

Body Image and Eating Behavior in Transgender Men and Women: The Importance of Stage of Gender Affirmation

Gayle Brewer

is a Senior Lecturer in the Department of Psychology at the University of Liverpool. Her research interests include sexuality, sexual behavior, and the wellbeing of marginalized or stigmatized groups.

✉ gbrewer@liverpool.ac.uk

Laura Hanson

is a postgraduate student in the School of Environment, Education, and Development at the University of Manchester working towards a doctorate in counselling psychology.

Noreen Caswell

is a Senior Lecturer in the School of Psychology at the University of Central Lancashire. Her research interests include disordered eating, exposure to nature for mental wellbeing, and the development of an enuresis alarm.

Previous research suggests that transgender men and women are more likely to experience body dissatisfaction and disordered eating. Few studies have, however, investigated the manner in which body dissatisfaction and eating behavior are affected by the gender affirmation process. To address this issue, semi-structured interviews were conducted with transgender men and women ($N = 22$) recruited from British support groups. Participants were aged 19–71 years. Participant sexuality included heterosexual, homosexual, pansexual, and asexual orientations and all participants identified themselves as white. For both transgender men and women, analyses revealed a shift from a focus on psychological wellbeing in the early stages of gender affirmation to physical wellbeing in the later stages. While body dissatisfaction appeared to dissipate as gender affirmation progressed, a common theme across the gender affirmation process was that both transgender men and women engaged in risky behaviors related to transforming body shape and size. Findings highlight the need to consider the influence of gender affirmation when researching the interconnections between attitudes, behavior, and emotions relating to gender identity.

KEYWORDS body dissatisfaction; eating behavior; gender affirmation; wellbeing

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Previous research has established that transgender men and women experience poorer physical and psychological health than cisgender populations (e.g., Connell 2021; Downing and Przedworski 2018; Reisner et al. 2015). Health behaviors that increase the likelihood of ill health are also more prevalent in the transgender community (e.g., Bishop et al. 2020). The prevalence of disordered eating (Romito et al. 2021; Uniacke et al. 2021) and risky body change strategies such as laxative use and self-induced vomiting (Diemer et al. 2015; Guss et al. 2017) have attracted particular attention. Behavior negatively impacting physical or psychological health may, in part, reflect separation from the primary social support network (Pflum et al. 2015) and increased exposure to social stigma, discrimination, and abuse in the transgender community (Bradford et al. 2013; Miller and Grollman 2015; Watson, Veale, and Saewyc 2017).

It is important, therefore, to acknowledge the transphobia and minority stress experienced by the transgender community (Cusack et al. 2021; Gordon et al. 2016) and the extent to which disordered eating or risky body change strategies may serve as a defense mechanism or coping strategy (Coelho et al. 2019). In addition, body dissatisfaction and disordered eating may reflect the discomfort with body shape prior to gender affirmation which characterizes gender dysphoria. Few studies have, however, considered the manner in which body dissatisfaction and associated health behavior vary across stages of the gender affirmation process. The present study was conducted to address this issue.

Case reports have documented the relationship between gender dysphoria, body dissatisfaction, and eating behavior. For example, Surgenor and Fear (1998) report the case of a transgender woman who expressed a belief that her eating disorder symptoms and gender identity were closely connected, and that her desire to obtain and maintain an idealized feminine shape triggered food restriction and purges. In addition, symptom remission was only experienced during a six-month period which involved an attempt to live as a woman. Similarly, Winston et al. (2004) reported on patients referred to an eating disorder service whose weight loss was motivated by a desire to achieve a more feminine shape and who during therapy began to present with symptoms of gender dysphoria. More recent cases involving young transgender women aspiring to achieve thin feminine body shapes and subsequent development of disordered eating have also provided evidence to support earlier reports (Couturier et al. 2015; Ewan, Middleman, and Feldmann 2013).

In contrast to transgender women, it has been argued that transgender men may perceive weight loss to be desirable because it leads to the suppression of secondary sexual characteristics and menstruation (Avila, Golden, and Aye 2019; Couturier et al. 2015). Large scale studies are consistent with these assertions and demonstrate that some members of the transgender community engage in disordered eating because it facilitates suppression of physical features or accentuates characteristics aligned to their gender identity (Ålgars, Santtila, and Sandnabba 2012). For example, disordered eating behavior may be focused on muscularity in transgender men (Kamody et al. 2020). There appears to be increasing evidence, therefore, that transgender men and women are at greater risk of developing disordered eating than cisgender populations and that this risk is likely to be intrinsically linked to their gender role identification, gender-specific ideals, and body image pathology (Jones et al. 2016; Murray, Boon, and Touyz 2013).

The effects of gender affirmation—i.e., the “process whereby a person receives social recognition and support for their gender identity and expression” (Sevelius 2013, 676)—on body image and eating pathology are less clear (Strandjord et al. 2015). However, it would seem likely that body dissatisfaction and disordered eating decline as a person’s body and role in society become more closely aligned with their gender identity. Previous research indicates that increased access to medical and legal gender affirmation reduces the risk of body dissatisfaction and disordered eating in transgender populations (Gordon, Moore, and Guss 2021; Kamody et al. 2020). Further, it has been argued that surgical treatment helps to reduce body image concerns and psychological distress (Bandini et al. 2013; Khoosal et al. 2009; Winston et al. 2004). Indeed, both hormonal and surgical treatments may be associated with improved psychological wellbeing and quality of life (Agarwal et al. 2018; Motmans et al. 2012; White Hughto, and Reisner 2016).

Other research indicates that eating disorder symptomatology continues post-surgery (Hepp and Milos 2002; Winston et al. 2004). The inconsistency between studies may reflect the complexity of the gender affirmation process. For example, an analysis of interview data (Ålgars et al. 2012) uncovered themes relating to both positive change such as improvements in body image and reduction in disordered eating, and negative change for example, unwanted weight gain from hormone therapy and continued eating pathology. In addition, current understanding has been limited by the tendency for research to consider one aspect or stage of gender affirmation only. It is, of course, important to note that there may be substantial variation in the gender affirmation process. For example, while some transgender men and women may want hormonal therapy and/or surgery, others may not pursue or have access to this medical intervention. Therefore, gender affirmation should not be regarded a linear process or one in which all transgender men and women seek or actually experience all stages.

In recent years, there has been greater consideration of conceptual and theoretical models in relation to body image and disordered eating in the transgender community. For example, Gordon et al. (2016) apply ecosocial theory and a gender affirmation framework to disordered eating among young transgender women, while Gordon, Moore, and Guss (2020) apply a conceptual model of risk and protective pathways to risky body weight and shape control behaviors among transgender and gender diverse populations. In the present study, a critical realist framework was adopted to identify, understand, and report the reality of the participant experience. This framework acknowledges that the world as we understand it has been constructed through our perspectives and experience (Bhaskar 2010) and has been applied to previous health behavior research employing thematic analysis (Bower, Perz, and Conroy 2020). Therefore, we focus on the reality of body image and disordered eating as experienced by transgender men and women rather than a more reductionist approach to documenting the incidence of such behavior. It is important to note that the critical realist framework should be regarded as a philosophical or ontological approach that guides the research approach rather than one that determines the specific factors increasing the likelihood of body dissatisfaction or disordered eating (Gorski 2013).

The experience of body dissatisfaction and eating behavior in transgender men and women requires further investigation, and research recognizing the importance of the stage of gender affirmation may be particularly beneficial. Therefore, the pres-

ent study investigated the extent to which gender dysphoria influences body dissatisfaction, attitudes to food, and eating behavior at various stages of gender affirmation.

METHOD

Participants

Transgender men and women ($N = 22$) aged 19 to 71 years were recruited. Seventeen participants identified as female, however five were not living “full-time” as women. Of these five, two individuals had only just “come out” as transgender, were “dressing part-time,” and self-medicating with female hormones; two were “dressing part-time” and had not “come out” as transgender women; and one individual who lived “part-

Table 1. Participant Information

Pseudonym	Gender Identity	Age	Dressing	Hormone Therapy Desired	Receiving Hormone Therapy	Surgery Desired	Post-Surgery
Helen	Woman	58	FT		Y		Y
Chantelle	Woman	35	PT	Y	Self-medicating	Y	
Nathan	Man	19	FT	Y		Y	
Josie	Woman	—	PT		Self-medicating		
Jane	Woman	65	FT		Y		Y
Robert	Man	41	FT		Y		Y
Katerina	Woman	40	FT	Y	Herbal	Y	
Rosie	Woman	49	FT	Y		Y	
Daisy	Woman	38	FT	Y	Self-medicating		
Molly	Woman	66	FT		Y		Y
Elizabeth	Woman	61	PT				
Dale	Man	50	FT	Y	Bridging T shot	Y	
Penny	Woman	55	FT		Y		Y
Kelly	Woman	52	PT				
Darren	Man	—	FT		Y		
Tanya	Woman	—	FT		Y		Y
Hope	Woman	55	PT		Y		
Cassie	Woman	47	FT		Y	Y	
Lorna	Woman	53	FT		Y		
Sally	Woman	64	FT		Y		Y
Jill	Woman	71	FT		Y	Y	

time” (PT) as a woman was receiving hormone therapy and classed herself as a “lapsed transvestite.” Four participants were transgender men, all living as men “full-time” (FT), but each at different stages of gender affirmation. One volunteer identified with both male and female genders; their interview differed markedly from interviews with other participants and was therefore excluded from final analyses. Participant sexuality included heterosexual, homosexual, pansexual, and asexual orientations. The sample was not ethnically diverse, and all participants identified themselves as “white.” Participants were at varying stages of gender affirmation at the time of the study. See Table 1 for full participant information.

Procedure

Previous research investigating body image and disordered eating in transgender populations has typically compared quantitative responses to standardized questionnaires to cisgender populations, recruited transgender women only, or not fully considered the impact of stage of gender affirmation (e.g., Ewan, Middleman, and Feldmann 2014; Khoosal et al. 2009). Hence, in the present study, each participant completed a private interview which addressed each stage of gender affirmation experienced. Interviews focused on participant’s own experiences and as some participants had not experienced later stages of gender affirmation (i.e., hormone therapy and mid- to post-surgery) they were not asked about this aspect of gender affirmation. All interviews were conducted by the second author. Qualitative research is particularly effective when recruiting marginalized or underrepresented populations such as transgender men and women, and for providing opportunities for participants to raise issues not previously considered by the researchers.

Semi-structured interviews were conducted to provide both consistency and flexibility. Interview questions were developed in collaboration with a member of the transgender community following attendance at LGBTQI+ awareness events and completion of online training courses provided by the Gender Identity Research and Education Society (GIRES). Questions were designed to elicit information relating to stressors, health behavior, and physical and mental health. For example, “What did you do in order to cope with these experiences” and “Can you tell me about your current experience living in your true gender identity.” Though a topic guide was developed, in a number of instances, the interviewer consciously stepped back from the initial questions to allow participants to tell their stories.

Interviews began by asking participants to discuss their early experiences of gender dysphoria and their responses shaped subsequent questions and prompts. For example, if participants described a specific event that was important to them, they were asked to expand on this (e.g., whether they received support and how they coped with the event). This approach allowed the interviewer to explore core issues specified in the topic guide while providing participants the opportunity to focus on those issues and events that were most important to them in a meaningful way rather than adhering to a stricter question format and order. Participants also completed a brief demographic questionnaire (e.g., sexual orientation, ethnicity, etc.).

Participants were recruited at transgender support group meetings in North-west England, either via distribution of information sheets by the group coordinator or attendance by the second author. People were eligible to take part if they self-iden-

tified as transgender and were at any stage of the gender affirmation process (i.e., intended to begin gender affirmation, were currently in the process of gender affirmation, or had completed their intended gender affirmation). Social support groups provide access to a diverse transgender sample, including older transgender men and women, previously described as “an invisible population” (Shankle et al. 2003, 159). Indeed, relatively few studies have considered transgender experiences in older populations (e.g., Fredriksen-Goldsen et al. 2014). All interviews were recorded and transcribed verbatim. Non-verbal behavior such as sighing and laughter were indicated in brackets, grammar was not altered, and participants’ idiolects were preserved. Pseudonyms replaced real participant names and any identifying information (e.g., support group name and location) was removed at the time of transcription. All participants provided informed consent and were given the opportunity to review a transcript of their interview.

The analytic strategy was based on Braun and Clarke’s (2006) six phases of thematic analysis and therefore involved familiarization with the data, generation of initial codes (completed on a line-by-line basis), searching for themes, reviewing themes, defining and naming themes, and producing the report. As the key research question involved a comparison of themes at various stages of gender affirmation, data codes were collated (adopting an inductive approach) with regard to their place within the narrative. Salient themes and subthemes were then identified. Codes and themes were reviewed in a systematic, iterative, and reflexive way (Braun, Clarke, and Terry 2015). Initial codes and themes were identified by the second author, and confirmed with the first and third authors, all of whom are cisgender women.

Calculation of an inter-coder reliability is not consistent with our methodological approach (Braun and Clarke, 2013) and we note that intercoder reliability is “a somewhat controversial topic in the qualitative research community, with some arguing that it is an inappropriate or unnecessary step within the goals of qualitative analysis” (O’Connor and Joffe 2020, 1). Instead, we focus on other measures of research quality intended for use with qualitative data including confirmability and credibility (Leininger 1994). For example, where information revealed by participants during interview was unclear or ambiguous, the researcher sought clarification to check understanding. Further, we have no reason to doubt the credibility of their personal accounts and there was a significant cost to participants providing their time and energy to discuss personal and sensitive issues.

RESULTS

Findings are organized by stage of gender affirmation: pre-gender affirmation, coming out and early gender affirmation, hormone therapy, and mid- to post-surgery.

Pre-gender affirmation

All transgender men ($n = 4$) and women ($n = 18$) interviewed reflected on their pre-gender affirmation experiences. Emerging themes were “managing gender,” “stress and depression,” and “consequence of other coping mechanisms.” Each theme appeared to be characterized by an ambivalence towards physical health coupled with a motivation to prioritize psychological wellbeing. Findings suggest transgender men and women

are at increased physical risk during this stage of gender affirmation.

Managing gender

Relationships between gender identity, body image, and eating behavior were complex. For some participants, eating behavior provided an opportunity to actively change their body shape and size as a response to their gender dysphoria. For example, a larger body could deflect attention from gender and from sexual orientation. In particular, Helen discussed the advantages of a larger body prior to gender affirmation. She stated, “you get jokes about being overweight but jokes about, from your classmates, and things about being overweight are so much less painful about being effeminate, and much less risky from being misunderstood as homosexual.” She used her larger body size to cope better with her pre-gender affirmation body, explaining,

If you're largely overweight you can sort of sculpt your body a bit in private, dress and behave as you really need/want to and in public just be someone who is not going to be assumed to be doing typically male activities. It acts as a very good protection and it's easy to deflect conversations into areas that are not gendered...It becomes very helpful as a sort of part of the disguise of being overweight. Probably not consciously, but subconsciously.

In contrast, though Katerina also associated body fat with femininity, she described reducing her food intake, purging, and excessive exercise. For example, she stated,

I tried to get rid of as much fat as I could by just doing a lot of running, a lot of weights, but when running I passed out because I wasn't eating properly and I was doing too much gym, quite a few times.

This behavior arose because Katerina felt ashamed of her gender identity and was attempting to demonstrate her masculinity. She explained,

I was trying to overcompensate for being feminine... I thought that would stop the feelings I had inside, but it didn't it just made them worse. ... I think I was trying to let others know that I was more of a man really, but everyone could see because of the way that I acted that I wasn't, cos I've always very feminine anyway, in my actions and stuff.

Ultimately her behavior can be theorized as an attempt to manage her dual genders—to suppress her female identity, she purged herself and attempted to lose weight, and to enhance her physical appearance, she tried to become more muscular. Similarly, Rosie used body size as part of an attempt to hide her female gender identity. She reported,

I used to be an eighteen stone bodybuilder because I used to train six days a week, two and a half hours a night, and I had a really big muscular body, again trying to mask the fact of who I actually was.

Of the four transgender men, two described restricting eating to manage gender. For example, Nathan commented “I have quite a big problem with my weight anyway. I don't like it. ... A lot of it was to do with not liking how I looked, so not eating was kind of the way forwards.” He also acknowledged practical issues, explaining that “it's really hard to bind when your chest is really big” and restricted eating allowed him to modify “the bits I didn't like.” Hence, Nathan's motivation to lose weight was

also related to his need to suppress feminine bodily features. Overall, transgender men and women appeared to use weight gain and loss to manage how they felt about their bodies and gender identities, as well as influence how others perceived them. In this sense, weight control formed part of an overall strategy for coping with dysphoric feelings. This theme was also associated with the emergence of disordered eating, indicating that individuals at this stage may be at risk of developing eating disorders.

Stress and depression

The incidence of stress and depression was clear and references to depression, anti-depressant medication, self-harm, or suicide were common among participants. As described by Sally,

it's only two and a half years since I last felt suicidal completely. ... Dysphoria gets you. It's little things, they add up and add up and add up, and then something triggers the whole thing and you just go into a depressive cycle.

Similarly, Tanya commented,

I got heavily depressed, very depressed in fact. ... They had a counsellor and the counsellor sort of helped, but they also then went bankrupt and I got very depressed—suicidal, you know. I come very close on more than one occasion.

Participants that did not specifically identify a history of depression, anti-depressant medication, or suicidal ideation ($n = 6$) also often discussed their mental health. For example, comparing her current mental health to earlier experiences, Jill stated, “my mental health has changed. There was things going on in my head. Was I mentally ill? Was I not mentally ill?”

These issues often impacted on eating patterns. For example, Darren recalled, “when it’s a struggle to get out of bed and it’s a struggle to get through the day, the last thing you’re going to think about is ‘Right well, what do I need nutritionally?’” Similarly, Nathan stated, “I don’t really eat. If you see me eating, you know it’s a good day. It’s like, yesterday I think I lived off a tube of pringles,” and, “My head is all over the place most of the time anyway, but when I’m having a good day I’ll eat, when I’m not having a good day I just won’t eat.” This suggests that although Nathan’s motivation to lose weight can be traced to his desire to suppress secondary sexual characteristics, it was his mood which dictated whether he ate and what he ate.

Both transgender men and women talked specifically about weight gain through emotional eating and the use of food as a source of comfort. For example, Darren described, “If I had any money, I would then buy voluminous food such as pasta, any kind of cakes, anything that, you know, that would fill me very quickly. It was almost like a comfort kind of food.” His emotional eating could be traced back to traumatic experiences of transphobic bullying at school and subsequent isolation and depression, highlighting how transphobic harassment can trigger a depression which drives a range of health risk behaviors. Chantelle described her binge eating and purging. She related this pattern directly to the person she saw in the mirror. She explained,

When I look in the mirror and I see me looking back at me that I don’t think is me—it’s a big fat hairy horrible man looking back at me. That’s how I feel—disgusted. That’s what it makes me feel. It’s horrible. I hate

it, cos I look stunning as a woman and that's how I see, when I look out of my eyes, that's how I think... It's like a stranger looking back at you. Self-loathing stopped Chantelle from caring about the effect of eating on her body. For example, she admitted,

I'd get really, really depressed, yeah, and I did, I did, what the hell—stuff your face. Do you know what I mean? Stuff your face, comfort eat, and it doesn't matter what I look like cos it's not what I want to be anyway.

Many participants spoke about emotional eating indirectly. For example, Jane described the stress of hiding her transgender identity from her wife as “just like a big knot inside me” and reported that she was overeating in regular binge eating episodes. For example, she described “Chocolate, fries, chips. You know, I'd fry chips at mid-night, yeah. Just a—just a chocolateaholic, yeah, and it would be a full box.” Similarly, Robert described overeating, stating,

I was eating about seven or eight packets [of crisps] a week and biscuits, maybe two or three packets, and bread—you know extra sandwiches that I shouldn't be eating... [because] I was very depressed cos I didn't like what I saw in the mirror. I didn't like the way I felt when I walked.

Overall, these accounts demonstrate that stress and depression arising prior to gender affirmation have the potential to lead to substantial disturbances in eating behavior.

Consequences of other coping mechanisms

The misuse of recreational drugs ($n = 3$) or alcohol ($n = 5$) was also apparent, which impacted eating behavior and body shape and size. For example, Rosie recalled that she lost weight because she often “wouldn't eat for days.” However, this was a by-product of a cocaine addiction, which developed while dressing in secret. She explained

I went through years of buying cocaine, not to go out and have it, but to have it in my bedroom and I— It was... I could only say, to describe the feeling, it would probably be like having, you know, an injection of female hormones instantly. It—the feeling—was just amazing. I mean, I'd be going out, if I had a line with friends, I'd just wanna stay in and dress up.

Her story demonstrates how the desire to be feminine can be so powerful for some transgender women that it leads to risky health behavior, and again supports the hypothesis that prior to gender affirmation psychological needs often take priority over physical health.

A comparable example can be drawn from Daisy's interview, as she gained substantial weight prior to gender affirmation, though she did not cite emotional eating. Rather, she related this to her alcohol consumption, explaining, “I started just buying lots of alcohol, for the last six months or something like that. I started buying lots of, you know, things like vodka. It'd be bottles and sort of, like, having too much, really.” Like Rosie, Daisy's abuse of alcohol was clearly associated with her need to be feminine, as she related her alcohol consumption to

when I was in the home, I was dressing all the time and it was kind of like, probably longing to be out there, kind of... sort of like it was to, kind of like, numb it or something.

Daisy's weight gain is therefore arguably a by-product of a coping mechanism which

involved alcohol.

Conversely, coping mechanisms can also help prevent weight gain. For instance, Josie, Tanya, Lorna, and Sally engaged in non-team, traditionally masculine sports to cope with their dysphoria. For example, Sally stated “I was pretty fit, by that time I was scuba diving, rock climbing, parachuting, so I’ve been fairly fit all my life.” She acknowledged that

it may have been beneficial in that I suppose in a lot of respects I was overcompensating. So, the sort of higher energy pastimes might’ve been a compensation for gender dysphoria and so I became fitter rather than the other way around.

Similarly, Lorna commented “They loved me because I was a great athlete... won its league and everything, all the cups for every year right the way through and broke all the records.” She added “I thought it would... The more masculine I tried to be, the more I thought that that would go away.” These coping mechanisms are not, of course, mutually exclusive. While Tanya and Lorna engaged in a range of sporting activities, they also reported binge drinking and recreational drug use respectively.

Coming out and early gender affirmation

Participants described how being discovered or “coming out” as transgender led to vicissitudes in their appearance, lifestyle, and relationships. For example, over half the transgender women interviewed experienced transphobic discrimination or abuse during this period. The themes emerging from this phase were associated with the management of individual and interpersonal changes, both positive and negative. Three themes—“new motivation,” “managing gender,” and “Stress and Depression”—dominated accounts of this stage. Overall, these themes suggest that this stage of gender affirmation necessitates managing a myriad of personal and social changes, and that this has both positive and negative implications for eating behavior.

New motivation

Participants embarking on the gender affirmation process were generally feeling positive about their bodies and were keen to eat a nutritious diet, reach a healthy weight, or maintain it. Rosie (at this stage when interviewed) reported she was “so conscious now of my body and keeping my figure, which is a size eight to ten, which I’m happy with.” Chantelle had recently come out as transgender when interviewed and reported she had begun to diet and exercise. She explained,

I want to look after myself when I’m Chantelle. I’ve got clothes, I like skinny fit jeans and stuff like that, that I want to get into. I want to look good, but as a man in a pair of baggy jeans and a baggy top, it doesn’t matter. I’m not bothered what anybody looks at me and thinks about, because I’m not happy anyway. I don’t care.

She further commented, “I’ve lived thirty-five years as a complete stranger to me. It’s my time to shine now,” and “I’m bursting now. I want to be out. I want to start living.” Her motivation was that “I’ve got too many nice clothes to fit into—well, Chantelle does anyway—so I want to start getting a nice figure.” These comments demonstrate Chantelle’s desire to safeguard the wellbeing and appearance of her emergent feminine figure. Weight loss strategies may not always be healthy. For example, although

Chantelle spoke of diet, she also admitted to recently “taking T5 fat burners and all this rubbish.” This motivation may, of course, extend to other (non-health or eating) aspects of life. For example, Jill described her experience since coming out, “Since I’ve discovered who I am, what I am, you can’t stop me, just totally different.”

Managing gender

Managing gender was evident in transgender men who seemed motivated to lose weight in order to suppress feminine bodily features. In particular, two of the four transgender men interviewed had attempted weight loss at this stage, with the explicit goal of suppressing feminine bodily features. For example, Darren stated,

The guys that I know, they all lost weight to try and hide their chest, but then they had, they had the bad posture because they would then walk round hunched everywhere to try and hide it. ... Me and my mates, we all lost weight in order to hide better.

Dale recounted,

I started using laxatives a lot because I didn’t want to put on weight, because, you know, if you put on weight, then, as you know, with the female and male body differences, I will get female fat distribution, so I’ll get big on top. And so, I think “I want them gone,” so get rid of body fat. So, I was eating very little and I was using laxatives two, three times a day to try and not have any fat on my body at all.

His disordered eating is unsurprising given the distress having breasts had caused him in the past. For example, he recalled

When I was twelve, I was—I developed sooner than all the other girls at school and I had my first period when I was only ten. So, by the time I was twelve, I was developed up top, which was horrible, horrific time.

And then I took a bread knife from the kitchen and tried to cut them off.

These findings suggest that transgender men may be at risk of developing eating disorders early in the gender affirmation process when they are reliant on binding and weight loss to mask their feminine bodily features.

Stress and depression

This theme reflected negative aspects of gender affirmation, such as the loss of close relationships and the manner in which distress impacted maladaptive behavior. In particular, participants engaged in emotional eating and selected poor-quality food at this time.

The impact of stress and depression on eating behavior was apparent in Josie’s interview. She explained how her gender identity triggered the breakdown of her marriage and bullying at work. She explained,

I was really, really heavy, because you’re comfort eating. You’re eating, you’re drinking, you’re trying to mask pain. You’re in pain all the time. The stress of going to work, stress of being laughed at, being joked at, being humiliated, you know all that stuff. Then you have your marriage break down and it’s all because of me—it’s all because of being transgender. So, if I didn’t have all this being transgender, all these things that I’m talking about, wouldn’t have happened to me. I’d have sailed

along.

Transphobic abuse could also cause stress and weight gain. Tanya described, “I was beat up several times—assaulted with people with baseball bats. An entire street come out at me, attacked me. Even when that happened the police didn’t turn up.” She continued,

I moved to my last address because people was uncomfortable with the way I was and were trying to force me out. I’ve had an arson attack at the house where somebody filled the letterbox with shredded paper, put lighter fuel or something—an accelerant—in and then put matches through the letter box.

She admitted that when she became stressed, she ate:

I would prob, probably each sommat fairly sweet or high carbs when I got stressed, yeah. Not necessarily bad food, I would just eat food with quite high carbs in. I would eat things like meat pie, cos I was so—I didn’t really feel like cooking, so I’d eat things like pies and pasties and maybe go and have fish and chips quite regularly or pizza.

Cassie developed severe depression during her early gender affirmation, she reported:

I just wanted my life to go away. I wanted to kill myself, but I was just too cowardly. You know, I wished I was dead, but there was no way of doing it, so best thing is just sit there and let myself rot.

Cassie also developed disordered eating, stating, “there was two cases where, like, I did starve myself completely for ten days a time over a six-month period.” Her self-destructive behavior can be understood as a reaction to long delays accessing treatment and feeling trapped. For example, she explained that while she was coming out as a transgender woman, she was anxious disclosing to others: “the last thing I wanted to do was tell anyone. ... I was ripped up inside. I couldn’t, and the more I couldn’t do, the harder it was because I still wasn’t there. Nothing was moving.” Cassie insisted that she had no previous issues with food or weight, however she admitted that “there was a part of me liked getting thinner.”

Receiving hormone therapy

Seventeen participants reported experience of hormone therapy, either delivered through formal healthcare providers or self-medication (often involving acquisition via internet sources). Two themes emerged for the hormone therapy stage: “increasing awareness and control” and “preparation for surgery.” The theme “increasing awareness and control” can be regarded as a continuation of the “new motivation” theme from the previous stage of gender affirmation. Both transgender men and women focused on either losing weight gained during earlier stages of gender affirmation or were anxious about gaining weight as a consequence of the hormone therapy. Participants discussed a variety of weight control strategies. Narratives regarding weight loss in “preparation for surgery” suggest that transgender men and women may be at risk of engaging in disordered eating behavior in a quest to meet criteria for surgery.

Increasing awareness and control

Some of those engaging in hormone therapy were concerned about elevated hunger and weight gain resulting from hormone therapy. Hence, participants discussed increased awareness of their appetite, healthy eating, and weight control. For example, Darren, who had been on hormones for an extensive period, described in detail his experience that “hormones change your eating habits massively.” He reported that “You have a massive appetite increase er because you need to fuel all the changes that are happening” and that “for the lads you have a massive, massive appetite increase, but it’s really, really hard, because if you don’t train you get all the aggression and you put on loads of weight.” He described the cyclical process of hormone injections, stating,

I’m every three weeks, so about one and a half weeks I’m at my peak.

So, at my peak I’ve got more energy, so I need to eat a lot of protein. I need to feed it a lot of carbs. And then you start going back down ready for your next injection, but then you start getting sluggish so you just need to eat foods that will give you more and more energy. And you just need... You get used to it because your body will crave certain foods.

Likewise, Hope claimed hormone therapy had a significant impact on her appetite, which she compensated for by periodically missing meals. She stated,

The biggest problem I’ve had, I suspect—and I blame this on something else and I shouldn’t really—and that is with being on estrogen has really increased my appetite somewhat chronically. I’m famished all the time! I’m hungry all the time and you put some—if my wife ever puts some food in front of me, I eat it, all of it, every bit! And then I’ll raid the fridge and whatever. So, weekends are a bad time for me because I’ll tend to eat a lot of food and come Tuesday morning, is about the next time I weigh myself when I’m at the hotel, gone to work and whatever. And then that’s when I’ll miss a meal out and just have a salad for tea. So, I’ll have my breakfast, nothing for lunch, and then a bit of a salad for tea and a couple of slices of toast and that’s enough to ensure that I lose this weight.

This suggests that some transgender women may attempt to control weight via risky calorie restriction strategies. Those taking herbal hormones were cautious that prescribed hormone therapy would impact body weight. As described by Katerina “hormones might put weight on me as well,” suggesting that the side effects of such medication may influence healthcare decisions at this stage of gender affirmation.

Transgender women who did not desire surgery (Josie, Kelly, Hope) were generally motivated to control or lose weight so that they could fit into particular clothes or styles. For example, having had a larger body, Josie stated

Now I want to reduce dress size. Now I want to get into better dress sizes, you know, and panties—get smaller panties and things. You know, that sort of thing. So, I’m very conscious now, cos I want to get my figure, you know, into proper shape and a proper waist, so I’m looking to lose another stone and get my—get my, you know, a good figure. ... You know, I want to have a slender waist, nice fitting skirts and things, you know. Tight fitting and that, as well.

Overall, comments reveal how the self and body are intertwined, and also how

reductions in bodily discomfort and increases in hormone fueled appetite led to increased awareness of eating behavior, body weight, and shape.

Preparation for surgery

Of the seventeen transgender men and women taking hormones, twelve either desired or had undergone surgery. Four of the five participants taking hormones and anticipating surgery discussed the implications of larger body size in relation to gender affirmation surgery. For example, Chantelle considered “the risks of being overweight, and it causes problems with the surgery cos there’s too much excess skin when they do the surgery. There’s higher risk of it not going to plan.” As a consequence, those preparing for surgery typically placed greater emphasis on physical health in preparation for her future surgery. Cassie commented,

I’m thinking about that a lot now, yeah. Diet and stuff. I’m trying to just eat fish and veg and stuff. I don’t eat any other meat other than fish. Exercise. I do a lot of walking and that, but I wanna get more healthy. I just wanna get my metabolism as good as it can be so when I... I can have a good shot at it [surgery].

Similarly, Dale discussed his current exercise regime, which was directly linked to his plans for surgery. For example, he stated,

They do say that the more upper core strength and more muscle you build—chest muscle you build up—then the much more successful the top surgery is when they do the male contouring. They do the double mastectomy, but also the male contouring. ... So, I’m thinking, okay, you know, if I lose the weight and do all the exercising, hit the weights and things and just build up my strength and upper core, then that is preparing for the surgery, so then at least even if I’ve got a way to go before the surgery, I feel as though I’m still progressing and heading towards something.

The relationship between body weight and preparation for surgery was echoed by transgender women who had undergone surgery. In particular, they reported the challenges presented by body mass index (BMI) targets and employing strict diets beforehand. Tanya stated,

I’d got the hormone treatment, transitioned, done everything ready for surgery. Got to see the surgeon and he said my BMI was too high and gave a target that was unreachable for me. Literally completely unreachable. It was less than I’d weighed when I was fourteen and I used to do all the sports and stuff like that. So. I mean I’d actually worked it out, I’d have to cut a leg off to reach that BMI, and I was actually seriously considering doing that, and I’m not joking.

Molly described how in order to lose weight for surgery she made substantial changes to her diet. She recalled,

I was getting towards the end of my counselling I need. I’m getting a bit too much. I need to cut down for my surgery, so I cut out meat and potato pies and went on cuppa soups at lunch times and got my weight down nearly two stone.

The same motivation to lose weight was evident in Sally’s interview. She explained,

I suddenly discovered before I was due to have the operation that maximum measurement around the widest part of your abdomen was thirty-seven inches because obviously a lot of the work is done around the abdomen and mine was forty. I was frightened to death! So, four weeks I had a five hundred calorie a day diet.

She further described a routine of

five hundred calories a day and a cycle at the local gym. I was down there for two hours a day, as well. I mean, going to the gym doesn't actually lose you much weight at all, but it does tone things up and basically, I was trying to get this down.

Interestingly both Sally and Molly described putting weight back on post-surgery. This is suggestive of the potential for extreme dieting to trigger fluctuations in weight.

Mid- and post-surgery

The recurring theme for the mid- and post-surgery stage of gender affirmation was “contentment versus control.” There were fewer interviewees ($n = 8$) from this stage of gender affirmation. All participants reported feeling more positive about their bodies and there appeared to be a reduction in emotional eating. Participants were cognizant of how their bodies and health had changed during gender affirmation and were generally keen to control their weight. Transgender women were more likely to discuss the use of restrained eating, whereas transgender men tended to endorse physical activity and weight training as a form of weight management or body shape control.

Contentment versus control

Participants expressed feelings of wellbeing and increased contentment both in general terms and with their body since engaging with surgery. For example, discussing their general contentment, Tanya asserted, “I’m happy with myself” and Sally commented, “it’s infinitely better, there’s none of the things associated with gender dysphoria—you know, depression, misery, heartache, arguments.” Similarly, Molly stated, “I feel more content. I’m becoming what I want to be, what I should be,” and Penny explained, “I do feel a lot more confident in myself, a lot more relaxed and a lot more open. ... Nothing’s really changed, just me, just being the person I always thought I was.” Illustrating greater contentment with body shape, Helen stated, “it’s quite nice seeing the fat distribution being more appropriate to one’s internal image of oneself. And yes, so, it’s a kind of balance of looking appropriate, feeling appropriate.”

At later stages of gender affirmation, transgender women ($n = 6$) described various weight control strategies. For example, Helen stated, “I try not to eat too much. I try to eat more slowly,” and Jane commented, “I weigh myself regular so I keep—make sure it’s not creeping. ... If I notice the scales are creeping in the wrong way, I live on porridge for a couple of days.” Like her counterparts, Sally also stated that she was happier with her body. However, this was juxtaposed with comments that “There are bits obviously that I would prefer not to have. I’d prefer this mummy tummy to disappear completely” and “I would love to lose another stone, but I don’t seem to be able to get round to it.” As a consequence, she described weight control strategies such as “eating more salads these days and eating—I tend to get things in bulk now and freeze them.” In part, Sally’s desire to lose further weight may reflect the common association be-

tween being feminine and being thin.

The transgender men ($n = 2$) also expressed contentment with their bodies and discussed controlling weight and physical health through diet. Darren who was mid-way through surgeries at the time of the interview, spoke at length about his new approach to food, with eating oriented towards nutritional value. For example, he explained,

I personally have problems with internal bleeds and things like that. That's one of my things, so I need to then eat a lot of green veg to combat, because you know the properties in the green veg, especially like cabbage and spinach and things like that, the iron and all the other properties do really well for your healing process.

Similarly, Robert approached food from a functional perspective commenting, “my iron's low so I have to eat a lot of vegetables” and “I have to drink a lot of water because I used to suffer—I used to suffer a lot with urinary infection through stress.” Both transgender men discussed weight control strategies. For instance, Darren commented,

I'm on quite a strict diet,—quite a strict training regime. So, I'm working to improve my health and everything that goes with it. Obviously, my physique, as well. I'm working on that slowly. I've set myself—I've got a goal for a year, so in a year's time I want to be a lot slimmer but have bulked—gained muscle.

These commentaries highlight the importance of controlling weight and maintaining health at this stage.

In contrast to the transgender women, whose focus tended to be on calorie restriction, Darren and Robert talked enthusiastically about exercise, weight training, and building muscular physiques. For example, Robert commented, “The most I can do in a week of tummy exercises is 2,500.” Darren also explained,

Obviously, you've spent all your life being female and now all of a sudden you've got all this testosterone and you've got—no matter how much you trained before, your muscle structure is never the same. But now obviously I build muscle. So, my arms—because you get really obsessed about muscle. Like, some guys don't, but more often than not we get really obsessed with body shape and muscle.

Participant commentaries on food and weight during this stage of gender affirmation provide evidence of a balancing of contentment with awareness of a need to control or lose weight. This does not necessarily mean all participants were successful in achieving this, however attitudes at this stage contrast starkly with pre-gender affirmation and reveal a shift in priorities which favors the safeguarding of physical health.

DISCUSSION

In the present study, the body dissatisfaction and disordered eating reported by transgender men and women were closely related to the pressures experienced at each stage of gender affirmation. Findings highlight the need to consider the importance of stage of gender affirmation when investigating the interplay between gender dysphoria,

body dissatisfaction, and eating behavior (McGuire et al. 2016; Staples et al. 2020) and have important implications for transgender health research and practice.

At the pre-gender affirmation stage, three themes emerged: “managing gender,” “stress and depression,” and the “consequence of other coping mechanisms.” In terms of managing gender, disordered eating was used by transgender men and women to manage self-perceptions and emotions in relation to their body and gender identity (e.g., to create or mask female anatomical features) and to influence the perceptions of others. This is consistent with previous research documenting the use of food restriction or compensatory eating behavior to prevent puberty onset or progression (Coelho et al. 2019). Disordered eating in order to achieve these goals could increase health risks for transgender men and women. Health professionals should be aware of these issues and ensure that appropriate support is provided at the pre-gender affirmation stage.

Similarly, negative affect (stress and depression), arising as a consequence of bullying/harassment, hiding one’s transgender identity, or hatred towards their body was linked to food consumption (either under-eating or emotional overeating), the consumption of nutrient deficient foods, and bulimic strategies. Indeed, the emotional aspects of eating behavior and relationships between mental health and eating behavior are well-established (Aoun et al. 2019). Maladaptive behaviors, adopted in order to cope with gender dysphoria (i.e., cocaine use, alcohol abuse, and exercise addiction), also influenced food selection and intake. Findings highlight the importance of contextualizing high-risk eating behavior in transgender populations (Sevelius 2013) and of supporting those experiencing distress during the pre-gender affirmation stage to develop adaptive coping strategies. Findings also contribute to evidence demonstrating the consequences of delays to gender affirmation treatment and the extent to which a lack of support can impact the health of transgender men and women (Carlile, Butteriss, and Sansfacon 2021; Ellis, Bailey, and McNeil 2015).

The coming out and early gender affirmation stage saw the re-emergence of two of the pre-gender affirmation stage themes: “managing gender” and “Stress and depression.” In terms of the former, here again the primary motivation (for transgender men) was food restriction leading to weight-loss in order to conceal breast tissue or self-harming behavior (i.e., attempting to remove them altogether). Stress and depression at this stage for transgender women was linked again with transphobic abuse, but also with having to cope with problematic interpersonal relationships (i.e., loss or conflict with spouses, family, and friends) or frustration associated with the speed of access to treatment, leading to either a starvation feeding regimen or emotional overeating. Findings are consistent with previous research documenting the relationship between stressful life events and health behavior in the transgender community (Miller and Grollman 2015; Peltzer and Pengpid 2016) and highlight the importance of developing adaptive coping strategies and accessing appropriate support.

The coming out and early gender affirmation stage also revealed the emergence of a new theme: “new motivation.” Transgender women expressed the wish to eat healthily and control portion sizes for two main reasons: to lose weight or maintain a low body weight in order to create and display a more feminine figure or to reduce risk in the light of anticipated surgery. However, risky weight loss strategies were evident (e.g., self-medication with weight-loss pills). Researchers must examine the relation-

ships between femininity, body weight, self-identity, and societal acceptance further, for example, the extent to which transgender women in Western societies believe that a low body weight is part of the “ideal” feminine body shape that must be reached in order to feel or be treated as attractive and feminine. Practitioners supporting transgender men and women during the coming out and early gender affirmation stage should be aware of the potential for both positive and negative associations with eating to develop in this phase.

For transgender men and women at the receiving hormone therapy stage, there was an increase in awareness and control of appetite, weight, and body shape. Consistent with the previous stage, there remained a “new motivation” to lose weight or maintain a low weight. However, hormone therapy was reported to be linked to a large increase in appetite, with the potential for weight-gain. As reported elsewhere (Ålgars, Santtila, and Sandnabba 2010), this creates anxiety in relation to the desired body shape and in relation to meeting weight criteria for surgery. This was sometimes dealt with by employing risky calorie restriction and exercise strategies in order to achieve the required pre-surgery weight. Findings are consistent with literature on the emergence of risky dieting behavior in transgender populations (Diemer et al. 2015; Witcomb et al. 2009) and contribute to existing research (e.g., Fisher et al. 2014) examining the impact of hormone therapy on transgender body image.

Greater acknowledgement and discussion of this issue is required, especially as the body mass requirements for gender affirmation surgery vary, data relating body mass and surgical outcomes are lacking, and body mass requirements for surgery may negatively impact patient health and wellbeing (Brownstone et al. 2021). The relationship between body weight, body dissatisfaction, and disordered eating should, of course, be considered in the context of weight related stigma (both from health practitioners and the general population) and the impact of this stigma on health and wellbeing (e.g., Major, Eliezer, and Rieck 2012; Puhl and Brownell 2006). For example, weight related stigma may increase unwanted attention that is especially problematic when experiencing gender dysphoria and in the context of discrimination and abuse targeted at the transgender community (Bradford et al. 2013).

At the final stage, mid- and post-surgery, the theme that emerged most strongly was “contentment versus control,” and a shift in priorities from a motivation to focus on psychological wellbeing to a focus on physical health. For some, contentment in relation to body image emerged, along with a reduction in emotional overeating. Transgender women expressed an increased feeling of wellbeing and greater satisfaction with body image. However, there was also a desire to be thinner, possibly because transgender women associate being thin with being feminine (Gordon et al. 2016). This stage was therefore also characterized by stringent weight control strategies for some people and further research exploring relationships between feminine body ideals, body dissatisfaction, and weight control in transgender women is required.

Similarly, transgender men expressed a greater contentment with their body image and used food in relation to physical health (e.g., consuming vegetables to promote healing after surgery or drinking lots of water to treat urinary infections). Though weight control was still a major concern, this time a stringent diet and exercise routine were combined to achieve the desired slender-but-muscular physique. This is consistent with recent research suggesting that transgender men become more mo-

tivated to care for their body as they progress through stages of gender affirmation (Linsenmeyer et al. 2021) and suggests that measures should be introduced to address existing delays to the gender affirmation process. Transgender men and women have important nutritional requirements that change across the gender affirmation process. There has, however, been little recognition of this issue or formal guidance for transgender men and women. Indeed, previous research has documented the use of social media to obtain transgender relevant nutrition information (Schier and Linsenmeyer 2019). Additional research and guidance are required to support the nutritional needs of transgender men and women at each stage of the gender affirmation process (Rozga et al. 2020).

Findings demonstrate the importance of considering the extent to which gender dysphoria influences body dissatisfaction, attitudes to food, and eating behavior at various stages of gender affirmation. Clearly, each stage of gender affirmation presents specific issues that must be understood and accommodated by health professionals. Further, it is important to recognize important barriers to effective healthcare. For example, weight has become a core issue for those addressing the health of transgender men and women and weight-based stigma can impede health provision, with a tendency for healthcare providers to attribute health issues to body weight (Paine 2021). Interventions intended to improve patient healthcare should ensure that they do not increase existing health inequalities by encouraging weight-based stigma, which reduces engagement with healthcare services and exacerbates the discrimination already experienced by the transgender community (Paine 2018).

Limitations and future research

Findings are, of course, limited by reliance on a relatively small sample, precluding the extrapolation of findings to the transgender community at large. In particular, all participants identified as white, and these findings cannot inform our understanding of the intersections of racism and transphobia in this context (e.g., Ghabrial 2017; Sevelius 2013). Further, it is important to acknowledge that gendered standards of beauty are racialized, such as through privileging thinness and non-Black hair types (Bryant 2019; Kelch-Oliver and Ancis 2011). These racialized standards may negatively impact the body image and eating behavior of non-white transgender women, especially where gender affirmation focuses on racialized aesthetic ideals (Gonsalves 2020). Additional research in this area is required. Similarly, future research should consider cultural variation in the gender affirmation process, including the influence of societal acceptance of transgender men and women and social support (Elischberger et al. 2018). Indeed, research indicates that there is considerable cross-cultural variation in transgender experiences (Reisner, Keatley, and Baral 2016).

Future research should ideally be prospective in nature, so that individual differences and changes in emotions, thoughts, and health behavior can be captured throughout the gender affirmation process, together with those factors exacerbating or lessening body dissatisfaction and disordered eating. These studies may elucidate the nature and timely implementation of interventions to offset the mental distress, negative body image, and maladaptive coping behavior reported here. Research investigating the effectiveness of treatment delivered to transgender clients with body image or eating disorders is particularly important as previous research indicates that

these services and wider mental health services are often inadequate (Duffy, Henkel, and Earnshaw 2016; McCann and Sharek 2016).

To conclude, the present study highlights the need to consider the influence of stage of gender affirmation when researching the interconnections between attitudes, behavior, and emotions relating to gender identity. For both transgender men and women, a shift was evident from a focus on psychological wellbeing in the early stages of gender affirmation to physical wellbeing in the later stages. While body dissatisfaction seems to dissipate as the gender affirmation progresses, a common theme at each stage was that both transgender men and women engaged in risky and often maladaptive behavior related to transforming body shape and size (although motivations changed across the gender affirmation process). It is, therefore, essential that transgender men and women are provided with support in these areas throughout the gender affirmation process.

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