understood, as neither had lived experience as a gender minority individual. Both coders made concerted efforts to question whether their own beliefs and assumptions were leading them to interpret findings a particular way.

Despite these efforts, study findings must be considered with certain other limitations in mind. We recognize that we may have missed perspectives of clinicians with radically differing attitudes toward gender minority patients given the voluntary nature of participation. Future studies should aim to focus on the perspectives and views of 1) clinicians with complete lack of knowledge/inability to make assumptions about this population’s care experiences, 2) clinicians
from cultural communities that have strong beliefs about traditional gender roles, 3) clinicians who are explicitly bigoted, and 4) clinicians who feel that gender minority individuals face no difficulties in life or ED care.

**Implications**

Clinicians demonstrated awareness of barriers to care for gender minority ED patients but expressed great uncertainty about methods of appropriate care delivery in this population. They expressed concern regarding lack of sufficient education about effective ED care for this population. Our findings highlight a need for understanding the clinician level limitations in training and potential for system change in the care space that would address needs identified by gender minority patients and their advocates.

**Conclusion**

Clinicians in our study were aware of a plethora of barriers to care facing gender minority patients that impair their ability to receive effective treatment for eating disorders. Improvements to eating disorder treatment spaces, clinician knowledge, and treatment approaches to better serve gender minority patients are warranted. Future research should expand upon extant studies that have identified weaknesses in the education of mental health clinicians, as well as clinicians’ ability and willingness to practice gender affirming and inclusive care.
**APPENDIX A. Interview Protocol**

<table>
<thead>
<tr>
<th><strong>Objective – To Investigate</strong></th>
<th><strong>Questions</strong></th>
</tr>
</thead>
</table>
| Personal experiences with transgender and gender diverse patients. | 1) During your time as a practitioner at your current practice or clinic, have you provided care to a transgender or gender diverse patient?  
   a. Were there challenges, ease, working with gender minority patients?  
   b. How did you adapt or personalize your approach to care?  
  2) If a patient presented to you with an eating disorder and gender dysphoria, how would you typically get started or proceed?  
   a. What types of questions would you ask the patient?  
   b. Would any questions you ask them differ from questions you would ask someone who is cisgender? Why or why not?  
  3) How confident are you in your skills necessary to effectively treat an eating disorder with a patient who is transgender or gender diverse?  
   a. Do you feel prepared to provide gender inclusive and/or affirming care?  
      i. In what ways do you feel prepared; in what ways do you not?  
| Coordinated gender affirming care, care networks, and clinic climate. | 4) Tell me about your comfort with engaging in coordinated gender affirming care with medical professionals outside of your clinic/practice… (i.e. would you feel comfortable writing a letter of support for gender affirming surgical intervention for a patient?)  
   a. If you have worked with patients who have come from other clinicians, have they said anything of note about their experiences with other clinicians related to their gender identity? Maybe 1 or 2 experiences or any generally common experiences? Good, neutral, or bad?  
  5) Do you feel comfortable referring a transgender or gender diverse patient to another clinician if you cannot provide care they need?  
   a. What factors would lead you to refer a transgender or gender diverse patient with an eating disorder?  
   b. What factors would influence who you refer that patient to?  
   c. At this time do you know other clinicians, outside of your practice/clinic who provide gender inclusive care? Inside your clinic?  
   d. If you did not know of one, how would you go about identifying a clinician for a gender minority patient? |
| **6) Tell me a bit about the climate in your office or clinic surrounding the delivery of care to transgender and gender diverse patients.**<br>a. What are some of the prevailing opinions among the staff about care needs of transgender and gender diverse patients?<br>b. What is the general familiarity of staff and other clinicians with gender affirming care?  
**Self-education**<br>**7) Tell me a bit about your personal engagement with gender affirming care practices, literature, and other resources for self-education?**<br>a. Which resources have you personally used?<br>b. Which resources have been useful, not that useful, pointless?<br>c. If you have never used any resources, where might you go to find them if you were hoping to learn something about gender identity?  
**8) Tell me about your education in college or university surrounding gender identity?**<br>a. Were there classes specific to gender identity?<br>b. What topics were covered related to gender identity?<br>c. Did you feel like your education around gender in college/university prepared you for working with gender minority patients? In eating disorder treatment?  
**Perceptions of how patient gender identity impacts eating disorder treatment.**<br>**9) From your experience and perspective, how might a patient’s gender identity impact their eating disorder care? Their mental health?**<br>**10) How might the care that transgender and gender diverse patients receive differ from or be similar to care provided to cisgender patients with eating disorders?**  
**Perceptions of barriers to care and evaluation of how barriers may impact care.**<br>**11) In the treatment of eating disorders, a support system can be valuable to a patient. How might you approach building a treatment plan that incorporates a support system for a transgender or gender diverse patient?**<br>**12) What barriers to accessing care might transgender or gender diverse patients experience when seeking eating disorder treatment?**<br>a. I.e. they haven’t found a clinician yet but are looking for one…what would impact ability to access care?  
**13) What barriers to appropriate care might transgender or gender diverse patients experience while actively receiving treatment for their eating disorder?**
a. I.e. they are working with a clinician, what might impact their care experience or desire to remain in care?

14) What has most impacted your perception of the needs of gender minority patients with EDs?
   a. Most impacted your understanding of gender minority individuals generally speaking?

15) Aside from those which you may have already mentioned: what changes/improvements, if any, do you feel are needed to improve eating disorder treatment for gender minority patients?
### Table 1:

Table 1. Participant characteristics of US-based mental health clinicians providing treatment for eating disorders (n = 19).

<table>
<thead>
<tr>
<th></th>
<th>Number of participants**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transgender identifying</strong></td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>1</td>
</tr>
<tr>
<td>Cisgender</td>
<td>17</td>
</tr>
<tr>
<td><strong>Gender identity</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Binary/Non-Conforming/Gender Fluid</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
</tr>
<tr>
<td><strong>Racial identity</strong></td>
<td></td>
</tr>
<tr>
<td>Asian/Asian American/Pacific Islander</td>
<td>1</td>
</tr>
<tr>
<td>Black/African American/African</td>
<td>2</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>13</td>
</tr>
<tr>
<td>Multiracial</td>
<td>2</td>
</tr>
<tr>
<td><strong>Ethnic identity</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic or Non-Latinx</td>
<td>15</td>
</tr>
<tr>
<td>Hispanic or Latinx</td>
<td>1</td>
</tr>
<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>6</td>
</tr>
<tr>
<td>31-50</td>
<td>11</td>
</tr>
<tr>
<td>51 and older</td>
<td>2</td>
</tr>
<tr>
<td><strong>Clinic/Practice Type</strong></td>
<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>4</td>
</tr>
<tr>
<td>Outpatient Treatment Program</td>
<td>5</td>
</tr>
<tr>
<td>Community Health Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Hospital-Based Clinic</td>
<td>2</td>
</tr>
<tr>
<td>Academic Clinic or Practice</td>
<td>1</td>
</tr>
<tr>
<td>College Counselling Center</td>
<td>2</td>
</tr>
<tr>
<td>Private Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Inpatient/Residential Treatment Program</td>
<td>1</td>
</tr>
<tr>
<td>Other: Peer Led Treatment Program</td>
<td>1</td>
</tr>
<tr>
<td><strong>Geographic region</strong></td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>3</td>
</tr>
<tr>
<td>Midwest</td>
<td>1</td>
</tr>
<tr>
<td>South</td>
<td>12</td>
</tr>
<tr>
<td>Northeast</td>
<td>3</td>
</tr>
</tbody>
</table>

*Regions, according to the US Census Bureau (Census Regions and Divisions of the United States, 1984)

**May not total to 19 as some participants preferred not to answer some questions.
### Table 2: Supporting clinician comments on barriers to accessing care among gender minority patients seeking and receiving eating disorder treatment.

<table>
<thead>
<tr>
<th>Stigmatization</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I mean, family, lack of support, abandonment, rejection...that's a huge barrier, because how can someone get the help they need if their family is not helping them when they have a health rejecting illness?&quot; (P01)</td>
</tr>
<tr>
<td>&quot;I think, just like, past experiences with past clinicians are like a huge barrier where patients have been like, 'oh, I went to this one person, and this bad thing happened. So, why would I ever put myself in that situation again’, which is totally valid.&quot; (P18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family support</th>
</tr>
</thead>
<tbody>
<tr>
<td>“…I've had a lot of people say, it wasn't until college, that they could even consider having access [to therapy], because the family didn't want the shameful secret, or that their child was not masculine enough or not feminine enough from their perspective, or, you know, the family didn't allow access to therapy with someone who would be gender affirming, and that was a bad thing, because it would only encourage this like delusion.” (P15)</td>
</tr>
<tr>
<td>“…the family education piece...specifically with this population, is to make sure that the parents are educated on not only good recovery skills, but also, why it's made more difficult or challenging in a situation where there are some identity things going on...so much of an eating disorder is about identity…we have to approach it as a whole person…we also have to make sure that your child feels comfortable being who they are in their skin…I think that helps parents have a little bit more buy in to the process.”” (P29)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;...a lot of the times the parent’s kind of cut them off, especially as they start to transition, they have a lack of support from various areas, and that includes financial. Eating disorder treatment is really expensive...some of our transgender clients might have to discharge early due to financial reasons and that's very sad.&quot; (P03)</td>
</tr>
<tr>
<td>“We've had clients in program who have been seeking gender reassignment surgery and for whatever reasons, financial or otherwise, maybe they couldn't afford it, and it could be like, ‘I have to choose between eating disorder treatment, or looking the way that I feel is appropriate. And I think that people are going to kill me in my community, because they won't accept me the way I am. So, it's like my eating disorder will kill me, or my community will kill me. So if I want to fit in, I have to get top surgery, but I can't afford it and eat at the same time.’ So sometimes people are having to make some pretty difficult decisions.” (P05)</td>
</tr>
</tbody>
</table>
"There was one incident with insurance, where there was no option for trans or gender expansive expressions. It was male, female, that was it. Because on their birth certificate, it said they’re a female, the insurance company wanted a female name. The female name on their bursary gave coverage to this individual for any kind of treatment. This patient was very flexible, very understanding, but I could see that being a barrier for a lot of folks...really invalidating, triggering, discouraging, and just like screw it, it's not worth it." (P11)

**Gendered clinics – cis female only**

“I've only worked in facilities that were female only, but some of our sister facilities...were coed. So we would have clients who would come to the place and say, ‘I don't feel comfortable, X, Y and Z.’ So we say, ‘Okay, well, we can transition you to one of our sister facilities that's in Florida or California,’ but they don’t have resources to get to Florida or California. So, it kind of just puts them in a crunch.” (P21)

**Scarcity of gender competent care**

"One of the states I've worked in is not a very liberal state, and can be kind of dangerous, sending certain clients to certain clinicians...the state of Texas, living there and working with several trans clients, I wasn't scared, but I just felt for them and wanted to make sure that I was sending them to doctors that were educated and appropriate with this population." (P07)

"The state of Kentucky is not a super welcoming place for anyone who isn't a heterosexual cis white man...I will say we're located in the biggest city in Kentucky so, I do think because it's a metropolitan area, it's more accepting...tolerant. I don't know that folks are like, necessarily feeling actively positive about the trans population but I think they're certainly more open than in some of the rural, small towns. And like if you don't want...somebody to see you walking into the clinic, even if they're not coming here...it might be hard to have that privacy" (P11)

**Religious communities**

"It’s a very conservative and a very religious community that is not LGBTQ affirming, that is not, in general, supportive of gender diverse individuals...So I think the barriers are both practical and financial...a huge way that people access services in this community is through like a religious or ecclesiastical clinician. They provide the referral and sometimes payment for services. It gets very, very thorny there because the person that is basically in a position of power, that religious figure, to pay for those services and may only refer to people who are not necessarily gender affirming." (P27)

"So my practice is in a predominantly conservative, religious community...there are unique challenges to that for our populations that we’re serving, because a lot of them are coming into our clinic, with beliefs about themselves that are quite negative or distressing to them personally...so, if they're living a life that they feel is outside of that, it's really eye opening [for them] to sit with someone and to have that person say, 'I think that you are still someone that can live your values and live your life, authentically and that's not such a black and white issue.'." (P29)
**TABLE 3:**

**Table 3.** Supporting clinician comments on barriers to successful care experiences among gender minority patients seeking and receiving eating disorder treatment.

<table>
<thead>
<tr>
<th>Discrimination and microaggressions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“…the boss that I left from, they were also an older male, who was very open about sexuality but when it came to gender and pronouns…they refused, because it wasn't grammatically correct. Like, we helped a lot of patients come out to their families and created a safe space but when it came to that (gender), there's no tolerance.” (P16)</td>
</tr>
<tr>
<td>“…we're like, okay, this person needs to go to this specialist…they need to have their gastro system looked at more carefully…the doctor on our team was like, ‘I mean, we can send them there and that's the only place we can send them but it's gonna be rough’, and then you try to help the client through it…prepare them what to say, how to navigate, what to expect. Like literally like you have to send them into an unsafe space…in Arkansas we don't have a lot of choices…there's only one or two doctors in all of the state…so when they need a specialist, it's really risky for them as far as their identities.” (P10)</td>
</tr>
<tr>
<td>“…there's a piece of legislation in this state it's called the Conscience Clause. So, essentially, it gives people (clinicians) a pass (on religious or conscience grounds)...we've had clients that said, ‘this person seemed okay or they were the only one that took my insurance, I had appointments,’ and then the person is telling him, ‘I need to refer you out because I don't have enough experience to treat you.’ They're back in the same place of, ‘I've been vulnerable (disclosed gender ID) and that person told me, I can't help you.’” (P17)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinician lived experience and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I think a much more fundamental issue is the lack of diversity within our fields...especially for the kind of treatment that I do in inpatient residential settings, where you're really living with your carers (sic)...you're not seeing somebody once a week for an hour. I think especially in that context, for the people around you not to be reflective of your experience, is a huge problem. It doesn't matter how well educated they are, it doesn't matter how well intentioned they might be, it doesn't matter how many seminars they might have taken, there's a fundamental difference in having some level of lived experience of the nuances that come along with whatever you might be talking about and just learning about something in an academic way.” (P25)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other patients and parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think, unfortunately, all levels of their care can be impacted, especially if they're male...or if they identify as male. It also makes it tricky, because I work with other clinicians at the residential part of our company and housing is really difficult with these particular patients because parents of [other] adolescents do not feel comfortable with a patient in their say, daughters, room who's heterosexual for all we know. They are 12, but you know, who knows? But then there is a 13-year-old that is transitioning, they find that out, then they cause a ruckus!” (P16)</td>
</tr>
</tbody>
</table>
“My patient that I worked with for a while talked very specifically about someone who had this ‘Back the Blue’ poster in her picture [in telehealth video group therapy] and me saying to him, 'so you're probably very fair about what those assumptions are, but we don't 100% know. And just because she has someone in her life, who is a police officer, doesn't mean that she doesn't accept you as you are. So, I get it, and I get why you're wary and let's also try to be fair, and if she says anything, let me know, because we're going to squash that very quickly and it's not okay.'...it's challenging.” (P02)

**Institutions of higher education**

"So our board...they hold a lot of power. The politics of my state have a big impact...we wanted to put out a statement, during some of the events that have been happening over the last couple of years, making sure that our students knew that we were welcoming of all people, specifically, our gender minorities...and we were not allowed...it's really run by the views of the board [of the university] and what messaging they want us to put out. So, we've got people that push and advocate but when it comes down to even little things, like changing the paperwork that our clients see when they come in so it's not, 'identify yourself as male or female'...it took a lot of time for us to get that approved.” (P10)

**Family-centered care**

“...a different nonbinary client...this person is only 11 years old...I kind of helped them go through that process of like telling their family and telling their doctors and everything like that. But that was incredibly difficult. And mom just emailed me and is still using the incorrect pronouns...apparently, they're using a completely different name now, and mom is still using the old one...and I think, working with families in this population...like this person is 11...I find really, really challenging because it's like, I don't want to step on these parents toes in any way, but I also want to advocate for my client.” (P07)

“some of the values and attitudes of family members...parents and family just kind of emotionally cut them off...a sense of personal rejection...so you've got that compounded on their sense of identity confusion that they've gone through on that, and trying, again, to be accepted by others...all the negative self-talk that goes on with an eating disorder, it just seems like it's compounded or exponentially higher, with an individual who is transgender...there have been other family situations or support systems where their partners have been very supportive...you need a support system in eating disorder recovery.” (P09)

**Gender-centered care**

“...a lot of treatment facilities are female only. That's going to be a big, big issue...I've worked in a clinic where we accepted a transgender male....and this client who was transgender, transitioning from a female to a male, he kind of felt, you know, like an outcast, an outlier because even though he had female body parts he identified as a male and a lot of the things that we were teaching and the discussions about the body that we were having you relate to more so as a woman, so that was kind of difficult for him.” (P21)

"So, I think even for cis males who have eating disorders, I know that most, if not many of them, would probably feel very uncomfortable in most treatment centers, just because of how gendered most treatment and the content of treatment tends to be...anybody who's not at least
female identifying would probably have a similar experience. Layer on top of that the relative lack of comfortableness in most healthcare settings, for somebody who's not cisgender and who probably is not straight either. The lack of sort of general competency in those realms...lack of welcomeness in those kinds of settings...I think that also then magnifies that disconnect for people coming into treatment...I don't think we're doing a great job." (P25)

“There was one point where I was filling in over there just because they moved us around to where people were needed the most. We had a client that was trans that identified as female, and they had them on the male unit, which even at that point, being as ignorant as I was compared to now, I would say, to me, that didn't seem quite right. And I asked about it and essentially, they were saying, this is the best fit [for the patient] based on how it was going. There were a lot of issues with that.” (P05)

**Traditional therapeutic techniques**

"You have clinicians trying to press acceptance of one's body shape and weight, or managing eating style without understanding gender dysphoria, and one's already complicated relationship with their body could actually exacerbate gender dysphoria. So, by having tried some of the typical interventions, like looking at a mirror and telling yourself positive things isn't going to work...it would be like the antithesis of your identity to have to be forced to accept certain parts of your body." (P15)

“…exposure, meal outings and going out in the world and eating…going certain places or clothing shopping…they might not feel fully comfortable. You know, getting looks from people or getting questions and, ‘why are you in the women's section?’…‘why are women in the men’s section?’… things that are even as seemingly simple as picking a dressing room when you're out in public trying to do those shopping exposures, I can see all of that being not impossible, but just an additional barrier for us to have to consider when trying these different therapeutic interventions.” (P11)
CHAPTER IV: EATING DISORDER SPECIALIST VIEWS ON GENDER COMPETENCY AND EDUCATION FOR TREATING GENDER MINORITY PATIENTS
Abstract

**Objective:** Studies exploring patient experience with clinicians specializing in eating disorder treatment have reported poor gender competency among clinicians. Through interviews with clinicians specializing in eating disorder treatment, we sought to 1) clarify how and why current practice and clinical training may not meet the needs of transgender and gender diverse patients, 2) assess where and how clinicians received education on gender identity, and 3) what changes can be made to meet educational needs so as to better serve patient needs.

**Method:** 19 clinicians were recruited and participated in semi-structured interviews. Their narratives were coded, by two independent coders, using thematic analysis.

**Results:** Four key themes emerged: Training and education received, importance of receiving training or education, self-education, and improvements recommended by clinicians. Only ~16% (n = 3) of clinicians reported sufficient training both in graduate school and through their place of employment. Most with sufficient education received it at their clinic/practice. Despite lacking formal training, all clinicians engaged in some form of self-education on gender.

**Discussion:** These findings support the need for standardized and comprehensive graduate curricula, in-service trainings, and continuing education requirements. Advocacy is required to encourage accrediting organizations to require training on gender among mental health clinicians.
Introduction

Gender minority individuals with eating disorders (EDs) often have difficulty finding gender-competent mental health clinicians (Duffy et al., 2016; Hartman-Munick et al., 2021, Cusack et al., 2022). Clinicians’ general lack of knowledge and education on gender identity has been acknowledged by clinicians and patients (Duffy et al., 2016; Hartman-Munick et al., 2021, Cusack et al., 2022; Ferrucci et al., 2022), but research regarding clinicians’ education and potential solutions to improve gender competency is lacking. Many gender minority patients desire clinicians who understand the importance of inquiring about and understanding gender identity as it relates to their eating disorder (Duffy et al., 2016; Hartman-Munick et al., 2021, Cusack et al., 2022). For some gender minority patients, seeking care in a body-focused treatment setting can be more harmful than helpful if clinicians are not attuned to their unique body experiences (Duffy et al., 2016).

Patients have described gender dysphoria (i.e., a feeling of discomfort or distress that often occurs in people whose gender identity differs from their sex assigned at birth or physical characteristics (“Gender dysphoria,” 2022), as something that is widely misunderstood by clinicians (Duffy et al., 2016; Hartman-Munick et al., 2021, Cusack et al., 2022). Microaggressions towards gender minority patients from mental health clinicians, like ignoring their identities or avoiding discussions around identity, are not uncommon (Duffy et al., 2016; Hartman-Munick et al., 2021, Cusack et al., 2022; Thapliyal et al., 2018). Some clinicians place their focus primarily on their patient’s gender dysphoria and identity; blaming gender dysphoria for their eating disorder, or vice versa (Duffy et al., 2016;). Clinicians may be reluctant to treat gender dysphoria before eating disorder symptoms subside (Giordano et al., 2017). Traumatic experiences of patients being coaxed by mental health clinicians to practice self-love of a body
that causes them distress have been reported (Cusack et al., 2022). Gender competency and sensitivity trainings, which may prevent some of these clinician-generated issues, are often lacking among mental health clinicians (Shipherd et al., 2010).

Patients often report that they themselves serve as a clinician’s main source of education on gender identity (Duffy et al., 2016). This is due to an absence of formal education on the topic, with some clinicians noting that comprehensive gender education is not often received unless clinicians pursue specialization (Teti et al., 2021). Medical school curricula often fail to include any substantial content pertaining to gender expansive identities (Safer & Pearce, 2013; Eriksson & Safer, 2016; Korpaisarn & Safer, 2018), and there is a paucity of research investigating education and preparedness among mental health clinicians (Obasi et al., 2022; O’Hara et al., 2013).

Clinicians too have acknowledged that their education and training around gender identity is not sufficient. Many have noted a lack of gender competency among clinicians that presents a barrier for gender minority individuals seeking care, especially in eating disorder treatment (Ferrucci et al., 2022). This deficiency in the curriculum can encourage clinicians, with little to no knowledge, to self-educate on the topic, but with no certainty that the resources they are using are reliable or accurate. Moreover, the choice to exclude or limit a gender-based curriculum downplays the importance clinicians should place on gender identity as a factor in delivering effective mental health treatment.

A plethora of resources and clinical guidance exist for clinicians in psychology and medicine (Burns et al., 2010; van Trotsenburg et al., 2012; Austin, 2018). Some guidance offers additional information for serving as a clinician-ally or activist (Singh & Burnes, 2010; Gonzalez & McNulty, 2010; Ratts et al., 2010), for improving care of transgender patients in certain
populations (Walinsky & Whitcomb, 2010), and for creating inclusive curricula for gender minority staff, faculty, and students in training (Craig et al., 2016). Whether these resources are widely known or utilized remains uncertain.

Previous studies have investigated gender minority patients’ perceptions of clinicians’ gender competency and how it had influenced their experiences in eating disorder treatment (Walinsky & Whitcomb, 2010). Yet, an assessment of how mental health clinicians’ varying degrees of gender competency may influence capacity to treat transgender and gender diverse people with eating disorders has not been conducted.

Clinicians have a direct relationship with those they treat; we explored their narratives to 1) clarify how and why current practice and clinical training may not meet the needs of transgender and gender diverse patients, 2) assess where and how clinicians have sought out or received education on gender identity, and 3) consider how systemic changes can be made to meet their educational needs, as well as the needs of patients.

**Methods**

We conducted semi-structured interviews to investigate a range of topics related to clinicians’ education and training opportunities about the delivery of ED care to transgender and gender diverse populations. We emailed clinicians a REDCap (Electronic Data CAPture) (Harris et al., 2009; Harris et al., 2019) survey before their interview including questions about their experience, comfort, education, and training about gender minority patients, and the inclusivity of clinic intake materials and website.
Setting and Participants

Potential participants were identified from all US states and territories, using a range of sampling methods including snowball sampling, social media messaging, and direct email solicitation. Those 18 years or older, who were licensed to provide mental health treatment, with at least one year of experience in their current role were eligible to participate. We aspired to recruit a diverse sample of clinicians across a range of ED treatment settings, with varying approaches to care and professional credentials. The sample was representative of the racial/ethnic and gender demographics of mental health clinicians in the United States (Zippia, 2021). Most identified as cisgender and female and more were in the U.S. South than any other region (see Table 1 in Ferrucci et al., 2022).

The current analysis focuses on educational experiences, gaps, competencies, and educational needs of mental health clinicians, as well as suggestions for improving education and training for ED clinicians.

Procedures

The procedures and analyses used in this study previously described in detail (in Ferrucci et al., 2022) are summarized below.

This study was reviewed and approved by the Institutional Review Board at the University of Massachusetts Chan Medical School (H00023851).

Study recruitment was conducted over 2 months. Using the Psychology Today website, we contacted most clinicians in all U.S. states and territories who provided a link to their contact information (via personal or clinic website), until we attained ample demographic representation and diversity in gender identity, race, and age. We also utilized personal academic networks and
social media to reach clinicians. Clinicians were sent survey links via emailed or direct messages via Instagram to complete a screening survey. Those who met inclusion criteria were invited to complete the demographics and background survey and were scheduled for an interview. Survey data were collected and managed in REDCap electronic data capture tools (Harris et al., 2009; Harris et al., 2019). Participants electronically provided passive consent and confirmed being 18 years or older. We assigned participant IDs to protect their privacy. Clinician IDs linked to participant names and email addresses were stored separately from their data. Data were retained on a secure research drive at the University of Massachusetts Chan Medical School.

Clinicians met individually with the interviewer (KF), via Zoom, for a single, 45 to 60-minute, semi-structured interview. KF is a doctoral candidate with qualitative research experience. Interviews were conducted in English using a protocol design based on the findings of Duffy et al. (2016) and Hartman-Munick et al. (2021) (See Appendix A). An IRB approved Fact Sheet was used to verbally review elements of consent with participants prior to the start of each interview. Audio recordings from Zoom were downloaded onto secure University of Massachusetts Chan Medical School laptops on secure verified networks and transferred to a secure network drive for storage. Video recordings from Zoom and Zoom chat records were deleted permanently.

Data analysis

Interviews were transcribed from Zoom audio files using Otter.ai. KF and EM cleaned, deidentified, and verified transcripts. KF and EM, who both identify as cisgender females, independently coded the final transcripts. Weekly meetings between coders reviewed new themes and coding discrepancies as they emerged. We used NVivo (QSR International Pty Ltd.,
2020) to code transcripts and we utilized inductive thematic analysis (Braun & Clarke, 2012) to identify themes. Interrater reliability was 94.3% between coders.

**Results**

**Training and education received (Table 2)**

Three clinicians reported having received both fully sufficient education on gender identity during their graduate studies and through in-service trainings within their clinic or practice. Five clinicians either agreed or strongly agreed that they need better education on gender identity to provide care to a gender minority individual.

**In-service training**

Among this sample of clinicians, those who received thorough education on gender identity typically learned via in-service education at their clinical site (n = 7). In-service educational programs often involved several of the following: training on general terminology and terminology related to gender affirming care, training on allyship, monthly reading syllabi and videos on inclusive care and gender competency, internal discussion boards and blogs, grand-rounds focused on gender affirming practices, specialized conferences, trainings from external or internal trans or LGBTQ-led groups, and discussions on pronouns, dead-naming (i.e., use of one’s name given at birth rather than their chosen name), microaggressions, trauma-informed care, and appropriately handling mistakes you may make with patients. Those who received limited in-service training typically expressed a lack of comfort or preparedness in working with gender minority individuals. Those with limited-in-service training experience described their gender-competency trainings as having lasted only a few minutes, briefly
addressing what transgender or non-binary means, and usually as part of a larger training on diversity and inclusion.

Graduate education

While many clinicians in this sample touched on gender identity in their graduate studies, clinicians almost always described this topic as only briefly discussed. Furthermore, it was usually part of a course on diversity or cultural sensitivity. Among those who had covered gender identity in their graduate education, few (n = 3) confirmed having taken graduate courses specifically on gender identity or gender and sexuality. One clinician detailed their experience in a graduate course that pushed students to ask deeper questions about their preconceptions of what different gender identities mean. The two other clinicians explained that the gender coursework they took primarily focused on sexuality, but that gender was often discussed in their courses.

Other opportunities in higher education

While many clinicians had no coursework dedicated to gender identity in their graduate studies, some clinicians still had informative experiences during their time in graduate school. One clinician described a “lunch and learn” series, offered to students, that covered appropriate approaches to maintaining clinical inclusivity, and how to ask about pronouns and inquiring about gender identity. Additionally, clinicians who had several classmates that identified as transgender or non-binary or who had graduate faculty who were well-versed on gender identity more often described themselves as feeling prepared to work with gender minority patients than clinicians who did not.
According to two clinicians, specialized continuing education courses on gender identity and diversity were available as electives while in graduate school. Ten clinicians stated that they had never received education on gender identity while pursuing a degree. However, where graduate education on gender identity fell short for some, their undergraduate courses provided sufficient coverage. All clinicians expressed a need for the inclusion and expansion of gender identity education within graduate level education, in-service or mandated trainings, and/or in continuing education courses.

**Importance of receiving training or education (Table 3)**

*Direct impact on patients*

All clinicians expressed that the lack of training and education on gender identity negatively impacts patients and patient-clinician relationships. Clinicians reported having trouble identifying ED treatment approaches that aren’t distressing to gender minority patients. Clinicians indicated that patients take longer to open up to clinicians, because clinicians lack the language to have appropriate conversations with patients. Clinicians reported that some patients express discomfort working with clinicians who lack knowledge about them and their unique needs. Several clinicians felt that the patient-clinician relationship is especially harmed when clinicians or clinics publicly (e.g., online, in brochures) falsely claim they are gender competent/affirming when they are not. While clinicians unanimously agreed that it is necessary for clinicians to be affirming with patients, many also noted that it is not beneficial to pretend to be gender competent. Moreover, clinicians felt that those lacking knowledge should receive training before interacting with gender minority patients, even those who are affirming and accepting. A few clinicians stated that they had discouraged or, in the future, would actively
discourage other clinicians who lack knowledge from working with gender minority patients until they reached competency.

**Quality of referrals**

An additional aspect of the lack of standardized training among clinicians has been the inability of clinicians to identify safe referrals for their gender minority patients. Some clinicians explained that they maintain high standards for the types of clinicians to whom they refer their gender minority patients. Often, clinicians in this study stated that few other clinicians are meeting their standards for gender competency. Ultimately, clinicians are limited in appropriate referrals for their gender minority patients.

**Patient to clinician ratio**

The need for expanded training was further supported by the number of clinicians in our study who, when they realized that a substantial portion of their patients were gender minority individuals, independently sought out self-education. Further, the majority of clinicians viewed a lack of gender-competent clinicians as a hinderance to gender minority patients receiving care, as there are not enough to meet the needs of the number of gender minority individuals flooding clinics and practices. Most clinicians in our study felt that gender competency is a necessity for clinicians entering the field of eating disorder treatment, because working with gender minority patients is unavoidable in this line of work.

**Self-education (Table 4)**

*Commonly used resources*
Clinicians had relied on one or more of the following resources to gain gender competency: their patient(s) (n = 10); conferences (n = 7); research literature (n = 6); transgender or LGBTQ-community run resources (n = 6); continuing education courses (n = 5); Google (n = 4), social media (mentioned: TikTok and Instagram) (n = 3); other clinicians (n = 3); lay literature (n = 3), cultural osmosis (knowing someone who identifies as transgender or non-binary) (n = 3), and workbooks (n = 2). Almost all clinicians had engaged in some form of self-education.

Patients as resources

Most of the clinicians who received little to no formal or in-service education on gender identity identified patients as their primary source of education. Several recognized the burden this places on patients. Some felt compelled to disclose their lack of knowledge and willingness to make improvements for patient treatment success. Many of these clinicians explained that they could understand why gender minority patients might not feel comfortable working with them because of their lack of knowledge.

Usage of ACA competencies, FEDUp, and WPATH

Few clinicians (n = 3) mentioned having used widely available training resources on gender identity alone or gender identity and eating disorders, such as FEDUp’s online resources and trainings or continuing education courses offered through The World Professional Association on Transgender Health (WPATH). Among those who did, they utilized these resources by taking advantage of clinician scorecards for patient safety, bringing in trainings to their clinic or practice, and participating in continuing education courses and mentorship.
programs. No clinicians mentioned or expressed awareness of the American Counselling Association’s (ACA) competencies for counseling transgender patients.

**Improvements clinicians recommended (Table 5)**

*Defining gender competence*

Clinicians described competence as a comprehensive understanding of the experiences of gender minority patients. Comprehensiveness was defined by clinicians as the education of the experiences of gender minority individuals going beyond learning about pronouns and what it means to be transgender to understand: 1) how your identity as a clinician impacts patients who don’t share the same identity as you, 2) how to avoid harm to patients in a very gendered care setting, 3) holding other clinicians accountable for transgressions towards gender minority patients (intentional or not), 4) creating safe spaces for patients with the background knowledge to support that safety, and 5) maintaining an up to date knowledge on gender identity.

*Re-designing gender and eating disorder education*

All clinicians emphasized that cultural sensitivity and gender competency training needs must be thorough, accessible, and standardized in graduate education programs. Clinicians shared improvements they would make to programs that educate future mental health clinicians, which included:

- Comprehensive coverage of essential gender identity terminology (i.e., pronouns, deadnames, different identities, gender affirming care)
- Specialized training on how patient gender identity and eating disorders interact
- Using real world case examples with gender minority patients in therapeutic scenarios
- Discussions of alternatives to traditional eating disorder treatment for this patient population
• Using language that is inclusive of all individuals when discussing eating disorders
• How to use trauma-informed care in eating disorder treatment when working with gender minority patients
• How to be an effective ally

Additionally, some clinicians noted that trainings run or designed by gender minority individuals/clinicians have typically been richest in content, and several clinicians felt that these trainings are more reliable and effective than trainings from someone who is cisgender or not an expert in the field.

Teaching styles and course formats

Several clinicians expressed interest in a range of options for delivery and format of educational materials. Generally, clinicians felt that courses should be taught with different learning styles and settings in mind (i.e., clinical observation, classroom, continuing education). Some clinicians desired role-playing or real-world examples, whereas more research minded clinicians felt that they could benefit from using established tools such as models of development or change.

Action steps for other clinicians

Several clinicians had resource recommendations for their peers who may wish to expand their knowledge on gender identity. They encouraged all clinicians to take so little as a few minutes to get online and access any of these tools to better their practices and create spaces where all patients can receive gender-informed care:

• Workbooks, textbooks, and standard books on gender identity for clinicians specifically or on other more concentrated topics (i.e., trans resilience, gender and mental health or intersectionality)
• Gender conceptualization tools (i.e., gender unicorn)
Clinicians additionally shared that they distribute these resources to others in their clinic or practice and encouraged other clinicians to do the same. Furthermore, many who circulate resources emphasized the importance of reinforcing what they have learned among their colleagues in the workplace (i.e., ensuring that all clinicians are using correct pronouns whether or not they are with a client). Clinicians also encouraged their peers to be proactive with patients, and that giving them space to explore or explain their identity presents opportunities for learning and growth as a clinician.

**Discussion**

In this report of the perspectives of 19 eating disorder clinicians about their education and preparation for treating gender minority patients, clinicians articulated a need for improvement regarding how clinicians are educated around gender identity at the graduate level, as well as in their post-graduate training. Most expressed a desire for trainings and courses during and following their formal education that reach well beyond surface level definitions of gender identity and other general terminology. Clinically relevant information pertaining to the role of gender in treatment and patient experience of eating disorders was also demanded from clinicians. In addition to expanding formal education around gender, more than half of clinicians remarked that in-service or onboarding trainings provided useful knowledge on gender identity.
that helped them to work with gender minority patients. However, the lack of standardized training and education on the topic was noted as a detriment by many, stating that inconsistencies in clinician training provides inconsistencies in clinician competency and care quality. Despite the absence or suboptimal quality of education on gender identity, many clinicians independently sought out resources to self-educate when necessary.

Previous studies have identified multiple barriers to successful care experiences for gender minority patients, among which experiences with clinicians who display a lack of gender competence are frequently cited (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022). Clinicians in this study received little coverage of gender in graduate program curricula—a common reality for many clinicians (Austin and Craig, 2015). A lack of education on gender minority populations among clinicians has been correlated with uncertainty and avoidance in working with gender minority individuals (Poteat, German, & Kerrigan, 2013). Consequentially, ambivalent clinicians may resort to gendered treatment methods that dismiss the bodily experiences of gender minority patients (Paine, 2018), especially nonbinary patients (Kattari et al., 2020), and produce difficult or traumatic care experiences for these patient groups.

Both clinician insights and the history of care for gender minorities in the field may shed light on why graduate psychology, counselling, and social work programs have been reluctant to expand their curriculums on gender expansivity. The clinicians in this study, detailed in Ferrucci et al. (2022), described governing boards of universities as barriers to establishing inclusive care climates for gender minority students, on both public and private university campuses; citing political and religious reasons for boards’ decisions to keep care spaces exclusive. These factors driving exclusivity in on campus care settings may extend to curriculum design. Additionally, stereotypes have long existed in the field of psychology as a byproduct of pathologizing
diagnostic terminology such as gender identity disorder (GID). This diagnosis suggested that gender expansivity qualified individuals as mentally ill (O’Hara et al., 2013). Following calls to de-stigmatize the healthcare needs of gender minority individuals (Fraser et al., 2010; Haraldsen et al., 2010; Bockting, 2009; Knudson et al., 2010), GID was removed from the DSM-V in 2012 (Heffernan, 2022) and replaced with “gender dysphoria”. Despite this new diagnostic term having received widespread support of WPATH, as well as numerous research and clinical experts, the stigmatizing effects of the former pathologizing DSM diagnosis persists in impacting care for gender minority individuals. A mixed methods study of 53 U.S. mental health clinicians found that 23% felt that identifying as a gender minority individual was not as healthy as identifying as a cisgender individual (Whitman & Han, 2017). Additionally, while several states have implemented bans on conversion therapy, this unfounded and damaging method of treatment continues to be practiced across the country. Further, how gender identity is discussed in graduate education and what practices continue to be permitted may remain enforced by dated beliefs about what it means to be gender expansive.

A majority of clinicians reported that all or most of their training on gender identity was received through in-service training at their place of employment. While office-supported educational opportunities served as a primary source of information for clinicians, what was taught about gender identity was reported to be both “surface level” and inconsistent (across clinicians). A previous analysis of US clinicians found that only 6% reported having received clinical training and supervision that specifically addressed the care needs of gender minority individuals (Whitman & Han, 2017). These findings, in conjunction with prior literature, further support the need for universally recognized and adopted standards of education in the field. Without universally recognized educational benchmarks, care may remain inconsistent and fail
to serve gender minority individuals in the way it does presently. Further, both clinicians’ lack of competency and experiences of discrimination have been identified by patients as key reasons for leaving their current clinician in search of a new clinician (Safer et al., 2016; White et al., 2019). Providing an educational standard for attaining competency may mitigate some of these issues that plague patient experiences in eating disorder treatment and mental health settings broadly.

All clinicians in our study had sought out opportunities to self-educate on gender, which they felt supplemented their formal education and in-service trainings. Though clinicians with a range of experiences seek out opportunities to self-educate, specifically those who specialize in the care of gender minority individuals best managed to locate guidance and specialized resources for the counseling of gender minority individuals. In addition to the numerous options available through internet searches, educational resources for mental health clinicians have been made available through several groups, including: 1) the American Counselling Association (ACA) which provides competencies for counselling transgender patients, 2) the World Professional Association on Transgender Health (WPATH), which provides numerous continuing education and mentorship opportunities, in addition to a globally recognized set of standards for gender affirming care, 3) Fighting Eating Disorders in Underrepresented Populations (FEDUp) which has numerous educational resources and trainings, tailored specifically for clinicians working with gender minority individuals with eating disorders, as well as a treatment scorecard for clinicians to enhance their practices, and 4) the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) which provides counseling competencies for working with sexual and gender minority individuals. Although clinicians used a variety of means to self-educate, utilization of educational resources designed
or led by gender minority individuals or organizations, including those mentioned here, were minimally acknowledged among clinicians in this study \((n = 4)\). Three quarters of those who did acknowledge these resources displayed extensive knowledge of gender identity broadly and as it related to eating disorders and considered their practices as having a major focus on the care of gender minority individuals. Barriers to identifying long-recognized resources may exist for clinicians who lack specialized training. Associations and organizations (i.e. WPATH, FEDUp) that lead in producing clinician competencies, standards of care, and educational programming/trainings should seek out new means of reaching clinicians with limited gender competency.

**Strengths and limitations**

This study provided key insights to the various ways in which mental health clinicians receive an education on gender identity. Clinicians represented a diversity of training experiences, specialties, and practice types and additionally were demographically representative of clinicians in the United States (Zippia, 2021). Clinician narratives of educational needs and recommendations fill a gap in the literature that has been minimally explored among mental health clinicians. These insights provide knowledge about how clinicians are supplementing aspects of a curriculum that has not been afforded to many of them and that they require while working with gender dysphoric patients in a field that is body centric. Recommendations may serve future program development for in-services and graduate programs that seek to standardize or further gender competency.

The lead author (K.F.), who served as the interviewer and as a coder, had prior knowledge of some of the shortcomings of training and education among healthcare clinicians, within higher education, in the United States. Prior content area knowledge may have affected
how codes were constructed and populated. To reduce the impact of researcher bias, we employed a second coder (E.M.) with limited prior knowledge of the subject matter and population. As universally accepted educational standards do not exist, coders referenced educational resources and competencies available to mental health clinicians from reputable associations and organizations, to establish standards of education and competencies. Coders additionally considered the narratives centered on specific clinician educational needs, shared in prior patient studies (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022).

Some limitations of this study included restricted interview time, which may have limited clinicians’ ability to offer thorough responses to more granular questions surrounding their education. Participants recruited for this study did not include those in training. Differences in generational training may have been missed. However, we sought to include clinicians of all ages to capture the experiences of those who graduated more recently. Additionally, in both their background questionnaire and interviews, clinicians were asked to identify how extensive and adequate they felt the training they received in graduate school and in their place of employment had been. Clinicians’ perceptions of what qualified as substantial was relative to what may have been deemed useful to the clinician rather than the patient and their treatment experience or outcomes, or other factors. While there is not a current educational standard by which to compare, future studies should seek to provide a standard definition for each category of sufficiency or lack thereof.

Validity in qualitative research can be impacted by reactivity, researcher bias, and selection bias. We sought to include clinicians from a wide range of practice types and educational backgrounds. Yet, participants may become aware of researcher preconceptions on the subject matter and feel compelled to alter responses. We made efforts to reduce participant
reactivity prior to the start of each interview by having the interviewer explicitly convey that all 1) experiences, 2) academic backgrounds, 3) maintained knowledge and 4) lack of knowledge related to the subject matter were critical and equally important to researchers in this study.

Implications

Because of the scarcity and inconsistent nature of formal education on gender identity in mental health professional training, we can expect clinicians to need to continue to rely on self-education and what knowledge is shared in diversity trainings to obtain substantial information to work with gender minority patients. While this outlook may appear suboptimal, many resources exist for clinicians to further their gender competency. Further, substantial efforts may be required to spread awareness of these resources among those who most need them; clinicians who do not specialize in the counselling of gender minority patients. There is also room for expansion and standardization of gender education in graduate training programs for future mental health professionals and advocacy among clinicians is warranted. Advocacy may be best directed towards accreditation and professional licensing bodies as curricular content is often driven by program accreditation requirements and exam content for clinicians who are seeking licensure.

Conclusion

Many graduate programs attended by clinicians in our study failed to sufficiently prepare them to work with, or anticipate the needs of, gender minority patients in eating disorder treatment settings. Supplementary education includes continuing education courses, in-service training, and online resources. There is a plethora of resources for clinicians to take advantage of to further their education and gain gender competency, if they received inadequate education on
gender identity, and they are encouraged to do so by their peers. Future research should explore the hesitancies or failures of graduate mental health programs to incorporate comprehensive gender education into their curricula.
### Objective – To Investigate

| Personal experiences with transgender and gender diverse patients. | 1) During your time as a practitioner at your current practice or clinic, have you provided care to a transgender or gender diverse patient?  
   a. Were there challenges, ease, working with gender minority patients?  
   b. How did you adapt or personalize your approach to care?  
   2) If a patient presented to you with an eating disorder and gender dysphoria, how would you typically get started or proceed?  
      a. What types of questions would you ask the patient?  
      b. Would any questions you ask them differ from questions you would ask someone who is cisgender? Why or why not?  
   3) How confident are you in your skills necessary to effectively treat an eating disorder with a patient who is transgender or gender diverse?  
      a. Do you feel prepared to provide gender inclusive and/or affirming care?  
         i. In what ways do you feel prepared; in what ways do you not?  
   4) Tell me about your comfort with engaging in coordinated gender affirming care with medical professionals outside of your clinic/practice… (i.e. would you feel comfortable writing a letter of support for gender affirming surgical intervention for a patient?)  
      a. If you have worked with patients who have come from other clinicians, have they said anything of note about their experiences with other clinicians related to their gender identity? Maybe 1 or 2 experiences or any generally common experiences? Good, neutral, or bad?  
   5) Do you feel comfortable referring a transgender or gender diverse patient to another clinician if you cannot provide care they need?  
      a. What factors would lead you to refer a transgender or gender diverse patient with an eating disorder?  
      b. What factors would influence who you refer that patient to?  
      c. At this time do you know other clinicians, outside of your practice/clinic who provide gender inclusive care? Inside your clinic? |

<p>| Coordinated gender affirming care, care networks, and clinic climate. |  |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. If you did not know of one, how would you go about identifying a clinician for a gender minority patient?</td>
<td></td>
</tr>
</tbody>
</table>
| 6) Tell me a bit about the climate in your office or clinic surrounding the delivery of care to transgender and gender diverse patients. | a. What are some of the prevailing opinions among the staff about care needs of transgender and gender diverse patients?  
b. What is the general familiarity of staff and other clinicians with gender affirming care? |
| Self-education 7) Tell me a bit about your personal engagement with gender affirming care practices, literature, and other resources for self-education? | a. Which resources have you personally used?  
b. Which resources have been useful, not that useful, pointless?  
c. If you have never used any resources, where might you go to find them if you were hoping to learn something about gender identity? |
| 8) Tell me about your education in college or university surrounding gender identity? | a. Were there classes specific to gender identity?  
b. What topics were covered related to gender identity?  
c. Did you feel like your education around gender in college/university prepared you for working with gender minority patients? In eating disorder treatment? |
| Perceptions of how patient gender identity impacts eating disorder treatment. 9) From your experience and perspective, how might a patient’s gender identity impact their eating disorder care? Their mental health? 10) How might the care that transgender and gender diverse patients receive differ from or be similar to care provided to cisgender patients with eating disorders? | |
| Perceptions of barriers to care and evaluation of how barriers may impact care. 11) In the treatment of eating disorders, a support system can be valuable to a patient. How might you approach building a treatment plan that incorporates a support system for a transgender or gender diverse patient? 12) What barriers to accessing care might transgender or gender diverse patients experience when seeking eating disorder treatment? | a. I.e. they haven’t found a clinician yet but are looking for one…what would impact ability to access care? |
|   | 13) What barriers to appropriate care might transgender or gender diverse patients experience while actively receiving treatment for their eating disorder?  
  a. I.e. they are working with a clinician, what might impact their care experience or desire to remain in care?  
  14) What has most impacted your perception of the needs of gender minority patients with EDs?  
  a. Most impacted your understanding of gender minority individuals generally speaking?  
  15) Aside from those which you may have already mentioned: what changes/improvements, if any, do you feel are needed to improve eating disorder treatment for gender minority patients? |
### Table 1: Clinician work and educational histories (n = 19).

<table>
<thead>
<tr>
<th>Highest degree awarded</th>
<th>Total</th>
<th>Received Gender Education in Graduate School (Fully Sufficient)</th>
<th>Received Gender Education in Graduate School (Some)</th>
<th>Did Not Receive Gender Education in Graduate School (None)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctorate (PhD, MD, DO)</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Masters (MS, MSN, LMHC, LICSW)</td>
<td>14</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Bachelors (RN)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Would need more gender education to provide appropriate care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree/Agree</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Strongly Disagree/Disagree</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Amount of gender training received through place of employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully sufficient (thoroughly addressed)</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Some (but not sufficient)</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>An insufficient amount (None)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know/can’t recall</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Has provided care to gender minority patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, Never to my Knowledge</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Yes, A Few Patients</td>
<td>11</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Yes, Many Patients</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

*Other clinician demographics can be referenced in Ferrucci et al., 2022*
**TABLE 2:**

Table 2. Supporting clinician comments on training and education received

<table>
<thead>
<tr>
<th>In-office training</th>
</tr>
</thead>
<tbody>
<tr>
<td>“So, there's also the lack of education and training, which is a huge barrier, because if a person doesn't feel competent, they're not going to want to work with this population.” (P15)</td>
</tr>
<tr>
<td>“I would say my education has just been on the job, real life training, like real life learning, I wouldn't even particularly call it training. I feel like I've learned both in eating disorder treatment and in LGBTQ treatment, I've learned from my clients. That said, my place of employment has also provided diverse training opportunities, as I've worked here. So, we do like in service trainings, and then attend a lot of the national or international conferences that I attend for my continuing education, and I've sought out specialty, ongoing training for both LGBTQ and eating disorder services.” (P27)</td>
</tr>
<tr>
<td>“We really need to have more education and training for our staff that's more basic about gender identity and sensitivity…we have had an in service, at our tertiary hospital for nursing overall on that just like pronouns, some of the transgender care processes, some of the cultural concepts and verbiage, you know, to be sensitive to that type of thing but there's a lot more I think that needs to grow on that.” (P09)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Graduate education</th>
</tr>
</thead>
<tbody>
<tr>
<td>“So first off, we kind of barely talked about it, but we did talk about gender non-conforming and trans individuals on a broader level, you know, in the sense of how systems of oppression affect people with those identities and things like that. But I wouldn't say it was ever woven into the curriculum…it was kind of siloed off in the couple of diversity classes we had.” (P17)</td>
</tr>
<tr>
<td>“Absolutely not sufficient at all…I would say that what I learned in school was not nearly sufficient and that it, it really does require a lot of continuing education and I am presented with a lot of situations in session where I will have to do self-education afterwards, just to stay up to date and relevant.” (P29)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other opportunities in higher education</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It was actually pretty extensively covered. Part of this was because the grad program itself had a high number of transgender and gender diverse individuals. So it was very much part of the general conversation. And the program itself emphasized a lot of inclusivity. So that was threaded through most of the programs, or classes. There weren't any specific classes of that focused on it, per se, I don't know that there was a formal approach to it as much as lots of workshops and a lot more informal training norming you to how to interact and work with diverse populations.” (P06)</td>
</tr>
</tbody>
</table>
“Formally, in terms of classes, I can't even say that that's something that was discussed or touched on. We did have one thing in the program, these ‘lunch and learn’ things about once a month. And there was a series of those that was done with an on-campus organization for LGBTQIA+ individuals. As part of that training, we learned about working with a variety of folks that are part of that population. But really, it wasn't about like treatment, it was more so about very basic stuff, like how do you inquire about somebody’s gender identity, how can our forms be more inclusive, how do you share your pronouns and let patients do too without making them feel like an alien? It wasn't like a clinical presentation it was a much more general situation. So, in terms of formal college, like university classes, I would say pretty much nothing.” (P11)

“In undergrad, I took an elective on human sexuality, and that would probably have been the only class in my undergrad that would relate to these topics.” (P10)

“In my continuing education requirements, I have to do like six hours of ethics training every two years and I think it would be cool to have a mandated diversity training that like could be part of like ongoing licensure. And that would be potentially a way to get more information in training. But that again kind of is difficult with this whole like granular versus like overview approach because these trainings tend to be like a few hours long. But all in all, the training would be definitely preferable to like a one hour in service training.” (P27)
Table 3. Supporting clinician comments on the importance of training.

<table>
<thead>
<tr>
<th>Direct impact on patients</th>
<th>Quality of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I mean, honestly, we had a training where someone spoke to us about, like, when you use inappropriate pronouns, it's an act of violence against that person. And it's because it's who they are. So, actually having never thought about it like that before, I was like, ‘Oh, my God, that's so true!’” (P02)</td>
<td></td>
</tr>
<tr>
<td>“I would tell them (other clinicians) if they felt like they just couldn't get on board with the sorts of attention to language and attention to different experiences, then they're better off probably just not engaging.” (P06)</td>
<td></td>
</tr>
<tr>
<td>“I've definitely had clients say, ‘This treatment center says they work with transgender individuals or gender diverse individuals, and they don't know anything about it.’ That's a really common thing I've heard. And from having worked in treatment centers, I kind of agree that we didn't really get the training that I think we needed or should have received on this population. But I think with clinicians in general, a lot of outpatient clinicians say that they work with these populations and don’t. I think that it's a huge disservice, especially to people with eating disorders, because this is like a very complex issue. And being gender diverse is also very complex. And so, both of those things together, with clinicians who don’t know what they’re doing, can be really catastrophic for our clients and just saying things that are really damaging or triggering can also turn people off to therapy in general. And that's the saddest part of this; when someone basically says, ‘Well, I had therapy 10 years ago, but it went so poorly that I haven't been back since and I'm 80 pounds and dying.’” (P07)</td>
<td></td>
</tr>
<tr>
<td>“I mean, a lot of people can slap on a symbol on their website, right? But that doesn't mean anything if they don't have clinicians or people that can understand this or that are open to it or to learning about it. If you have a doctor in their 60s, or 70s and they don't understand what the f*ck you're talking about, excuse my language…but I can imagine if you're in a treatment center, and you're getting somebody that's about my parents age, they're gonna be like, “Honey, you need to embrace being female. Like, get on with it.” I mean…that is definitely going to hinder somebody who's in recovery, because they're not spending time learning about somebody that's embracing who they are, who they want to be. That could be really detrimental to someone's progress.” (P26)</td>
<td></td>
</tr>
</tbody>
</table>
"There is no other physician in this area that I know of who practices from a Health at Every Size framework besides our medical doctor here. So, it’s really challenging…I wish we could work with more people outside of our clinic better. There should be a standard approach to care and training. But it's just very hard when there are like, so few clinicians that are meeting our standards of how they're treating people with different gender identities.” (P17)

**Patient to clinician ratio**

“We need more research, we need more information, we need more funding, we need more education. And I just don't see the tide of need for eating disorder care going down and the LGBTQ population is overrepresented there.” (P27)

“…we see such high rates in the trans population, we see such elevated rates in generally an LGBTQ plus community…I think that represents a significant sort of psychological barrier for those of us in the field…I think the number of people who really understand the issues that come up for this population, is very, very small. And I think as long as that remains so, the quality of treatment for people is going to really suffer.” (P25)
**Table 4.** Supporting clinician comments on self-education.

<table>
<thead>
<tr>
<th>Patients as resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>“And a lot of times when the clients call me, they say, ‘Hey, I'm transgender…’, I tell them up front that I don't have a lot of experience working with transgender clients, but I do a lot of research, and I'm willing to work with you, you know, as long as you help me help you. I think it's important for people to be honest, and not just take clients to take clients, like you need to be able to know that you're doing this for the right reasons and ability to help someone.” (P21)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Usage of ACA competencies, FEDUp, and WPATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>“WPATH does have a whole lot of educational resources. There are a ton of clinicians out there who are providing new trainings for continuing education credits and a lot who are providing consultation relationships, such that a person can be getting ongoing supervision to enhance their ability to avoid causing harm, if not even beyond that to enhance care so that it is effective. So it's out there, but one would have to take the time to access resources and probably have some financial resources to do so. Although there are also grants and scholarships for a lot of these things too. Like WPATH has scholarships and grants to reduce costs.” (P15)</td>
</tr>
<tr>
<td>“I found FEDUp. They have a scorecard for treatment for you know, just different marginalized populations. But our team was looking through that and kind of thinking about… how we can do better, even though we're outpatient.” (P17)</td>
</tr>
</tbody>
</table>
**TABLE 5:**

<table>
<thead>
<tr>
<th>Re-designing gender and eating disorder education</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think we need to, sort of in many ways, re-language and redefine how we think about eating disorders, because you know, as I said, a while ago, the focus on thinness, I think, automatically makes it seem to be a particular thing that certain people experience. Even though these are conditions that affect many people, I think we're also coming to understand that it goes much deeper than that, and it's certainly as much more nuanced than that. I think, it does necessitate a little bit of a change in how we both think about and therefore language things like body image and broaden that to really focus in on multiple images because that starts to then incorporate identity. That's a huge element of this illness and a manifestation of this illness for so many people. And it's a particular relevance, it's particularly exclusionary to those folks who, who have divergent identities of one kind or another. We will continue to miss people.” (P25)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teaching styles and course formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I would love to have a gender diverse led training if that would be possible. I don't know, it just sounds so tricky to say that, right? But when we received training about being racially sensitive, and think it was really helpful when we received training from people from racial minority groups. Same thing with when I received training about fat positivity and Health at Every Size, it's helpful to have body diversity representation in that training. So I think in receiving more training, it would be really great to have gender diverse or queer individuals teach about that. But I definitely don't think that's the only way to learn about it, I think you can also receive training from people who are experts, have done research, and continue to work with these populations, to provide kind of more insight.” (P27)</td>
</tr>
</tbody>
</table>

“I'm a very, like science-based information person. So, one of the biggest things that I gained outside of the formal university setting are different identity development models. I find that really helpful, both just for me to know to share with clients and again, empower, validate, and think about like, ‘What stage do you think you're in? What needs do you have that could help move you to the next phase? Or are you ready to make that change?’ So, I think that's something that would have been really helpful.” (P11)

“I like learning from other clinicians or people in the field that use examples. I’ve found that that really helped me with my current clients. I also like hearing tangible suggestions. So, for one client, showering was really uncomfortable for them. So, one of the clinicians that I talked to was like, ‘Have them turn the lights off. Or have them put on soothing music or have them wear a bathing suit or like all these different things.’ And those tangible examples were really helpful, because, I mean, I could come up with some of those things, even for people with body image issues, like of course, I can come up with some of those, but it's hard because with eating disorders in general, we want to expose patients to the discomfort.
But if you have a body that doesn't even feel like your own body, it's very complex. I don't know why we didn't have that earlier on in my training, or even at the treatment center that I trained at.” (P07)

**Action steps for other clinicians**

“If you literally just search (online), ‘books on providing gender affirming care for clinicians’, you're going to get some great resources, immediately available, with self-reflection questions, as well as exercises that you can do immediately with clients in session. Or, you know, in order to promote queer and transgender resilience, there are workbooks that exist that are written by clinicians who are transgender and gender nonbinary, gender diverse, such that you immediately enhance your practice. If people even take 5-10 minutes to do that, it's not it's not hard.” (P15)

“In session, I'm going to have to take a position down approach, because I don't want to mess up with a client. So I'm going to ask, “help me understand this” or “what are your pronouns” or “what would you like me to use”, and I actually had a client last week, this was the first time that I've heard this…their pronouns were Xe, Xir, Xem. After that, I went to Google and I Googled these pronouns to help me understand this. And the client came back, Xe came back. And so we kicked it off really good. We’ve been building rapport, but I’ve tried to Google stuff and then I also go through my library, the EBSCO Host, where you can go look at all of the journals, get research from peer reviewed journals. So that's where I go to get any type of accredited, peer reviewed articles.” (P21)

“In terms of resources, I would push them to look at the gender unicorn. It's one that was used a lot for college training and, to me, I think it's a very clear sort of way of presenting gender, sex, romantic attraction and relationships or an identity and breaks it down in a completely different way…I think that helps to provide a lens for people to start seeing that it's not just male, female, heterosexual or gay…everything is on a spectrum.” (P06)

“…articles and webinars that I would just kind of either have, yeah, just either show an excerpt to my staff or pass on the article to them or ask questions and supervision about how they're, you know, this person sounds like they might be giving you clues that they are gender diverse, or, or sexually more diverse than they've led on to their family what, you know, how are you addressing that? Are you bringing that up?” (P01)

“Yeah, so working in the treatment world, I was really lucky to have a lot of just really highly skilled clinicians at my fingertips like all over the country. So, I touched base with one of my old supervisors of the treatment center I worked with, and she actually led me to someone that worked for another treatment center that was kind of like the transgender expert in their facility. And she actually sent me like a bunch of information. And then I went to a couple of her trainings that she led. So that that was really helpful. But even still, I still don't know half as much as I probably could. And so, I'm definitely interested in learning more.” (P07)
CHAPTER V: DISCUSSION AND CONCLUSIONS
Discussion and Conclusions

In this dissertation my aims were to: 1) Produce clinically validated prevalence estimates of eating disorders among gender minority individuals in the United States, 2) Explore clinician awareness of barriers and facilitators to accessing and receiving care among gender minority patients with eating disorders, and 3) Assess the formal, workplace-required, and self-led gender-based educational experiences of mental health clinicians in the U.S. and how their education impacts their self-perceived ability to deliver eating disorder treatment to gender minority patients. The first aim leveraged 2018 claims data from the IBM® MarketScan® Commercial Database. Aims 2 and 3 used data I obtained from a series of semi-structured individual interviews with U.S. based mental health clinicians specializing in eating disorder treatment.

2.43% of people identifiable as transgender with evidence of gender affirming medical intervention had a record of an eating disorder. No prior study, with a sample of this size, has employed clinically validated records of diagnosis. We utilized methods established by (Dragon et al., 2017; Ewald et al., 2019; Proctor et al., 2016; Progovac et al., 2018) to identify a cohort of assumed transgender and non-binary individuals, using ICD (International Classification of Diseases) and HCPCS (Healthcare Common Procedure Coding System) codes that indicate the receipt of gender affirming health care. Among transgender-identifiable patients aged 12-15 years, 5.60% had an eating disorder diagnosis, whereas 0.52% had an eating disorder diagnosis in patients aged 45-64 years. This is consistent with knowledge that younger individuals are more likely to be afflicted by eating disorder symptomology than adults, particularly those who identify as sexual and gender minority individuals (Silén & Keski-Rahkonen, 2022). This overall estimate (2.43%) is substantially lower than that found in prior studies that relied on self-reported eating disorder diagnosis history (Diemer et al., 2018; Diemer et al., 2015; Nagata et al.,
2020; Duffy et al., 2019) and lifetime eating disorder prevalence among the general U.S. population (9%, Deliotte Access Economics, 2020). The occurrence of eating disorders in populations of gender minority individuals is likely undercounted. We assume this to be particularly true in adolescent and young adult populations, who may struggle to gain access care (Duffy et al., 2016) or who may avoid sharing their identity with clinicians due to fear of discrimination or rejection from family members and/or community, and clinicians. Lastly, gender minority individuals who receive gender affirming care have reported reductions in eating disorder symptomology (Ristori et al., 2019). However, this dissertation could also not draw comparisons, with clinically validated eating disorder records, to those not receiving gender affirming medical intervention.

In aim 2, we examined perspectives of U.S. based mental health clinicians of barriers and facilitators to care for gender minority patients. We crafted interview protocols informed by prior studies that had explored patient narratives regarding patient-clinician encounters and treatment experiences in eating disorder care settings (Hartman-Munick et al. 2015, and Duffy et al. 2016). Extant insights allowed exploration of known and relevant factors that impede patients from receiving quality and inclusive treatment, as well as elicitation of additional factors the clinicians identified. Clinician narratives produced the following themes for key barriers and facilitators to accessing care: stigmatization, family, financial factors, gendered clinics, scarcity of gender competent care, and religious communities. Clinician interviews also explored barriers and facilitators affecting care while in treatment and we identified these themes: discrimination and microaggressions, clinician lived experience and education, other patients and parents, systems of higher education, family-centered care, gender-centered care, and traditional therapeutic techniques. These findings fall in line with those from patient narrative studies.
Semi-structured interviews with mental health clinicians were conducted, asking clinicians’ educational histories to better understand their educational needs on the subject of gender identity. I pursued understanding of their formal education, work-place educational requirements and norms, as well as their efforts to independently seek out educational resources to further or establish their gender competency. Clinicians reported little coverage of gender minority populations in their graduate curricula. In both graduate education and office mandated trainings the majority stated that any coverage was minimal, and usually addressed briefly during diversity trainings or classes. Despite only addressing gender identity at a surface-level, many gained their knowledge of gender identity through their clinic or practice in-services. Remarkably, when faced with uncertainty on gender-related topics, most clinicians identified educational resources to best support their gender minority patients, despite minimal gender competency. Clinicians encouraged their peers to self-educate and advocated for the expansion and inclusion of gender identity in graduate education programs, with many pushing for standardized and comprehensive gender education. These findings support claims made by patients that suggest a general lack of competency among clinicians (Duffy et al., 2016; Hartman-Munick et al., 2021; Cusack et al., 2022), as well as a lack of formal gender education (Austin & Craig, 2015). Limited competency and lack of meaningful acknowledgement of gender identity in graduate curricula may explain flawed treatment approaches that traumatize gender minority patients and hamper their progress in care (Cusack et al., 2022; Ferrucci et al., 2022)
Strengths and Limitations

This dissertation was the first to produce prevalence estimates of clinically recognized eating disorders among (assumed) transgender and non-binary individuals. I used a validated approach to identifying a sample of people with diagnoses indicating transgender status and/or gender affirming care procedures. I additionally explored clinician narratives of perceived barriers and facilitators to care for gender minority patients receiving care for eating disorders. I designed clinician interview protocols informed by prior reports of narratives of gender minority patients receiving care for eating disorder(s), which aided in maintaining relevancy of questions and probes to real patient experiences. My clinician sample was reflective of clinician demographics in the United States (Zippia, 2021) and provided a diversity of experiences across educational programs, practice type, workplace training histories, and gender competency (based on additional specialization). Lastly, a mixed methods approach allowed me to address multiple gaps in the research literature.

Some limitations of this study included generalizability of Aim 1 findings, being limited only to those who have received gender affirming care. Additionally, no race/ethnicity or socioeconomic information was available in this claims data resource. Aims 2 and 3 included those licensed to provide mental health counselling clinicians, thus could not include perspectives of other types of clinicians from inpatient/residential facilities, such as dieticians and nutritionists. Interview time restrictions may have limited clinicians’ ability to provide thorough responses to a plethora of questions.

All authors identify as cisgender, and despite employing self-reflective practices, our perspectives may have masked us to important aspects of study design, implementation, interpretation, and the development of implications.
Future Directions

Due to high self-reported prevalence of eating disorders among gender minority individuals, exploration of clinically validated prevalence estimates in those not receiving affirming medical care is needed. To my knowledge, no other clinically validated records of this size exist. Expansion of demographics in claims data would improve monitoring disease prevalence and incidence among gender minority populations. The inclusion of gender markers, in addition to other demographics, in claims data is warranted. In doing this, patient privacy and confidentiality should be maintained. Additionally, those pursuing research using these methods should consider the impact that their published work may have for these populations and consult members of these communities or experts in the field throughout their study design, analysis, and reporting. Additionally, future studies that seek to explore eating disorder prevalence among young gender minority individuals, using similar methodologies, should consider the impact of state level bans for gender affirming care on the relationship between gender dysphoria and eating disorder symptomology and severity.

Our findings supported clinician awareness of barriers and facilitators to eating disorder treatment that gender minority patients face. A lack of standardized education among clinicians was the primary barrier to their understanding of how to best care for gender minority patients. These findings reinforce the need for an investigation of what has hindered graduate programs or professional associations from implementing and enforcing educational standards for gender competency among clinicians.

Conclusion
This dissertation furthers existing research concerning the state of eating disorder prevalence and treatment among gender minority patients in the United States. Novel prevalence estimates of eating disorders among gender minority individuals were produced, using validated methods for identifying a sample of people identifiable as transgender from administrative clinical coding. Clinician narratives delivered rich insight as to not only what barriers are top of mind for clinicians working with gender minority ED patients in an extremely gendered care setting, but also what can be done to improve care quality, clinic inclusivity, and patient treatment success. These findings support further efforts to improve gender competency through standardized educational initiatives set forth by associations responsible for educational program accreditation, professional licensing boards, as well as institutions awarding degrees.
REFERENCES
Chapter I


Conron, K.J. LGBT youth population in the United States. (September 2020). The Williams Institute, UCLA, Los Angeles, CA.


**Chapter II**


Conron, K.J. LGBT youth population in the United States. (September 2020). The Williams Institute, UCLA, Los Angeles, CA.


Chapter III


Chapter IV


**Chapter V**


