Eating Disorders in Transgender and Gender Diverse Youth

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Objectives for Today

- Overview of diagnostic criteria for eating disorders
- Review data on eating disorders in transgender youth and relevant information regarding diagnosis, treatment and special considerations
- Understand basics of Family Based Treatment for Eating Disorders and considerations for trans population
- Understand role of multidisciplinary care in supporting this population

Diagnostic Criteria
DSM-5: Feeding and Eating Disorders

- Pica
- Rumination Disorder
- Anorexia Nervosa
  - Restricting Type
  - Binge/Purge Type
- Bulimia Nervosa
- Avoidant/Restrictive Food Intake Disorder
- Binge Eating Disorder
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder

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Anorexia Nervosa (AN): Basic Criteria

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

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Anorexia Nervosa: Subtypes

**Binge-Eating/Purging Type**

During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

**Restricting Type**

During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

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Level of Severity - BMI Percentile in Children
Anorexia Nervosa: Key Facts

- **Lifetime Prevalence:** ~1% for cis women
- **Female/Male ratio:** 10:1
- **Peak incidence:**
  - 15-19 yrs for women
  - 10-24 yrs for men
- **Recovery:**
  - ~50-60% recover
  - ~30% improved
  - ~7-15% chronic course
- **Standardized mortality ratio (SMR = ratio of observed to expected deaths)**
  - SMR for AN = 3.86 (about 20% due to suicide), highest of any psychiatric disorder.
  - In comparison:
    - SMR for schizophrenia = 2.8 for males and 2.5 for females
    - SMR for bipolar disorder = 1.9 for males and 2.1 for females
    - SMR for unipolar depression = 1.5

Bulimia Nervosa (BN): Basic Criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

Bulimia Nervosa: Basic Criteria continued

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
What constitutes a binge?

Three principles

- Objective binge eating
  - Actual quantity of food
- Subjective binge eating
  - Personal feeling about quantity of food
- Context of binge eating
  - The amount of food consumed is larger than what would be expected for the context in which it occurred (e.g., Thanksgiving)

Level of Severity

- Based on frequency of compensatory behaviors

Bulimia Nervosa: Key Facts

- Lifetime Prevalence: ~1.5 - 3%
- Female/Male Ratio: 10:1
- Peak incidence: 16 - 20 years old in women
- Recovery:
  - Short-term success of treatment: 50 - 70%
  - High relapse rates: 30 - 85% at 6 months - 6 years
  - Standardized mortality ratio (SMR) = 1.9 (~20% due to suicide)

Avoidant/Restrictive Food Intake Disorder (ARFID)

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food, avoidance based on the sensory characteristics of food, concern about aversive consequences of eating) as manifested by the persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
2. Significant nutritional deficiency.
3. Dependence on enteral feeding or oral nutritional supplements.
4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of AN or BN, and there is no evidence of a disturbance in the way in which one’s body weight or shape is experienced.
Binge Eating Disorder (BED): Basic Criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

This is exactly the same as for bulimia nervosa, but without compensatory behaviors.

Binge Eating Disorder: Basic Criteria continued

B. The binge-eating episodes are associated with 3 (or more) of the following:
   1. Eating much more rapidly than normal
   2. Eating until feeling uncomfortably full
   3. Eating large amounts of food when not feeling physically hungry
   4. Eating alone because of feeling embarrassed by how much one is eating
   5. Feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. Not part of AN/BN

Binge Eating Disorder: Key Facts

- Lifetime Prevalence:
  - ~3% women
  - ~2% men

- Age of onset: teens-20s (retrospective data)

- Strong association with obesity

- High rates of medical and psychiatric comorbidities

- Level of Severity
  - Most often based on frequency of binges
  - Mild, Moderate, Severe, Extreme
Rates of Eating Disorders in Trans Youth

- Limited data regarding rates of EDs in this population
- Study of almost 2,500 high school students
  - Transgender students had highest prevalence of diet pill and laxative use (4.8%)
  - Fasting >24 hours in last 30 days (9.5%)
  - Similar to cisgender female students

Rates of Eating Disorders in Trans Youth

- Diemer et al, 2015
  - Roughly 290,000 college students
  - Transgender Students:
    - ~4.6 times more likely to be diagnosed with an Eating Disorder in the last year vs cisgender heterosexual women (15.82%)
    - Roughly 2 times more likely to use diet pills in the last month
    - Roughly 2.4 times more likely to engage in vomiting or laxative use in the last month
  - Limitations
    - No breakdown in transgender females vs males
    - No breakdown regarding specific ED diagnosis

Etiology: Eating Disorders

- Unknown, but likely Multifactorial
  - Biological
  - Psychological
  - Familial/Social
  - Sociocultural

- Why could rates be elevated in trans youth?
Etiology: Eating Disorders in Trans and GNC Youth

Important to Note First:
- Although they are risk factors, sexual orientation and gender identity concerns are neither necessary nor sufficient to cause eating disorders
- Most transgender or gender diverse youth never develop an eating disorder
- Those that do are likely influenced by same genetic and neurobiologic vulnerabilities as their peers

Theorized Factors Specific to Transgender Population

- Body Image/Dissatisfaction
- Minority Stress
  - Higher rates of harassment and discrimination linked to higher odds of binge eating and fasting or vomiting
  - Protective Factors: family and school connectedness, social support, caring friends
- Non-affirmation of Gender Identity
- Increased Contact with MH providers?

Body Image/Dissatisfaction

- Body image plays a central role in both Gender Dysphoria and Eating Disorders
- Association between body dissatisfaction and Gender Dysphoria
  - Lower congruence between external and internal representations of self associated with lower body satisfaction (Kozee et al, 2012)
- Area of Focus
  - Sex-specific body parts vs all gender-related parts
  - Latter may be associated with increased risk of disordered eating
Body Image/Dissatisfaction
- Effects of GD Treatment
  - Bandini et al, 2013
    - Trans individuals who had not received any gender-affirming surgeries had levels of body uneasiness similar to those with EDs
  - De Vries et al, 2011/2014, Jones et al, 2018
    - Decreased body dissatisfaction and ED symptoms after beginning of hormone treatment
  - De Vries - Additional improvement 1 year after gender-affirming surgery
- Addressing body image
  - Psychological and social aspect
  - Challenging negative thoughts, positive re-framing, challenging perceived negative reactions from society

Body Image and Disordered Eating
- Witcomb et al, 2015
  - Trans, ED, control populations
  - Results:
    - Body Dissatisfaction: ED > trans > control
    - Cis female < TMS > Cis male and TFS
    - TMS = ED cis males
  - Disordered Eating
    - TMS + TFS participants > cisgender participants
    - However, still lower than ED patients
    - TMS - highest risk

Trans Patients’ Perceived Causes of Disordered Eating
- 35% - Suppression of characteristics associated with non-identified gender
- 21% - Accentuation of characteristics associated with identified gender
- Other Noted Causes
  - Being an outcast
  - Feelings of control
  - Expression of autonomy
Relationship between Gender Identity and ED

Presentation and Screening

Assessment Considerations for Trans Patients

- May appear in either ED treatment or GD treatment setting
- If you don’t ask, you won’t know
- Important to assess for gender concerns in adolescents with EDs and eating concerns during and after GD treatment
- Trans youth – body dissatisfaction, eating
- ED patients – Underlying motivations
- Clinical Presentation (AN)
  - Thinness vs Muscularity
- Eating Disorders can be severe and enduring
  - Very important to continue assessing/screening
### Treatment for AN

#### Weight Restoration
- Cornerstone of treatment for low weight patients

#### Psychotherapy
- Family-Based Treatment (FBT)
- Adolescent-Focused Therapy
- Cognitive Behavioral Therapy (CBT) – for adults

#### Pharmacotherapy
- Not primary treatment
- Possibly helpful in comorbid conditions
- Mixed data with antipsychotics
- Aripiprazole and Olanzapine most commonly used
- No evidence for appetite stimulants
- Appetite reducers should be avoided
Treatment for BN

Psychotherapy
- CBT (gold standard in adults)
- FBT
- Interpersonal Therapy (IPT)
- Dialectical Behavioral Therapy (DBT)
- Self-help

Nutritional counseling
- Possibly helpful (but not supported in the literature)

Pharmacotherapy
- Fluoxetine (Prozac) = FDA approved
- All SSRIs used

Nutritional counseling
- Possibly helpful (but not supported in the literature)

Common Components of Effective ED Interventions

- Psycho-Education and Psychotherapy
  - True mainstay → No medication has been shown to be equivalent to psychotherapy in the treatment of eating disorders
- Behavioral interventions
  - Weight checks
  - Self-monitoring of intake and eating disorder behaviors (e.g., binge eating, purging, exercising) with daily logs
- For low weight, emphasis on weight restoration
  - 2-3 lb/wk inpatient or 1-2 lb/wk outpatient

“Maudsley Model” Family-Based Treatment (FBT)

- Developed at the Maudsley Hospital in London
  - Manualized by Jim Lock and Daniel Le Grange
  - Designed to be delivered for a 6-12 month period with 10-20 sessions total.
- Assumptions
  - Adolescent is embedded in the family
  - Adolescent with AN is regressed
  - Family must focus on refeeding to free adolescent from eating disorder
- The goal of Maudsley family therapy is to mobilize and empower parents to refeed their child
  - Family issues unrelated to the eating disorder are deferred
Who Benefits from FBT?

- Adolescents with a short duration of AN (< 3 years)
- Older adolescents (aged ≥ 17 years) and those with a longer duration of illness don’t do as well
- Family must be willing to invest the time and effort necessary to refeed an underweight child
- Parents and siblings need to be on-board
- Greatest benefit in those who respond quickly (within first 4 weeks)

Members of the Treatment Team

- Primary clinician: Therapist experienced in the treatment of adolescent eating disorders, e.g., social worker, psychologist, psychiatrist
- Consultants: Medical providers, dietitian
- Family
- Patient
- Other Medical/BH providers

First and foremost, team members need to be on the same page (and communicate!)

Role of the Medical Provider

- Help establish diagnosis
- Identify any acute and chronic medical complications and treat as appropriate
  - Explain medical seriousness of ED to family
- Consultant to parents – empower to make decisions for their child
- Consultant to primary therapist – update on medical status and family interactions
- Assess safety, need for hospitalization if necessary
Treatment Considerations for Trans/Gender Diverse Youth

- Family Support Considerations
- Utilize non-parental family and friends
- Priority of Treatment?
  - ED "versus" GD treatment?
  - Addressing body dissatisfaction
- Need for more research

In the end, it's most important for clinicians to focus on effective treatment in an affirming environment.

Good news: Recovery is possible with effective specialist treatment.

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Questions?

Thanks!!

Resources

Resources, continued


Inclusion on the list below does not mean we are endorsing these sites. CED is not responsible for the content of these sites.

- AED – Academy For Eating Disorders  http://www.aedweb.org/
- ANAD – National Association of Anorexia Nervosa and Associated Disorders  http://www.anad.org
- ANRED – Anorexia Nervosa and Related Eating Disorders  http://www.anred.com
- NAMI – National Alliance for the Mentally Ill  http://www.nami.org/
- EDAP – Eating Disorders Awareness & Prevention  http://www.nationaleatingdisorders.org/
- Eating Disorder Bellringer and Information Center  http://www.edbellringer.com
- Maudsley Parents  http://maudsleyparents.org/
- The New Maudsley Approach  http://thenewmaudsleyapproach.co.uk/

References


