

# Providing Gender-Affirming Eating Disorder Care

**Kai Schweizer (He/they)**  
**BA, MSexol**

# Acknowledgement of Country

I acknowledge the traditional custodians of the lands on which this presentation was created and is being viewed. I pay our respects to Elders past and present. I recognise that sovereignty was never ceded and that decolonisation is an ongoing project. This always was and always will be Aboriginal Land.

I note that the gender binary and homophobic attitudes arrived in this land with colonisation and these attitudes and beliefs are upheld today through a colonial lens and structure in so-called "Australia". Prior to colonisation, trans and gender diverse people were not only accepted but celebrated on this continent. I acknowledge Brotherboys, Sistergirls, and other gender diverse Aboriginal and Torres Strait Islander people and recognise their leadership in the LGBTQIA+ community.

We cannot truly have equality for LGBTQIA+ people unless we have equality for everyone; meaning full sovereignty for Aboriginal and Torres Strait Islander people, the return of all stolen land, and the abolishment of patriarchy and the colonial gender binary.

# ACKNOWLEDGEMENTS

## UWA/THE KIDS RESEARCH INSTITUTE TEAM:

- Felicity Austin
- Professor Ashleigh Lin
- Professor Ben Jackson\*
- Dr Kemi E Wright
- Dr Penelope Strauss\*
- Xander Bickendorf
- Jessica Luke
- Associate Professor Bonnie Furzer\*
- Dr Sav Zwickl\*

## INCLUDED TEAM:

- Dr Jane Miscovic-Wheatley\*
- Dr Philip Aouad
- Dr Sabina Vatter
- Marcellinus Kim

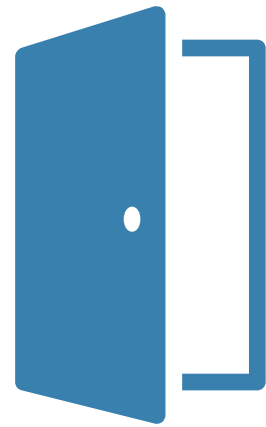
## OTHER COLLABORATORS:

- Dr Romany McGuffog
- Rosiel Elwyn
- Lumen Gorrie
- Majella Jones
- Laurence Cobbaert
- Mel Keller-Tuberg
- Kai Thomas
- Hayden Moon
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# BE GENTLE WITH YOURSELF



**You can take a break at any time – no explanations needed. Come back when you're ready.**



**Support is available. If you need to talk, reach out to a trusted person or professional.**

# ABOUT ME

- PhD Candidate with the University of Western Australia and the Kids Research Institute Australia
- Non-binary trans masc
- AuDHDer
- Lived experience of an eating disorder

## Contact details

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# SESSION OUTLINE

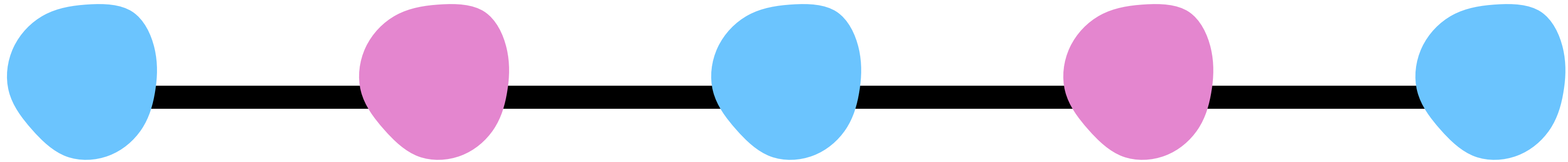
**Introductions**

**Part 1: Basics**

**Part 2: Risk  
Factors**

**Part 3: Support &  
Treatment**

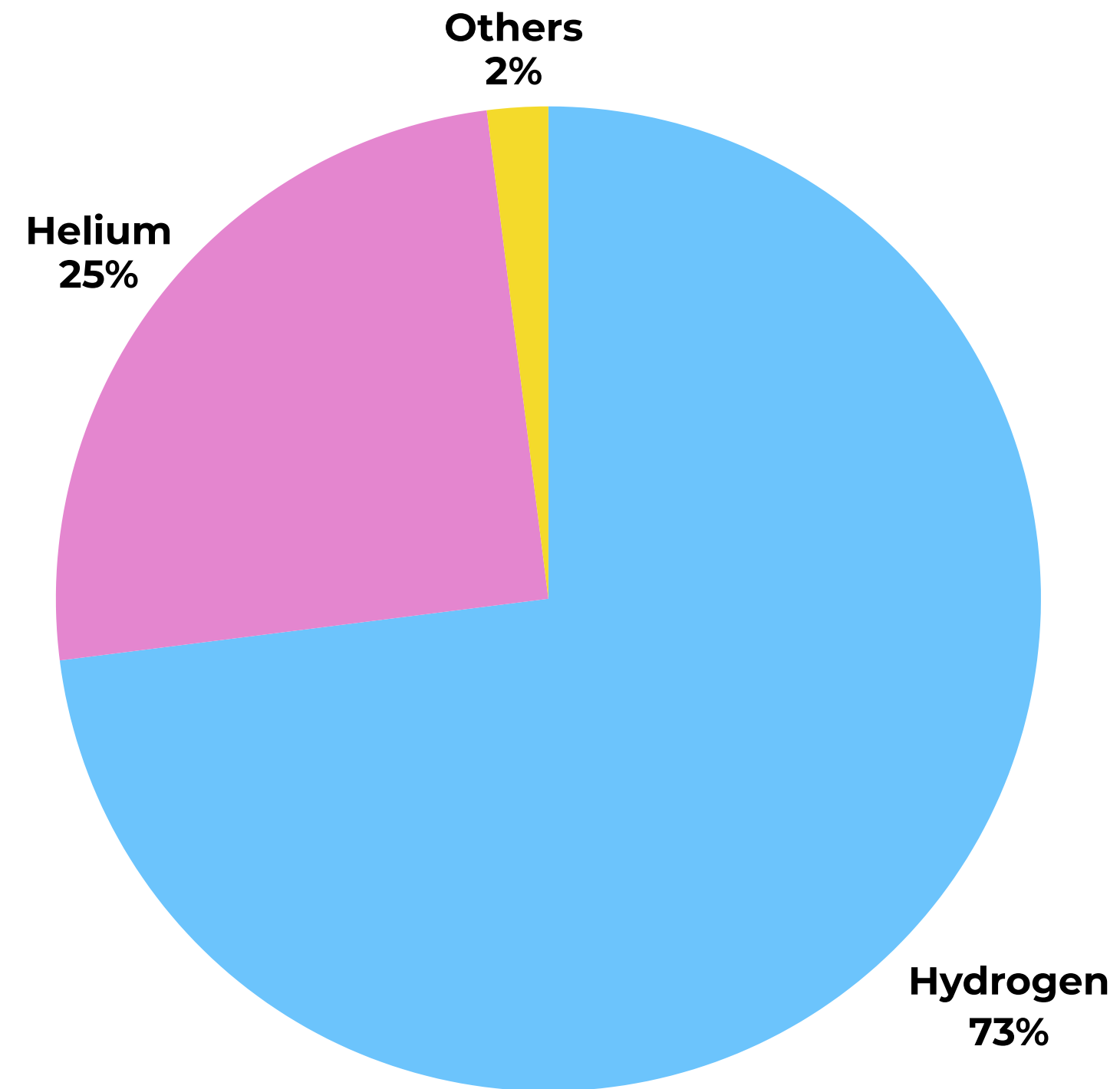
**Questions &  
Discussion**





# **GENDER DIVERSITY**

# THE UNIVERSE





1 H																	2 He
3 Li	4 Be											5 B	6 C	7 N	8 O	9 F	10 Ne
11 Na	12 Mg											13 Al	14 Si	15 P	16 S	17 Cl	18 Ar
19 K	20 Ca	21 Sc	22 Ti	23 V	24 Cr	25 Mn	26 Fe	27 Co	28 Ni	29 Cu	30 Zn	31 Ga	32 Ge	33 As	34 Se	35 Br	36 Kr
37 Rb	38 Sr	39 Y	40 Zr	41 Nb	42 Mo	43 Tc	44 Ru	45 Rh	46 Pd	47 Ag	48 Cd	49 In	50 Sn	51 Sb	52 Te	53 I	54 Xe
55 Cs	56 Ba	57-71	72 Hf	73 Ta	74 W	75 Re	76 Os	77 Ir	78 Pt	79 Au	80 Hg	81 Tl	82 Pb	83 Bi	84 Po	85 At	86 Rn
87 Fr	88 Ra	89-103	104 Rf	105 Db	106 Sg	107 Bh	108 Hs	109 Mt	110 Ds	111 Rg	112 Cn	113 Nh	114 Fl	115 Mc	116 Lv	117 Ts	118 Ar

57 La	58 Ce	59 Pr	60 Nd	61 Pm	62 Sm	63 Eu	64 Gd	65 Tb	66 Dy	67 Ho	68 Er	69 Tm	70 Yb	71 Lu
89 Ac	90 Th	91 Pa	92 U	93 Np	94 Pu	95 Am	96 Cm	97 Bk	98 Cf	99 Es	100 Fm	101 Md	102 No	103 Lr

**Globally, trans people are estimated to make up:**

**4.5%**  
of adults

**8.4%**  
of children and adolescents

**In Australia, trans people make up:**

**7.1%**  
of secondary school students

# TERMINOLOGY

## **Trans man:**

- **A man who was presumed female at birth.**

## **Trans woman:**

- **A woman who was presumed male at birth.**

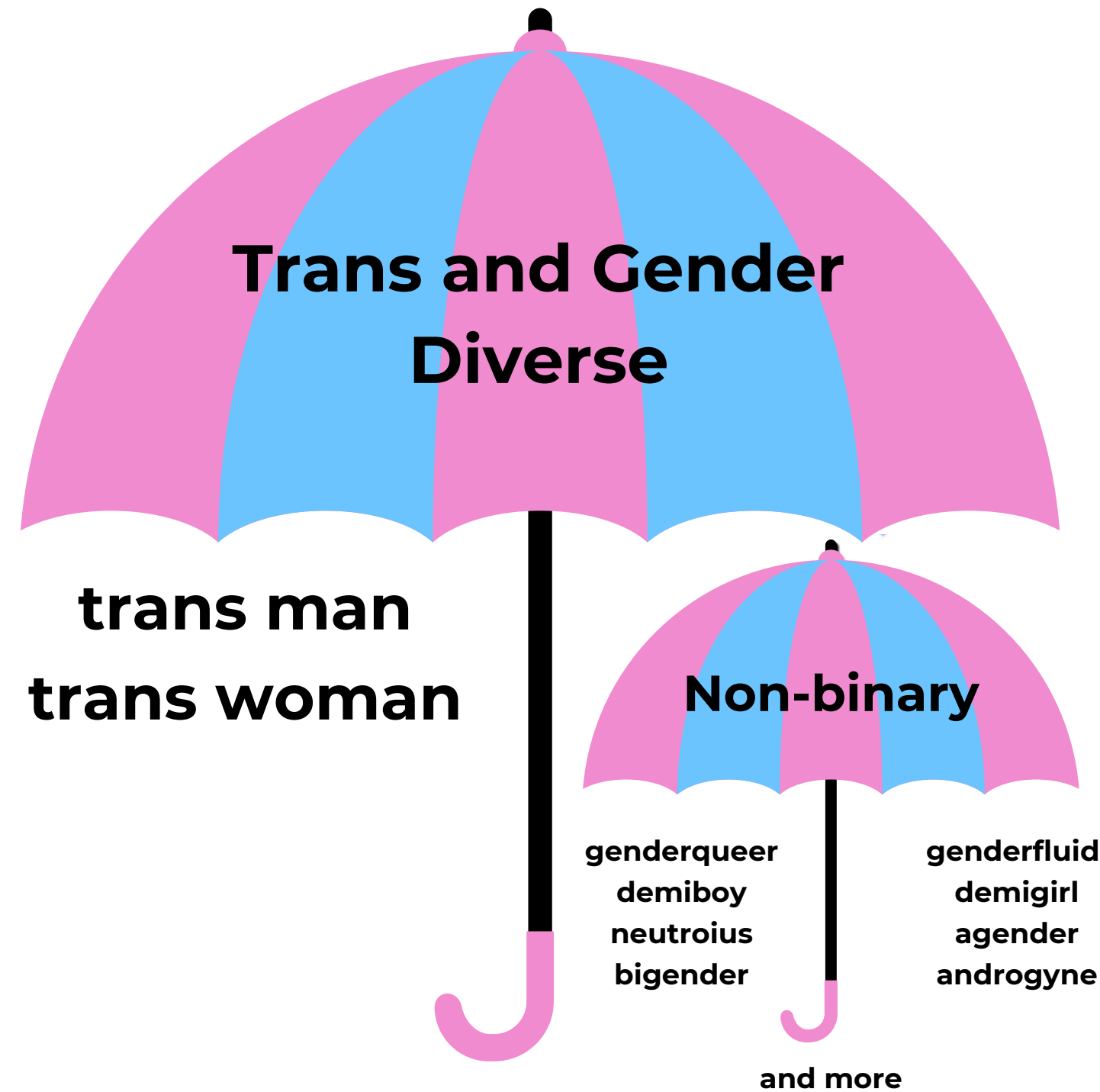
## **Non-binary:**

- **A person whose gender is not exclusively or entirely a man or a woman.**

## **Cisgender:**

- **People whose sex presumed at birth matches their gender identity.**

# WHAT IS GENDER DIVERSITY?



# DECOLONISING GENDER

## BROTHERBOYS AND SISTERGIRLS



Sistergirl: A First Nations person who has a feminine spirit but was assigned male at birth.

Brotherboy: A First Nations person who has a masculine spirit but was assigned female at birth.

## HIJRA



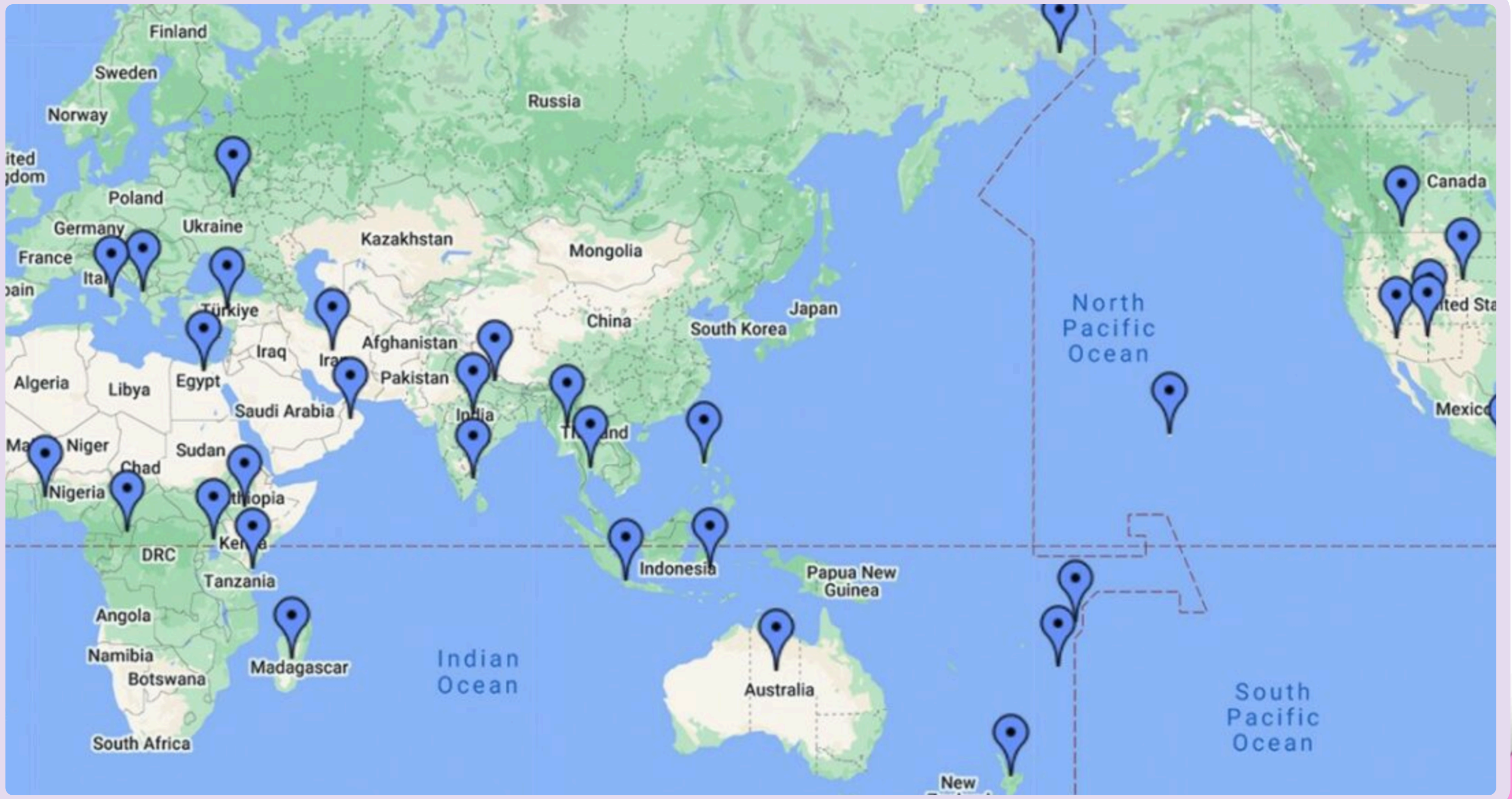
A person who was registered as male at birth but who identifies as a woman, or as neither a man nor a woman.

## TWO-SPIRIT



A person who identifies as having both a masculine and a feminine spirit.

Used to describe sexuality, gender identity, and/or spiritual identity.





**DISORDERED  
EATING &  
EATING  
DISORDERS**

## EATING DISORDERS

- **Persistent** and severe disordered eating.
- Impacts both physical and emotional well-being.
- Requires **professional support** and treatment.

## DISORDERED EATING

- Unhealthy eating behaviours
- Doesn't meet full criteria for an ED, but **can still cause distress and health issues.**
- Not always severe
- **Early intervention is key.**

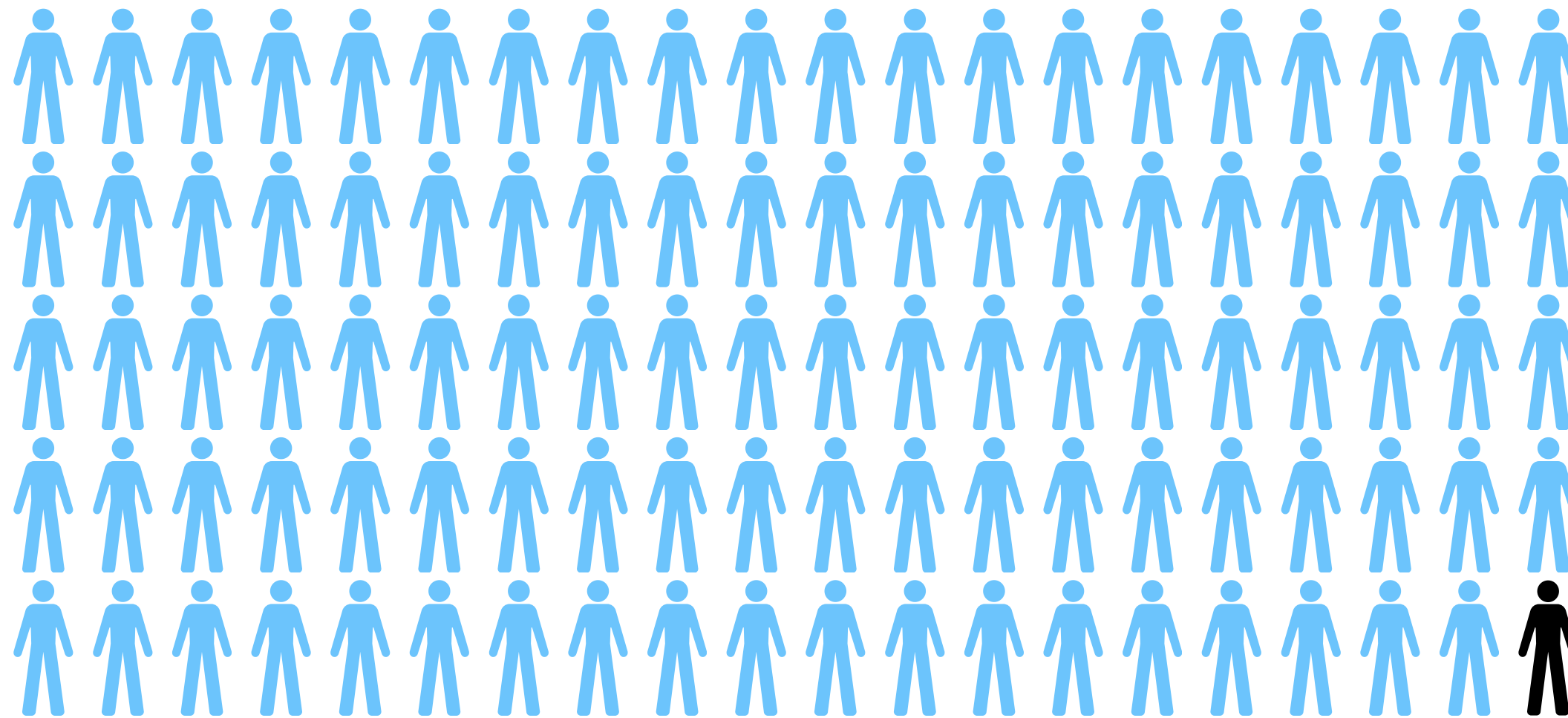
## EATING DISRUPTIONS

- Eating behaviours are driven by **circumstances** rather than distress or control.
- Addressing **root causes** (e.g., access to food or medical care, grieving) is key.

## EATING DIFFERENCES

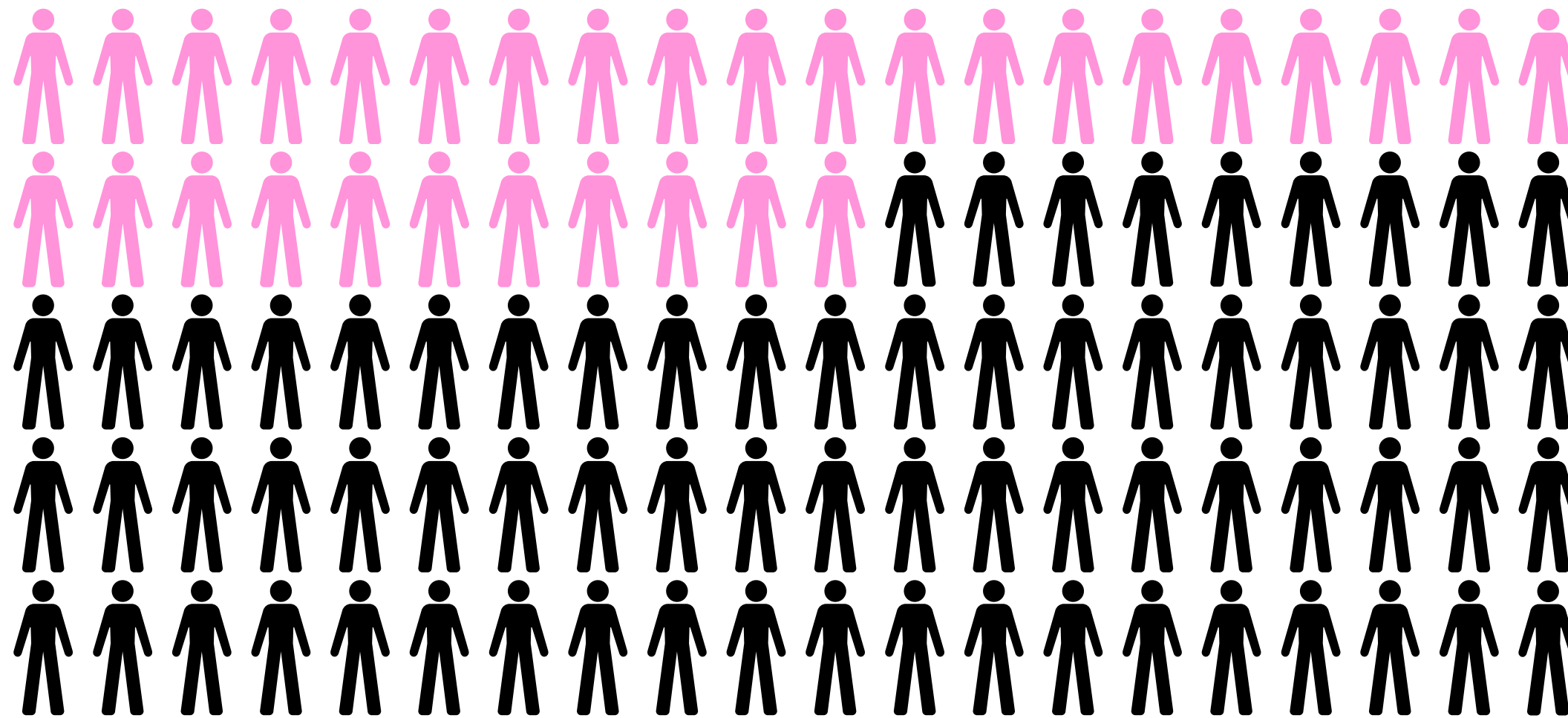
- Eating behaviours differ from **accepted norms** but are not inherently harmful.
- Not a disorder: should be **respected and accommodated** rather than 'fixed'.

# PREVALENCE



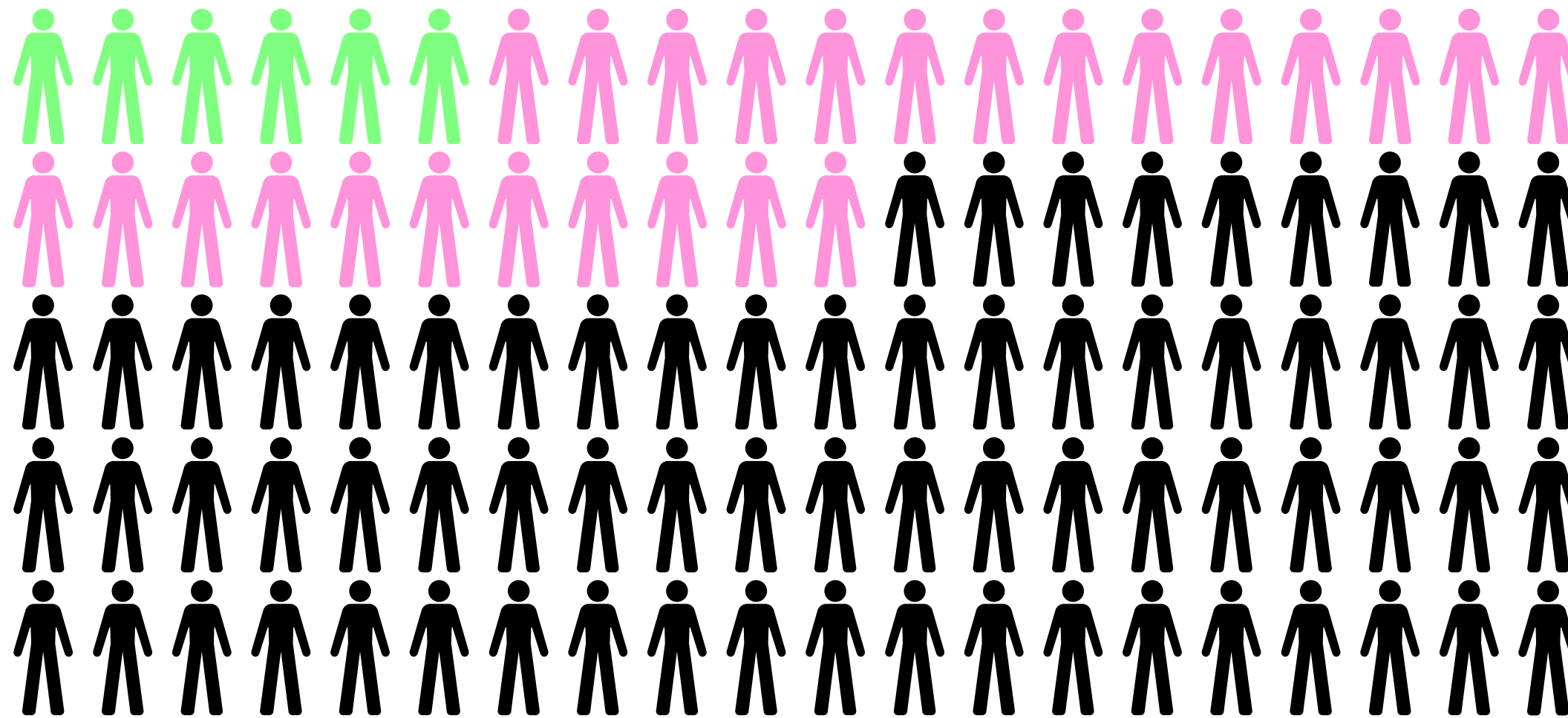
**over 99% reported disordered eating behaviours in the past 3 months**

# PREVALENCE



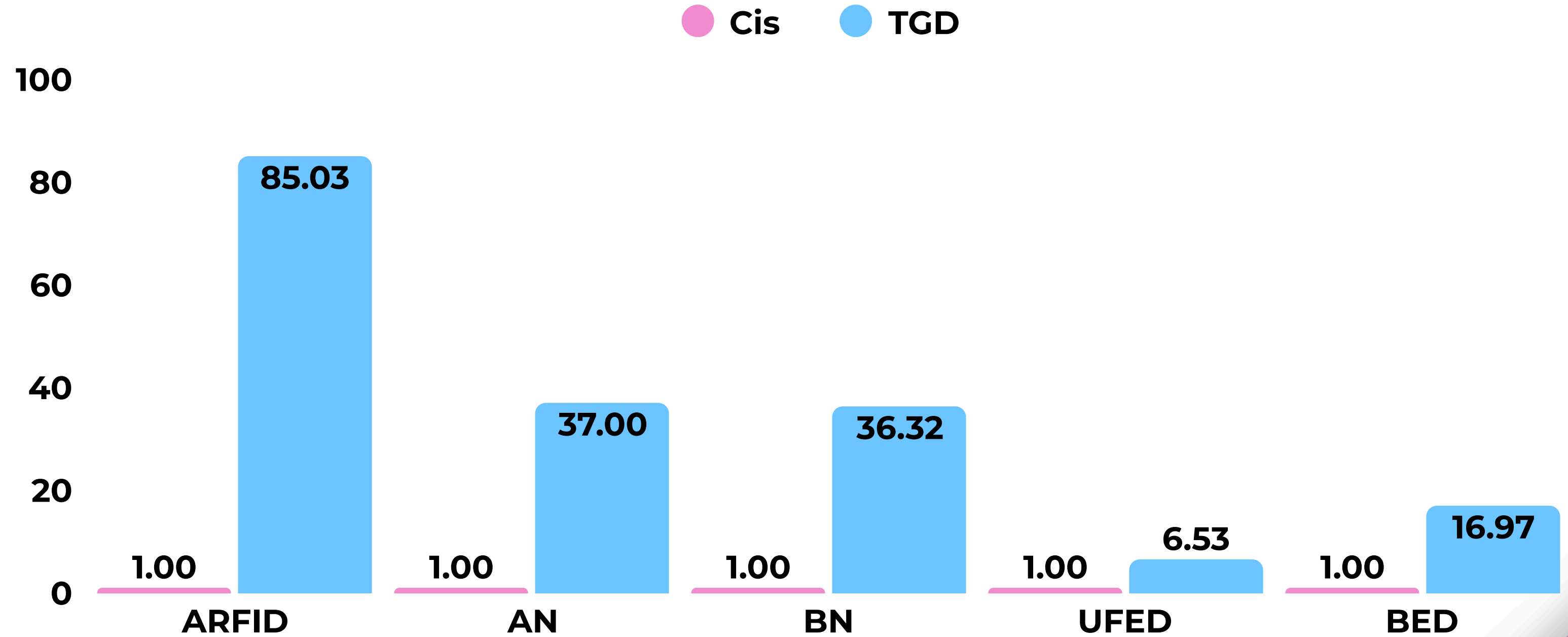
**31% had an EDE-QS score above Clinical cut-off**

# PREVALENCE



**but only 20% had been diagnosed**

# DIAGNOSES



# DISORDERED EATING BEHAVIOURS

- Fasting
- Dieting
- Binge eating
- Self-induced vomiting
- Laxative use
- Diuretic use
- Chew and spit
- Non-prescription steroid use
- Diet pill use

# UNIQUE DISORDERED EATING BEHAVIOURS

**1**

Weight cycling

**2**

Excessive phytoestrogen  
consumption



“nuts have higher estrogen. So, I know a lot of trans feminine people who have eating disorders, who gravitate to only wanting to eat those sorts of things and restricting other kinds of food”

“putting on a lot of weight and then losing a lot of weight and cycling that way to achieve with trans women a more feminine shape. That's the theory behind it. I don't know how much that's true.”





**WHY THE  
ELEVATED RISK?**

# WHY THE ELEVATED RISK?

**GENDER  
DYSPHORIA**

**MINORITY STRESS**

**CO-OCCURRING  
NEURODIVERGENCE**



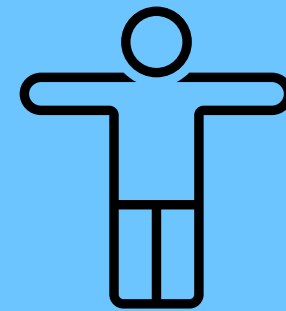
# **GENDER DYSPHORIA**

# GENDER DYSPHORIA

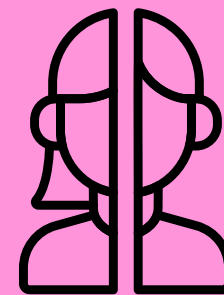
The distress, discomfort, or sense of disconnect that can arise when a person's gender identity is a) not aligned with their physical body and/or embodied experience, and/or b) not aligned with or affirmed by societal or interpersonal perceptions of their gender.



**SOCIAL**

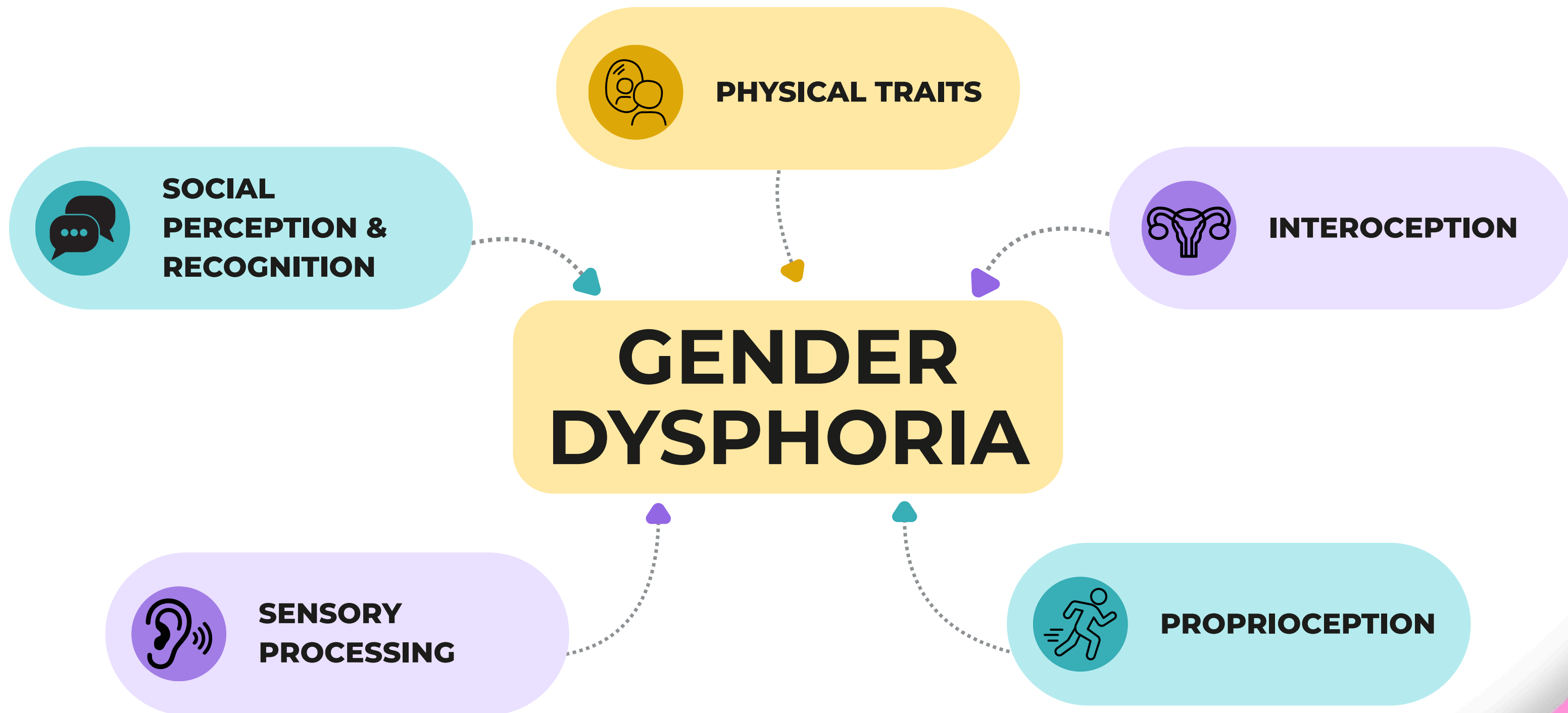


**PHYSICAL**



**DISSOCIATIVE**

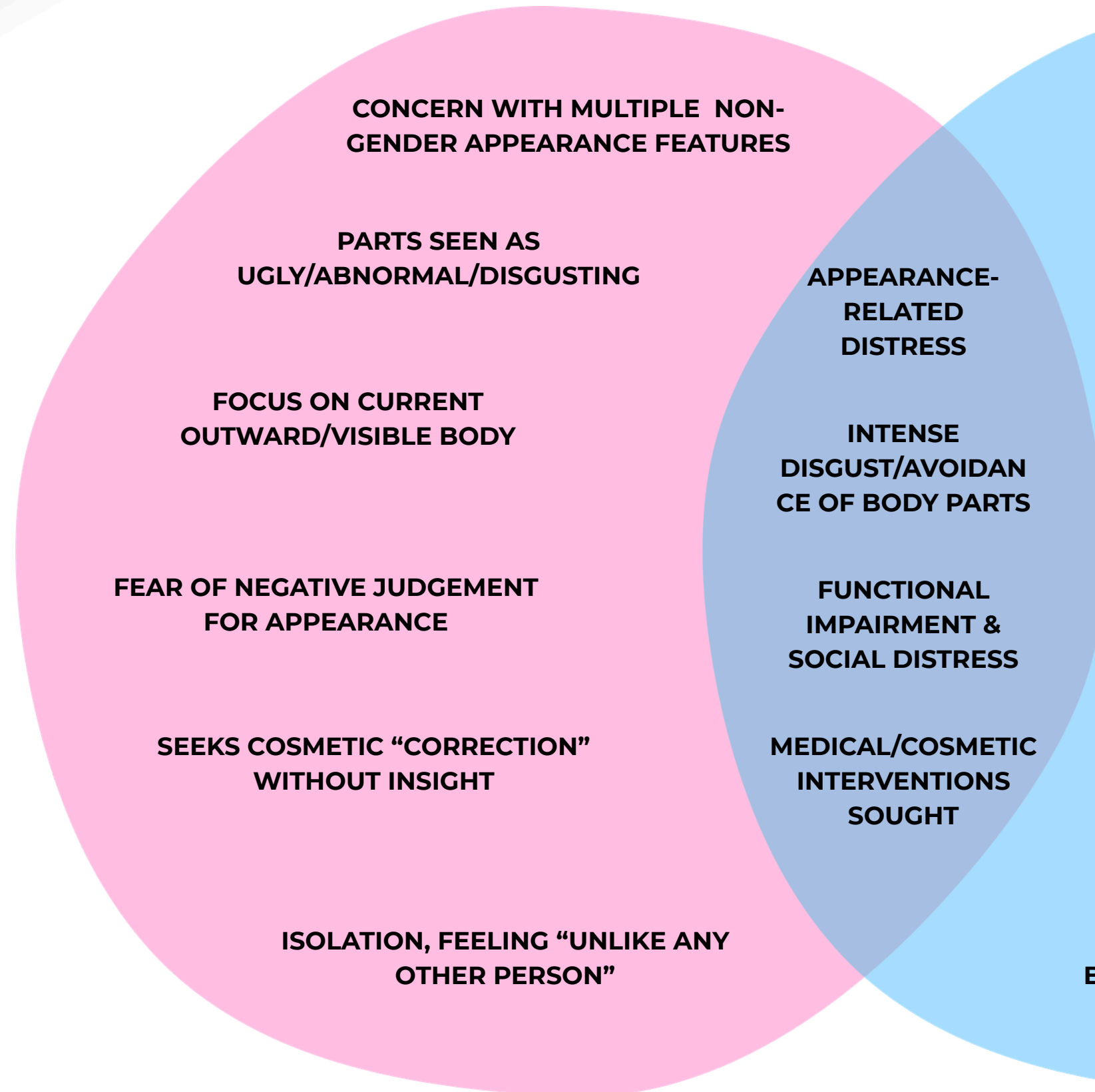
# MULTIDIMENSIONAL MODEL



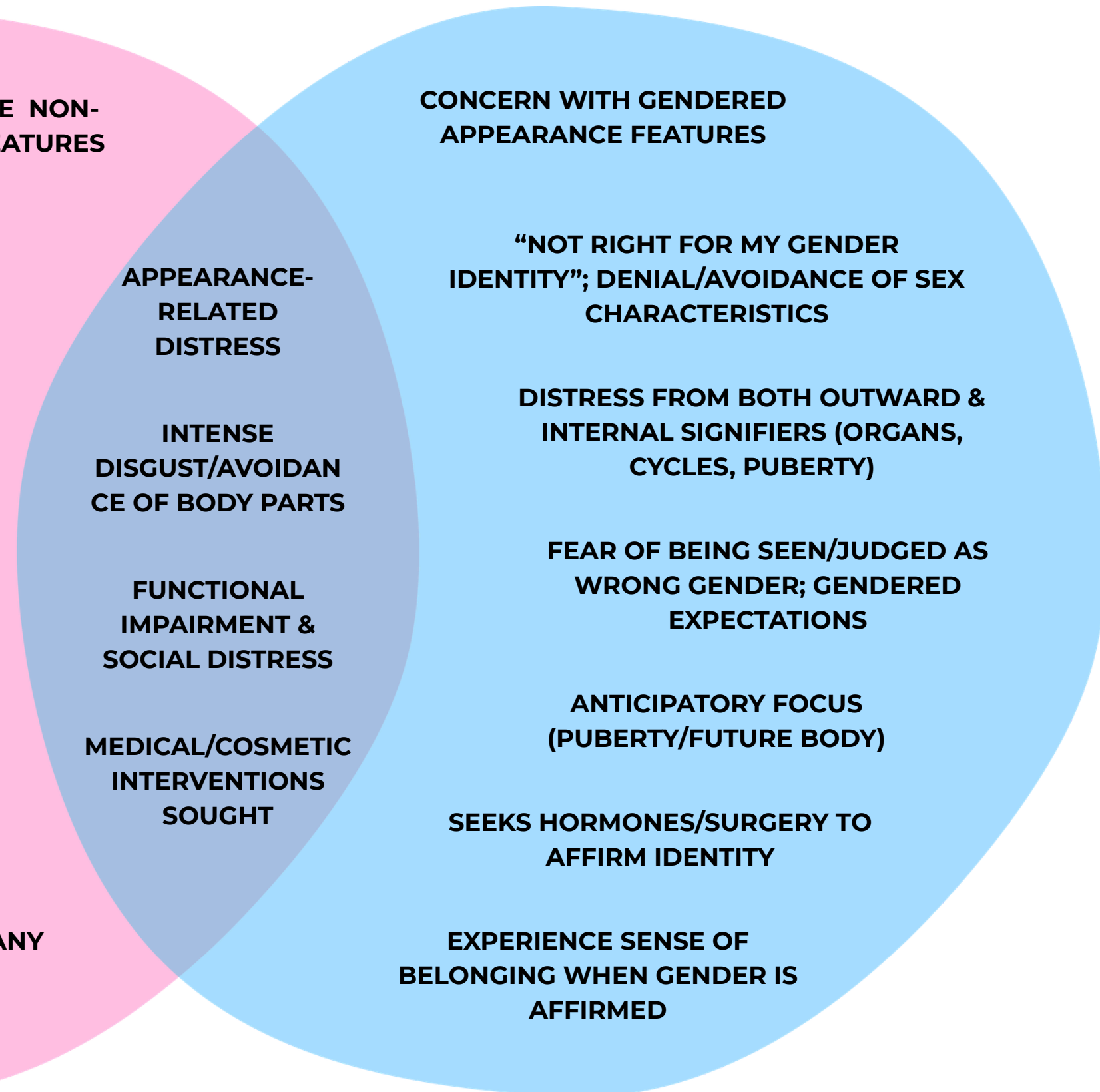
# GENDER DYSPHORIA

Type of Gender Dysphoria	Definition	Key Features
<b>Social</b>	Distress due to being misgendered or socially perceived in a way that doesn't align with one's gender identity.	<ul style="list-style-type: none"><li>• Misgendering (incorrect name/pronouns)</li><li>• Perceived as assigned sex at birth</li><li>• Exclusion from gendered spaces</li><li>• Social anxiety related to gender perception</li></ul>
<b>Physical</b>	Distress related to body characteristics that do not align with gender identity, particularly secondary sex characteristics.	<ul style="list-style-type: none"><li>• Distress over chest, genitals, or facial/body features</li><li>• Discomfort during puberty</li><li>• Desire to change body through binding, tucking, hormones, or surgery</li></ul>
<b>Dissociative</b>	Feelings of detachment or disconnection from one's body or self due to gender-related distress.	<ul style="list-style-type: none"><li>• Body parts feel "not mine"</li><li>• Detachment from voice or body</li><li>• Emotional numbing</li><li>• Depersonalisation or derealisation</li></ul>

# BODY DYSMORPHIA



# GENDER DYSPHORIA



# CIS WOMEN

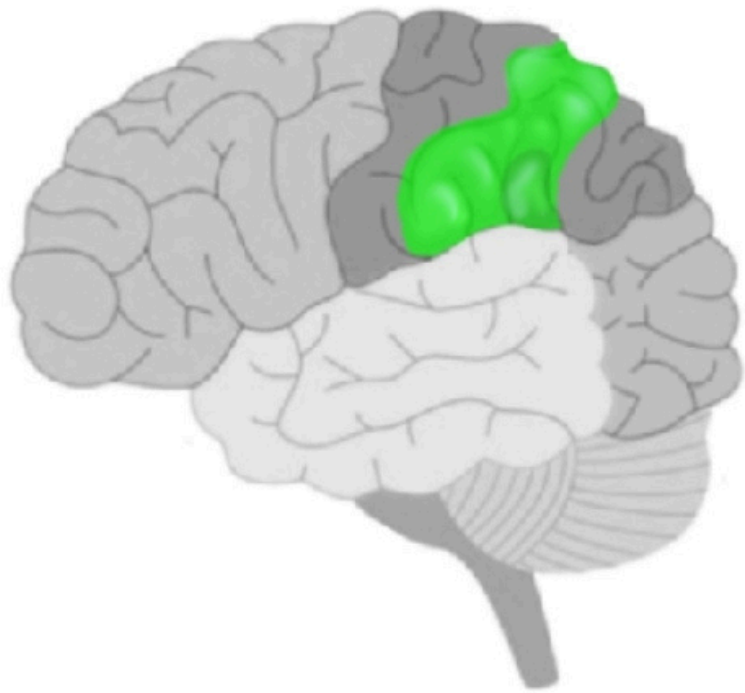
# TRANS MEN

**ACTIVATION OF THE SUPRAMARGINAL GYRUS AND SECONDARY SOMATOSENSORY CORTEX**



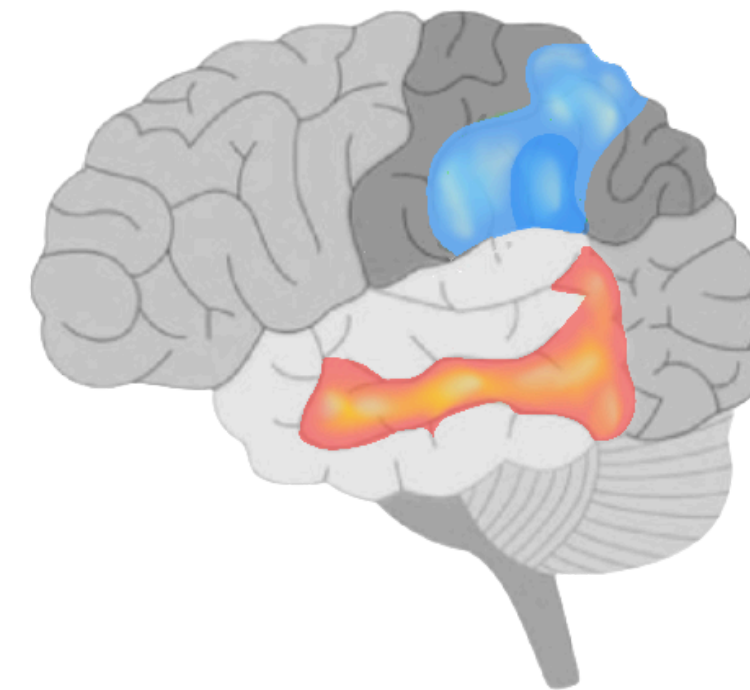
# CIS WOMEN

ACTIVATION OF THE  
SUPRAMARGINAL GYRUS AND  
SECONDARY SOMATOSENSORY  
CORTEX



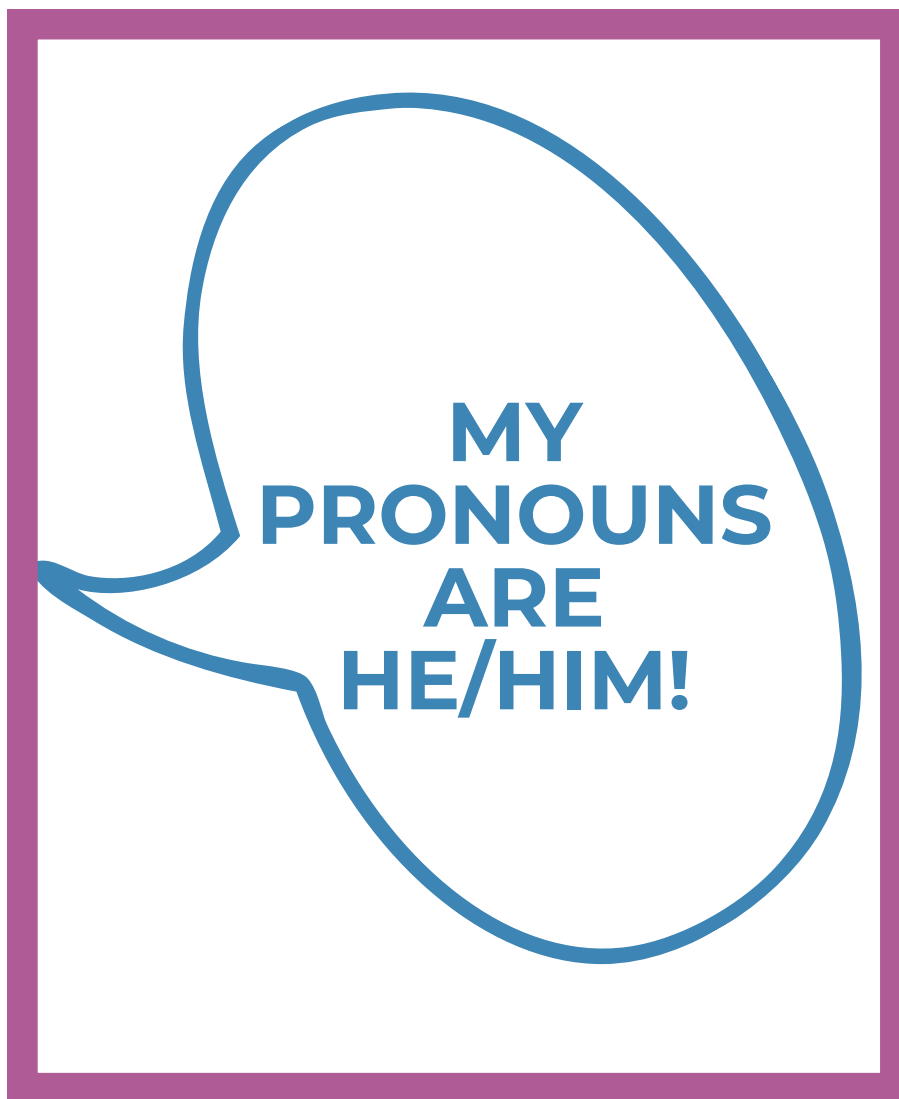
# TRANS MEN

SAME REGIONS PLUS MEDIAL  
TEMPORAL LOBE

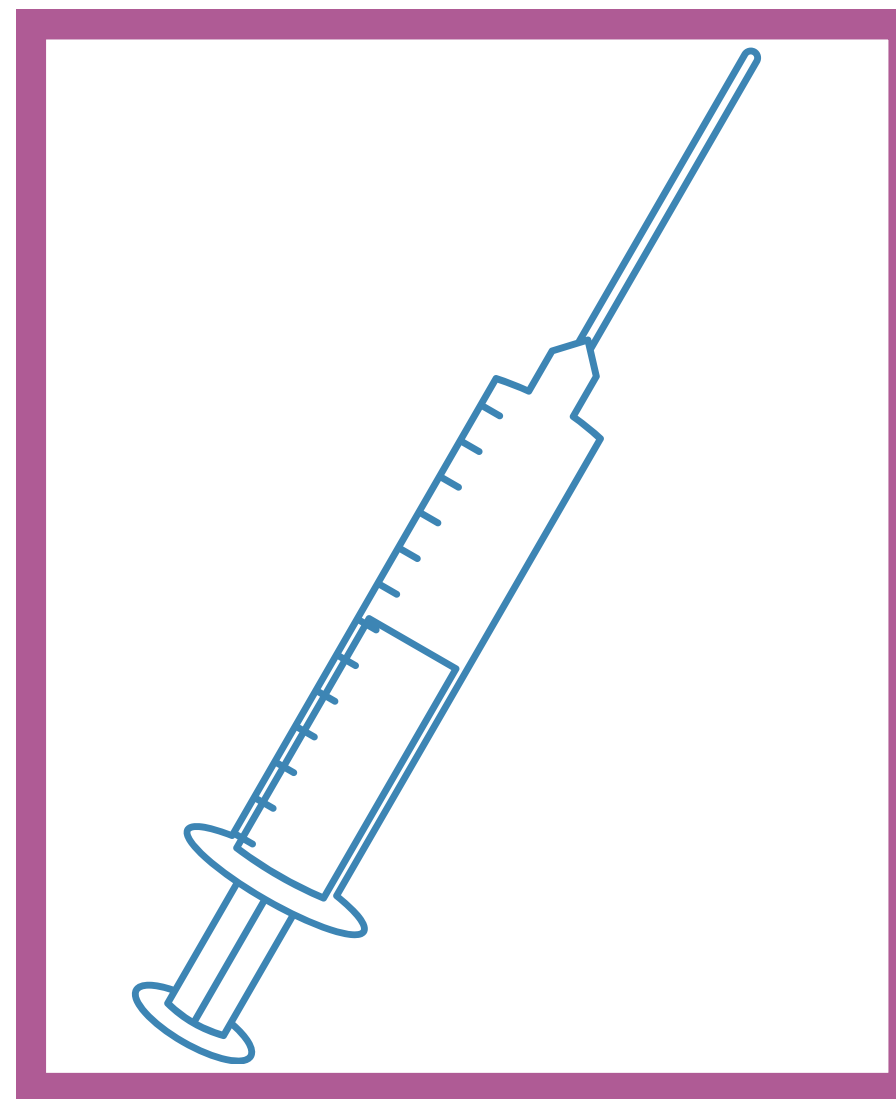


# AFFIRMATION

## SOCIAL



## MEDICAL




## LEGAL




# MANAGING GENDER DYSPHORIA

- Pubertal suppression
- Reducing appearance of gendered traits (e.g., breasts, hips)
- Passing as affirmed gender
- Suppression of menses
- Wasting of muscle mass
- Compensatory restrictive eating for lack of exercise (e.g., binding beliefs, etc.)



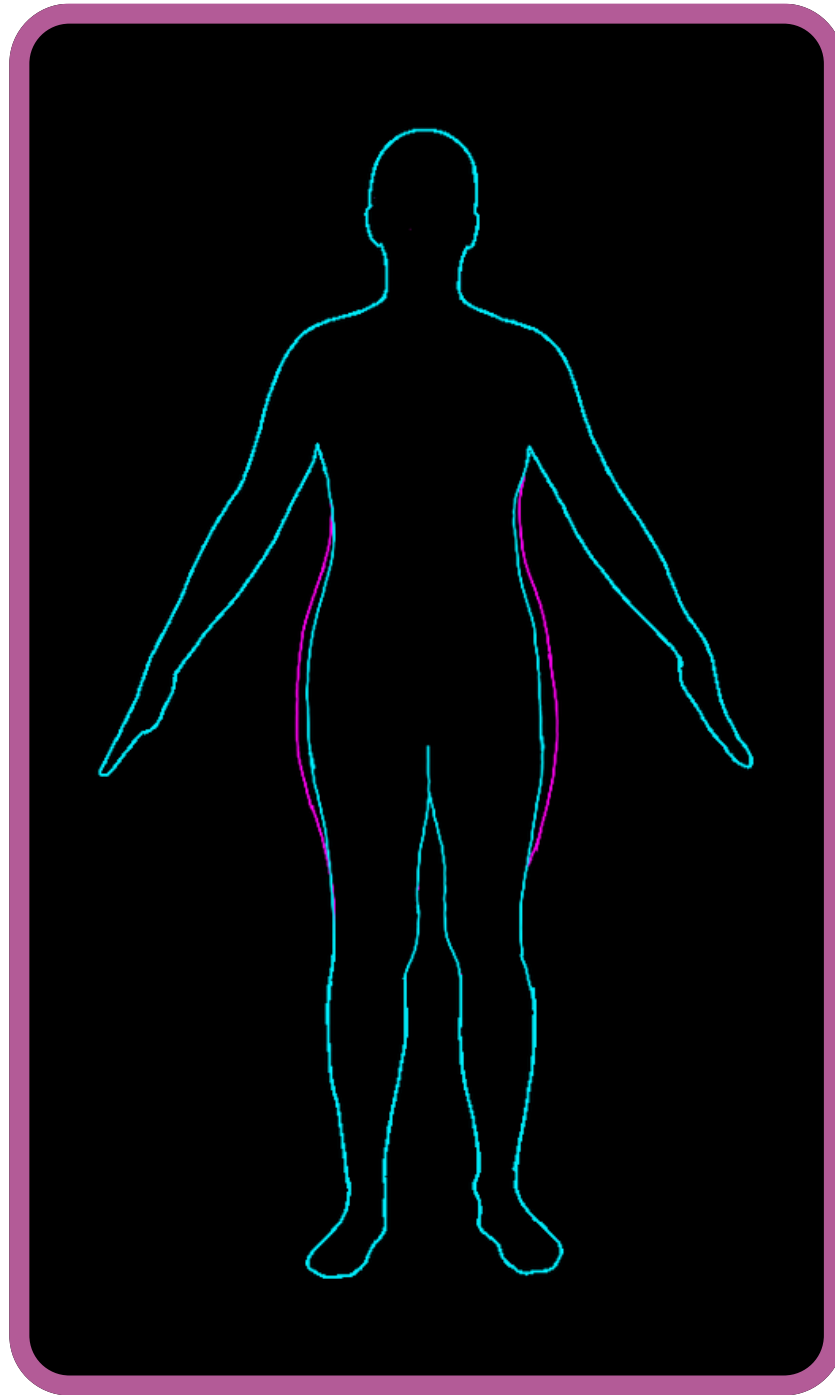
“I didn't know about top surgery or HRT. The only conclusion I could come to is: the only way I can change my body to reflect how I want people to treat me and my inner world is by starving it.”



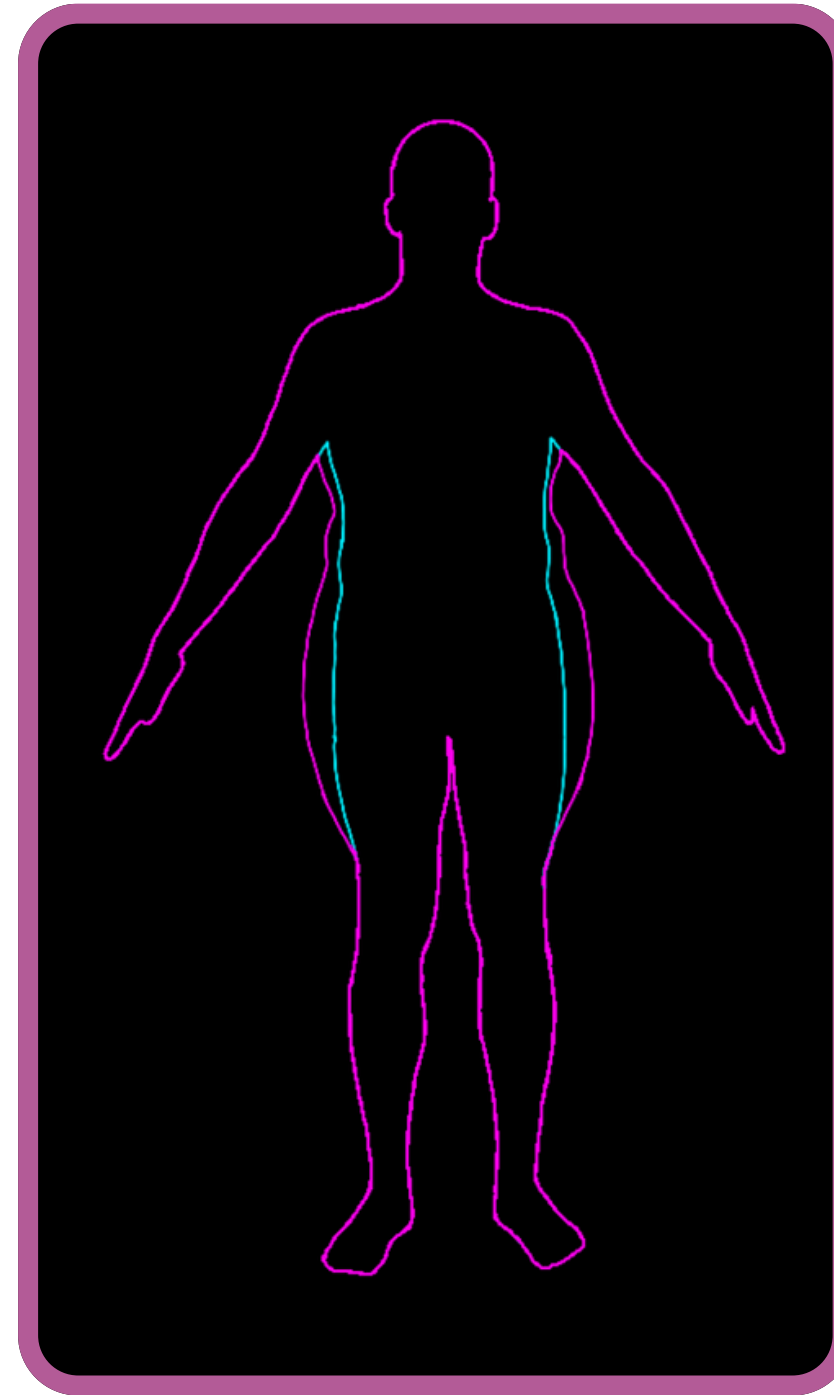
“the goal is to be so underweight that you don't have a period anymore, that you don't have breasts, and that you don't have hips”

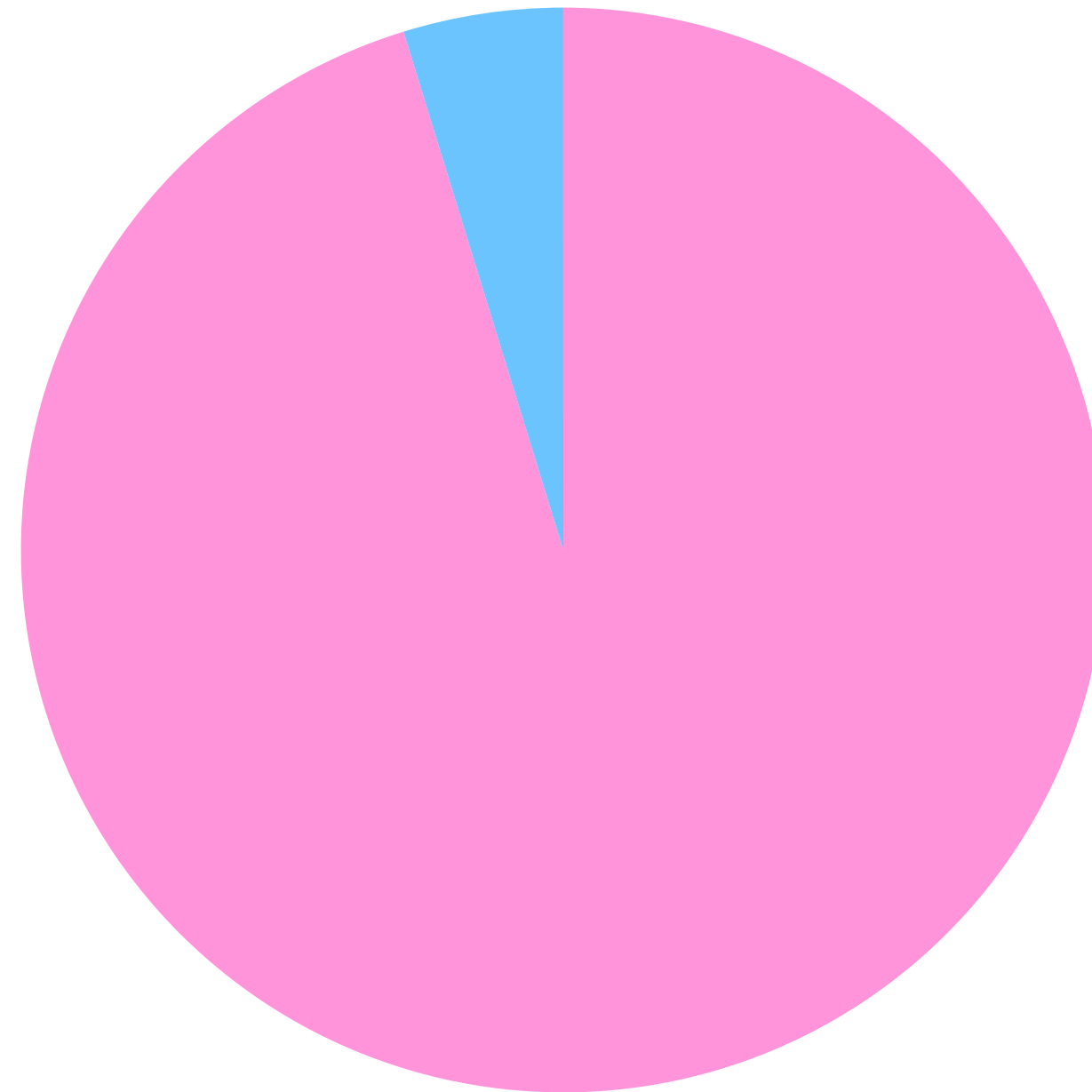
## Body fat distribution changes with GAHT.

Testosterone



Oestrogen

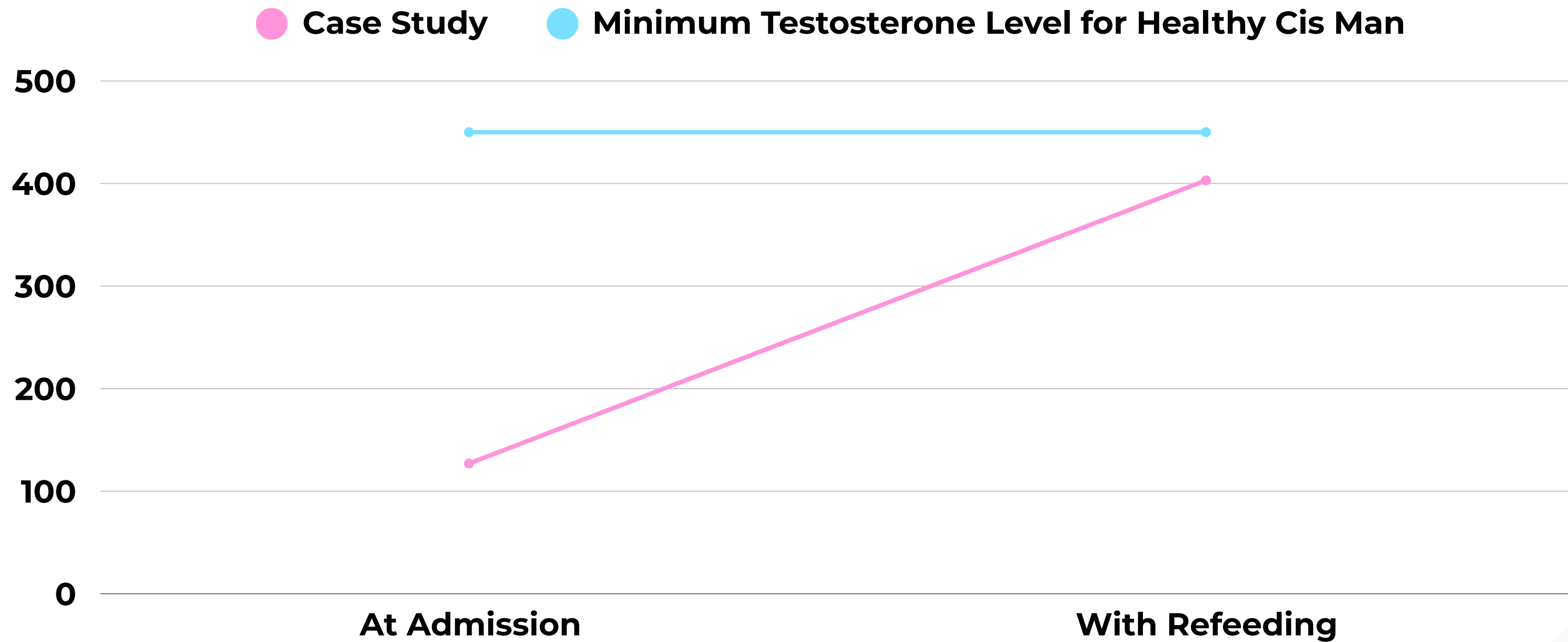




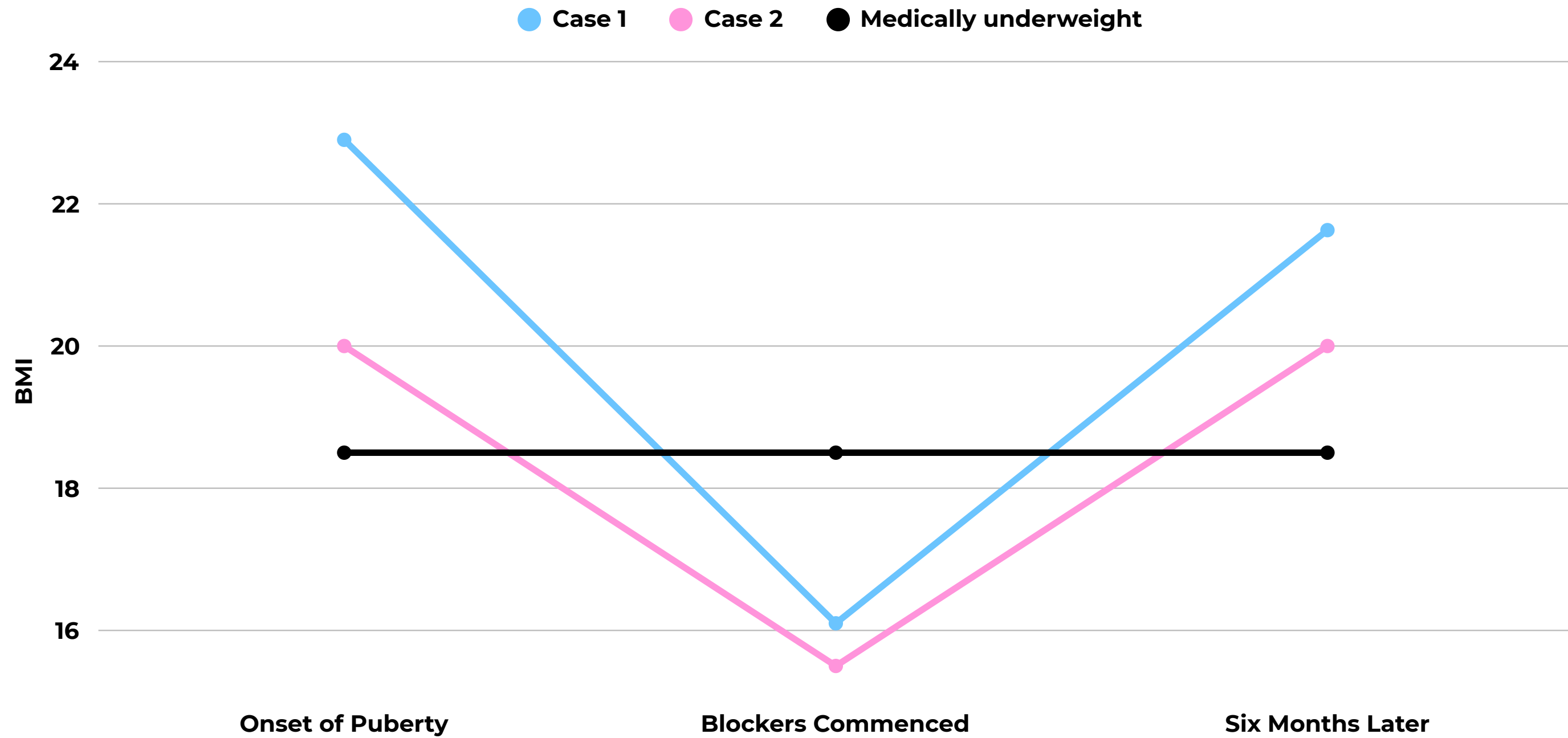
**Function  
unrelated to  
gender  
4.8%**

**Function  
related to  
gender  
95.2%**

# HORMONAL SUPPRESSION

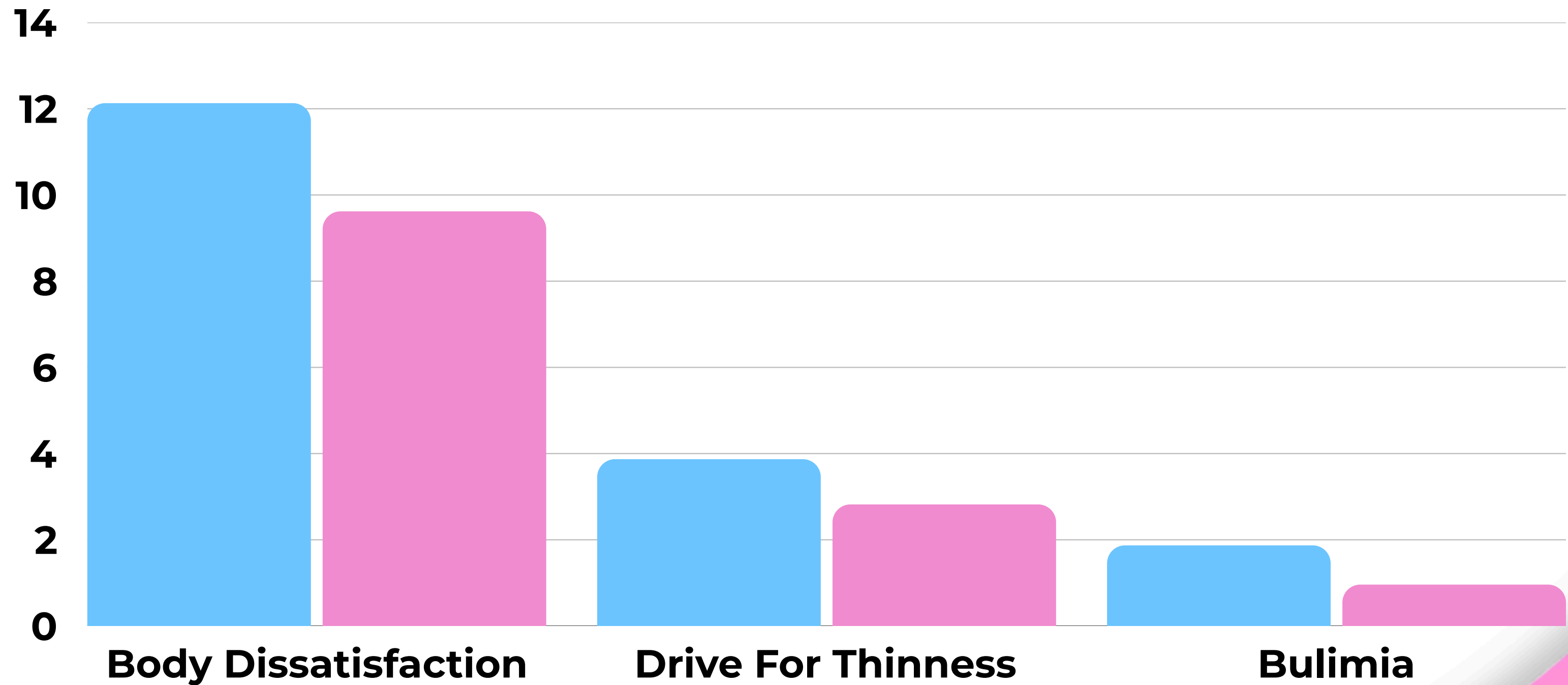


# PUBERTAL SUPPRESSION



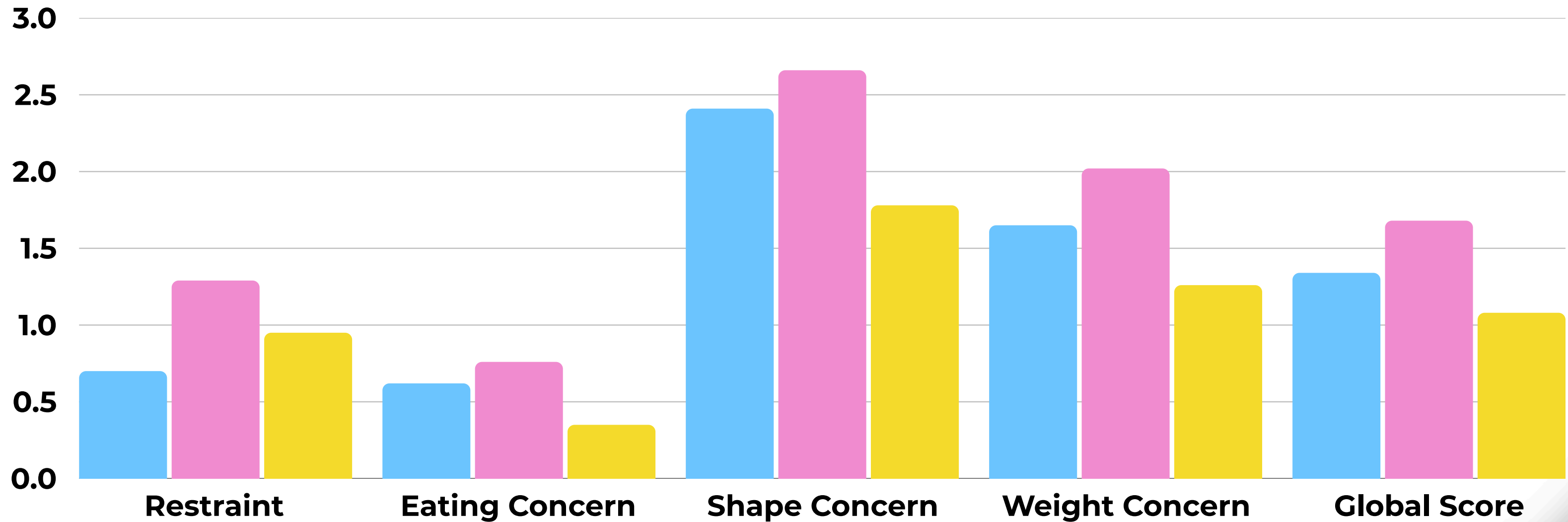
# IMPACT OF HRT ON DEBS

● No Hormones    ● Hormones



# IMPACT OF HRT & SURGERY

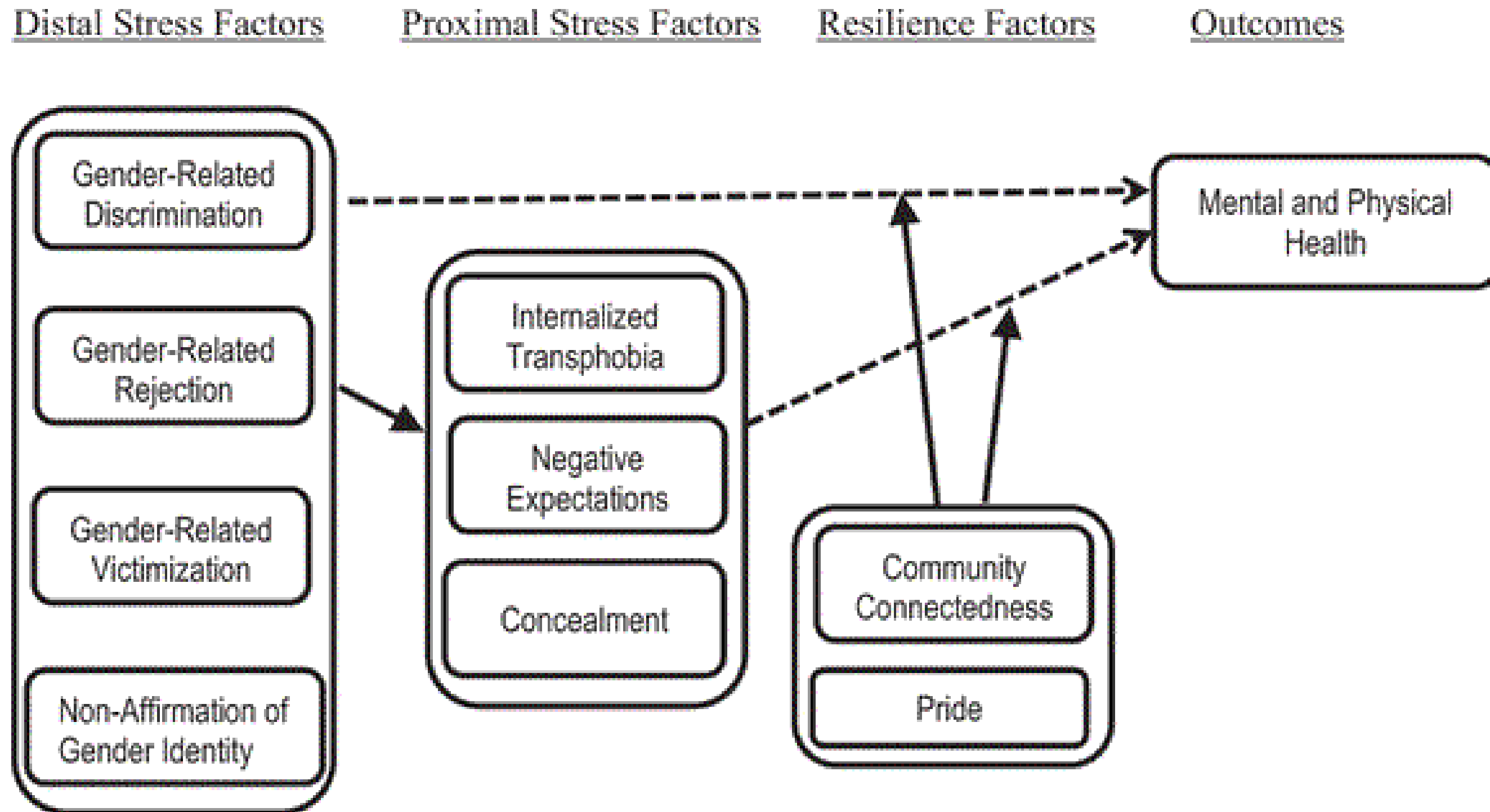
● Hormone/Surgery-Naïve    ● Hormone-Experienced/Surgery-Naïve  
● Hormone/Surgery-Experienced



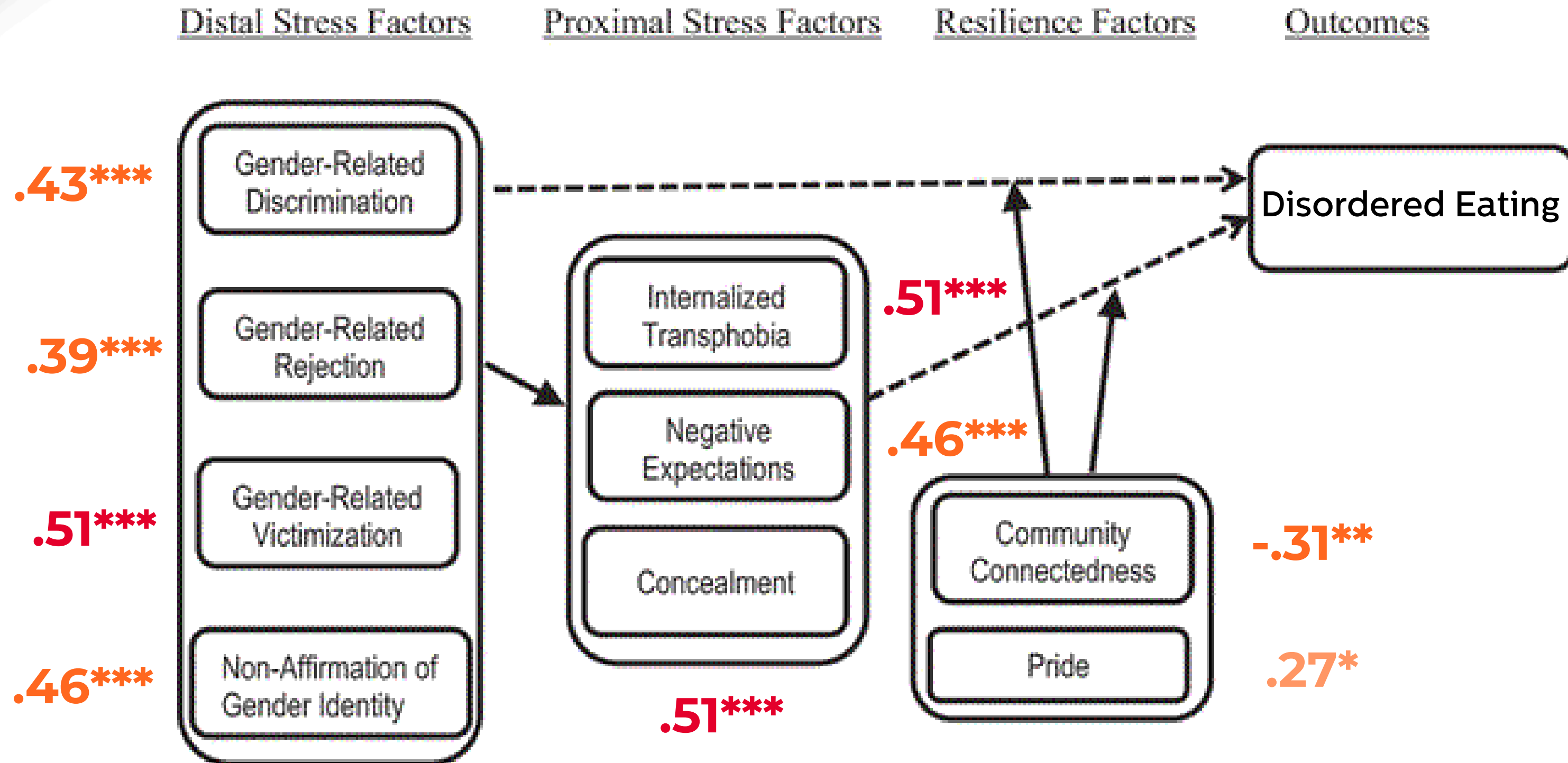


# MINORITY STRESS

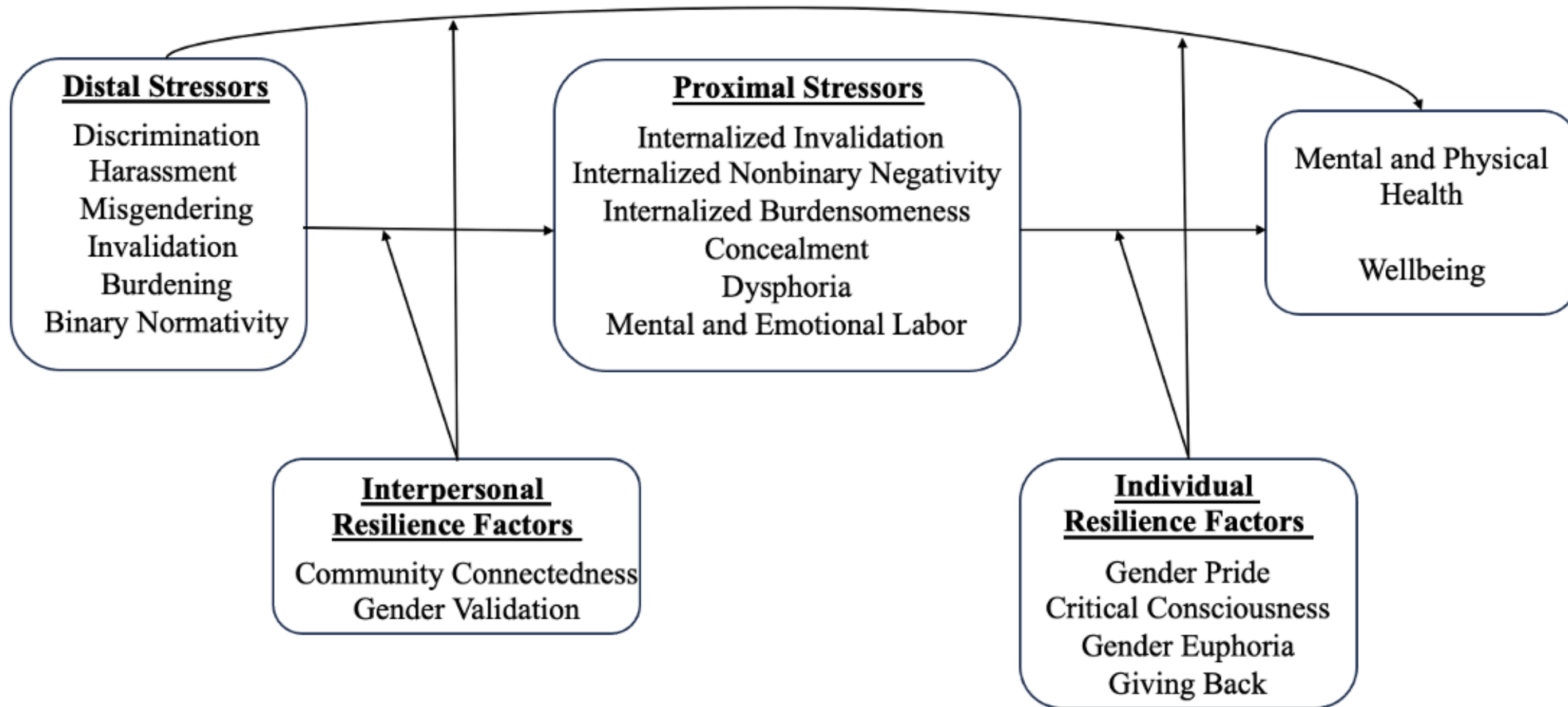
# GENDER MINORITY STRESS MODEL



# GENDER MINORITY STRESS MODEL



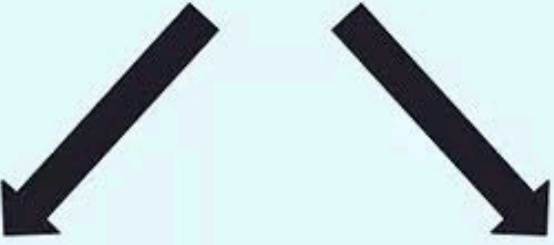
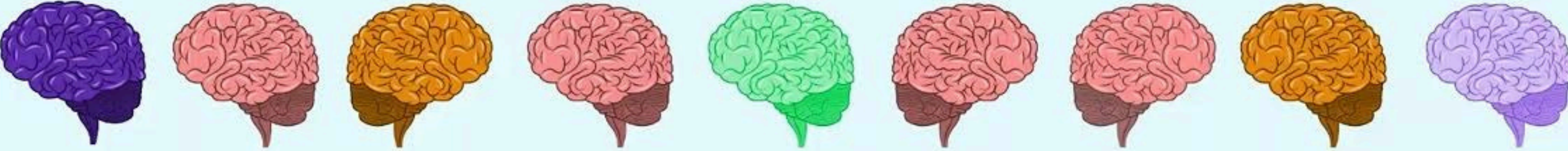
# NON-BINARY MINORITY STRESS MODEL





# NEURODIVERGENCE

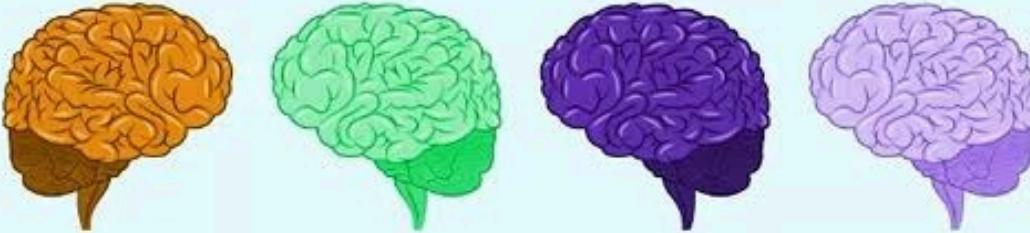
# Neurodiversity



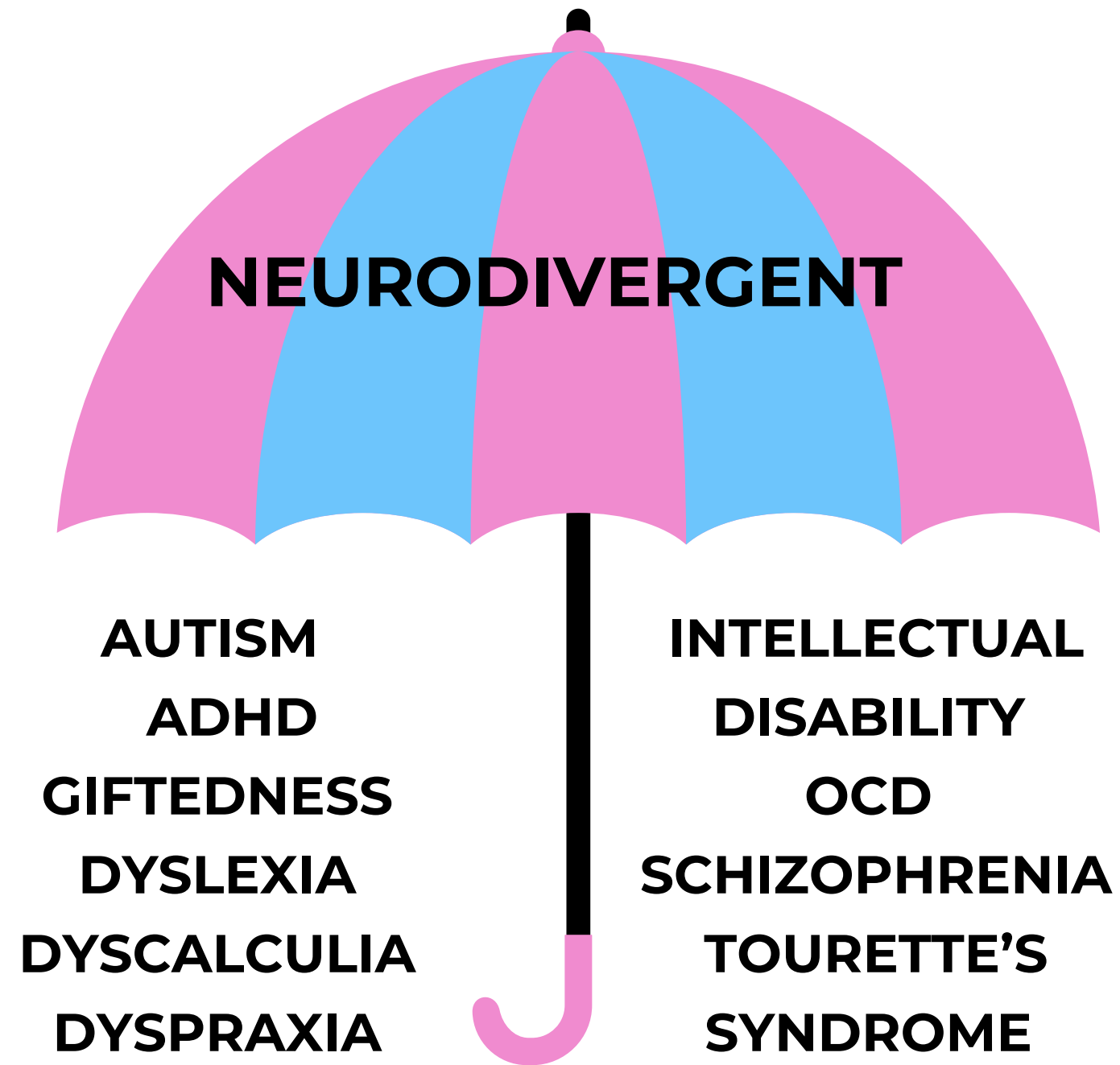
## Neurotypical



## Neurodivergent



# WHAT IS NEURODIVERGENCE?





**SENSORY PROCESSING**



**EXECUTIVE FUNCTION**



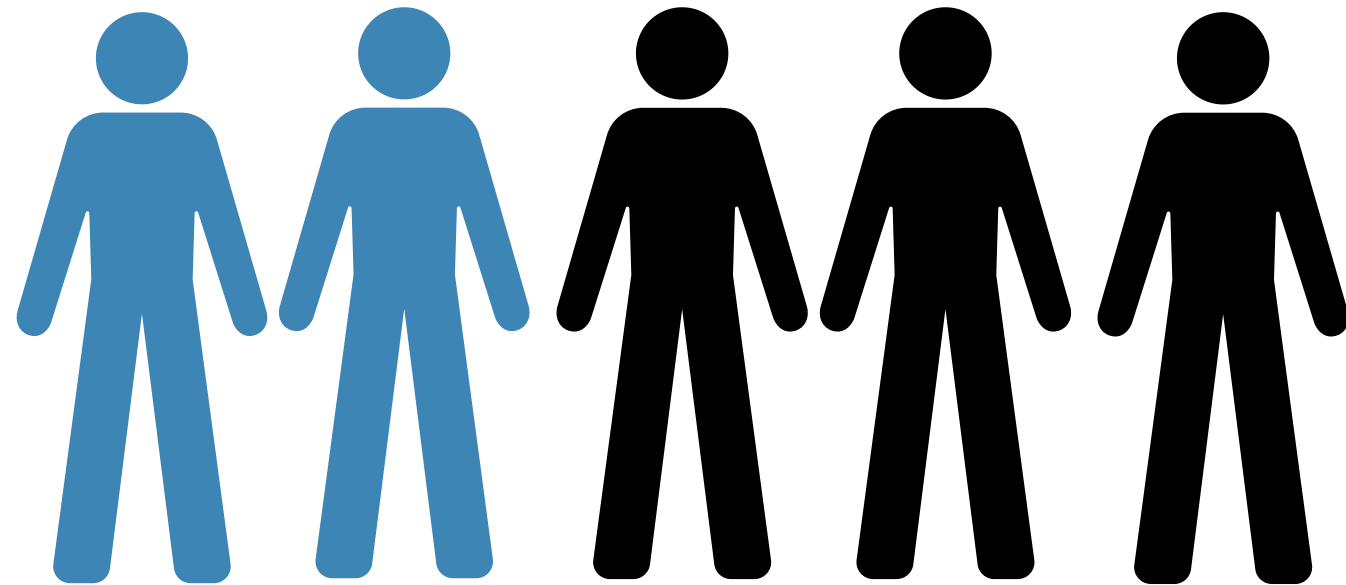
**SOCIAL AND COMMUNICATION**



**THINKING AND LEARNING  
STYLES**

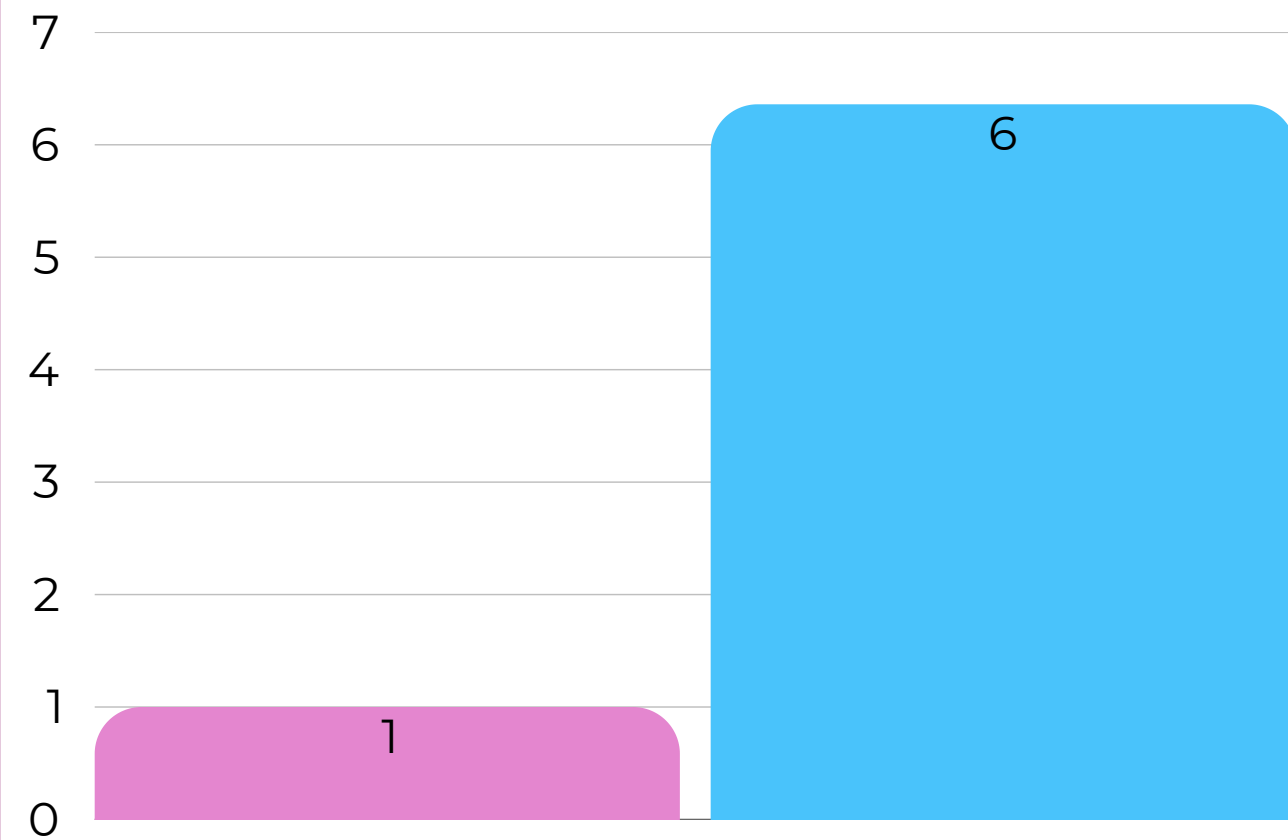
# AUTISM

2 IN 5



( BOUZY ET AL., 2023)

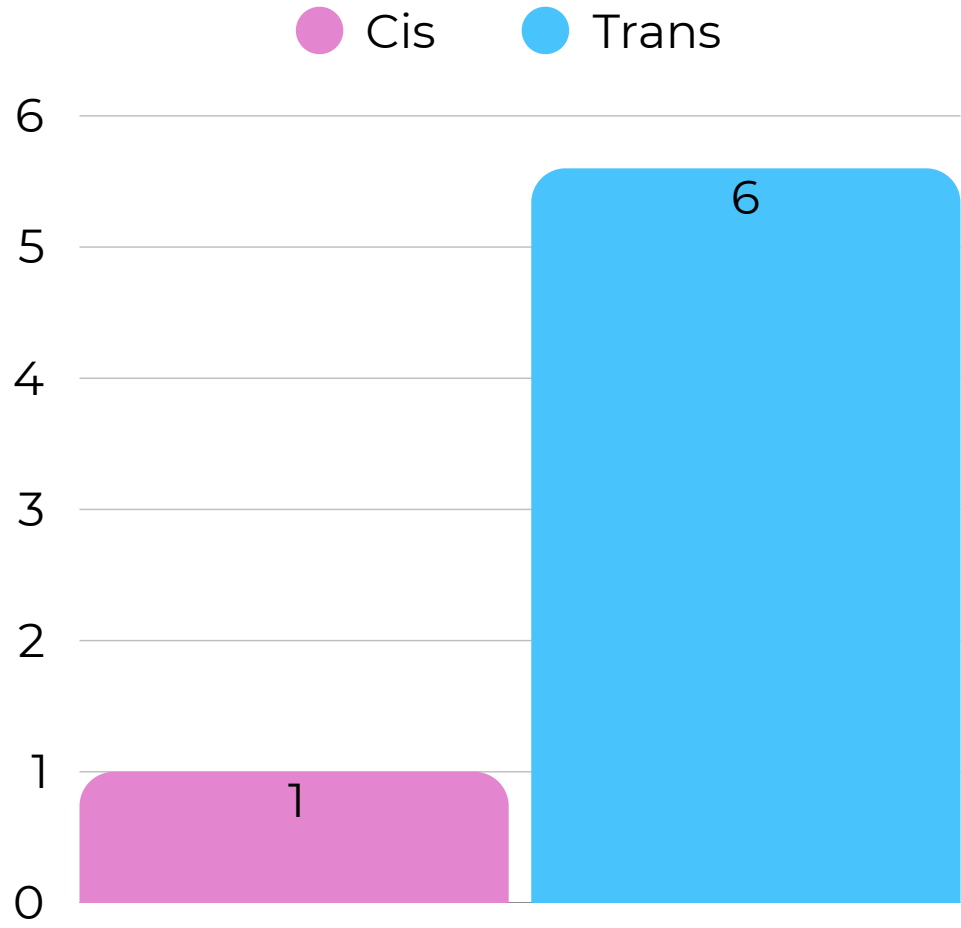
● Cis ● Trans



( WARRIER ET AL., 2020)

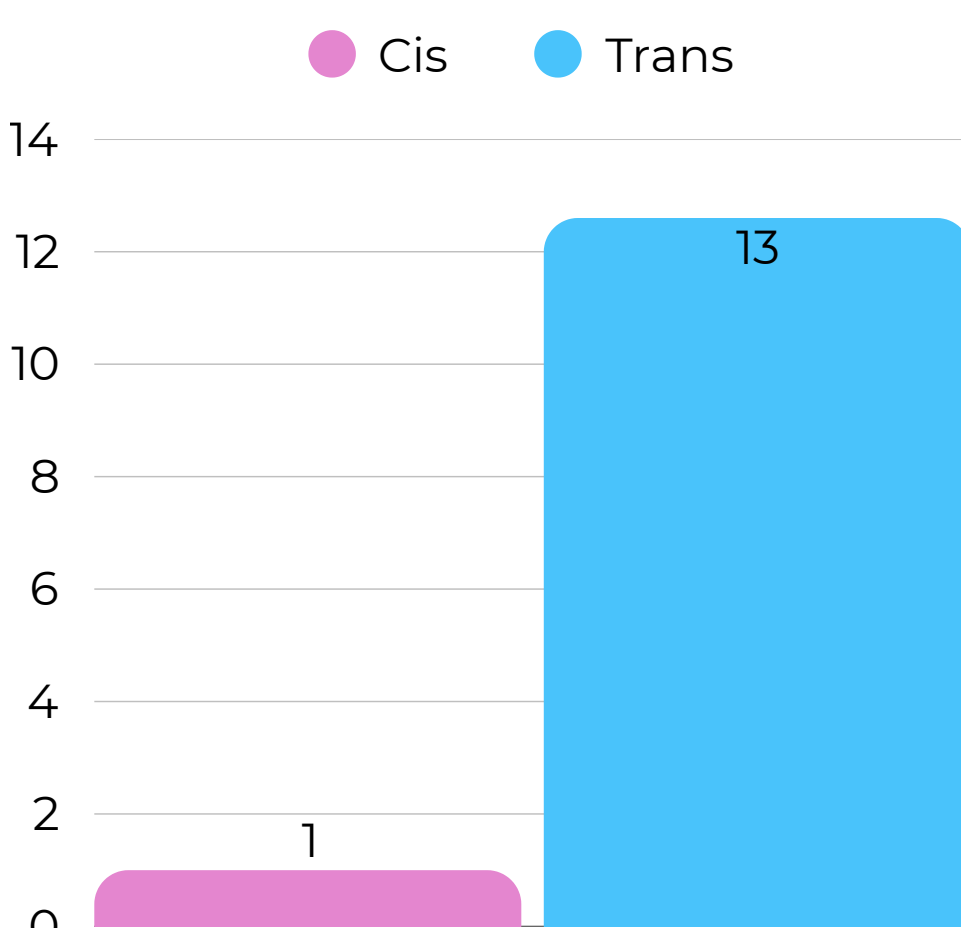
# ADHD

## CHILDREN



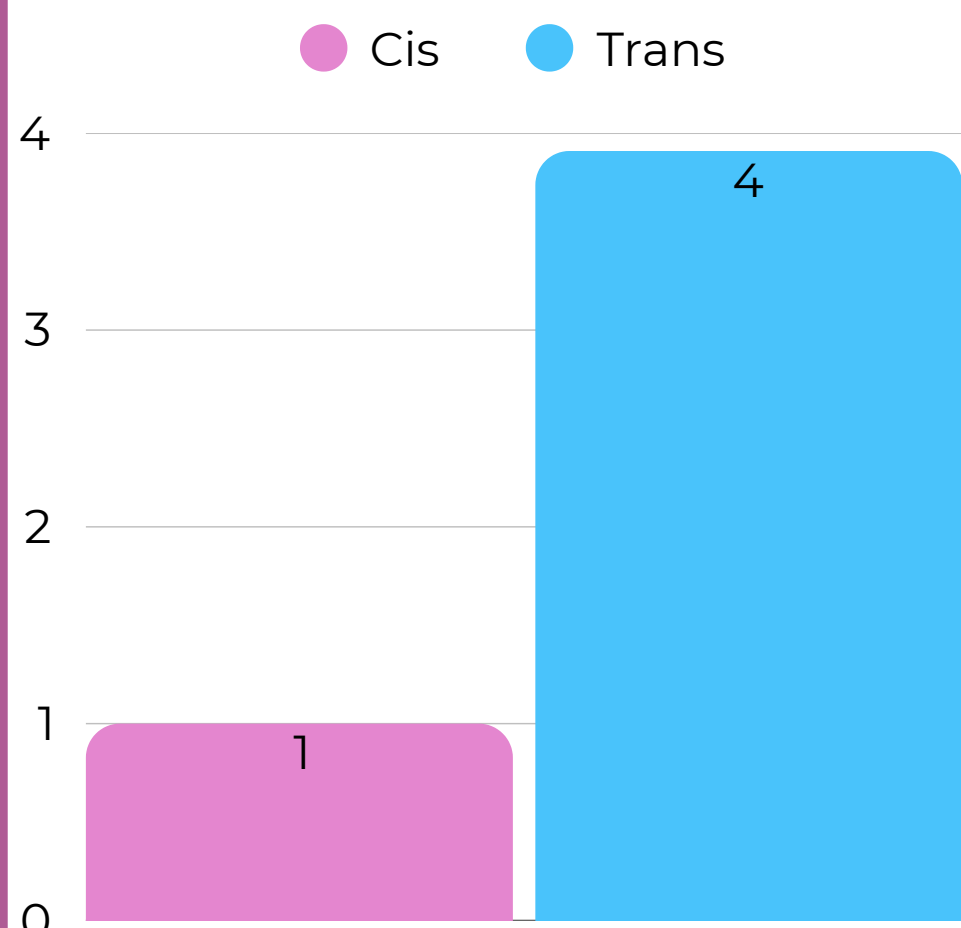
(BECERRA- CULQUI ET AL., 2018)

## TEENS



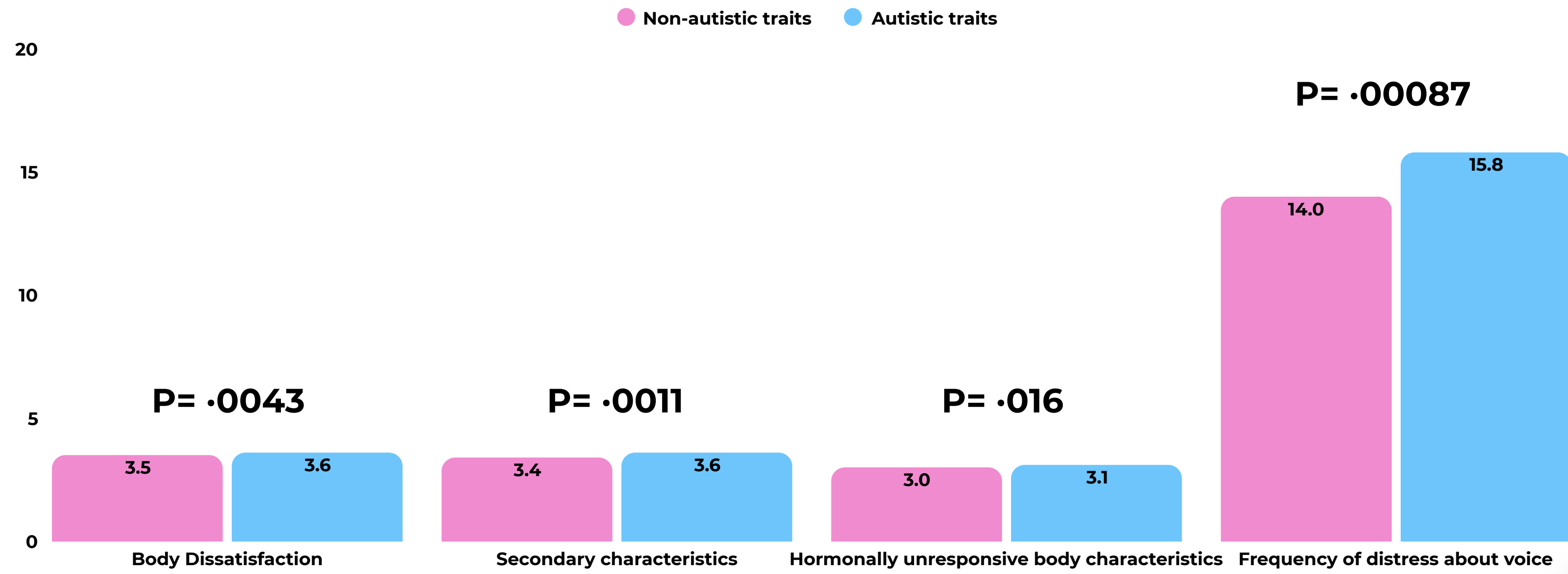
(BECERRA- CULQUI ET AL., 2018)

## ADULTS

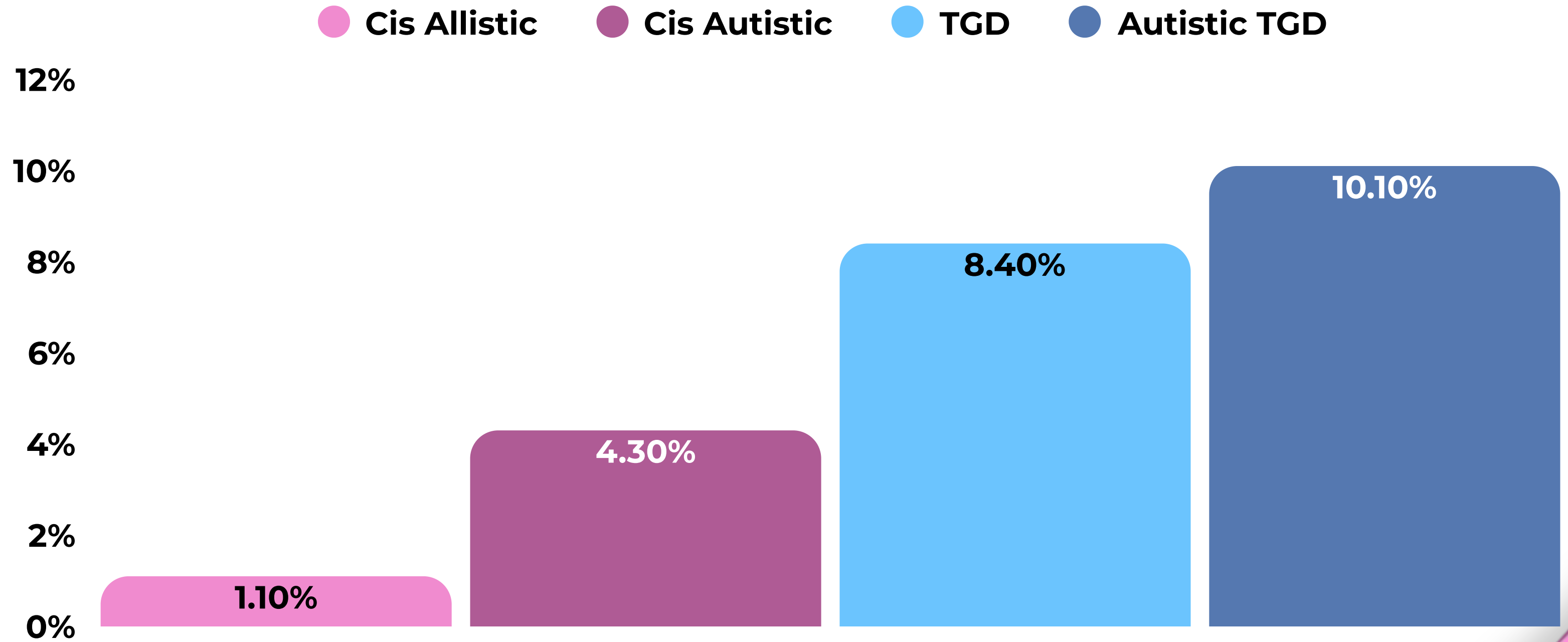


(CHEUNG ET AL., 2018)

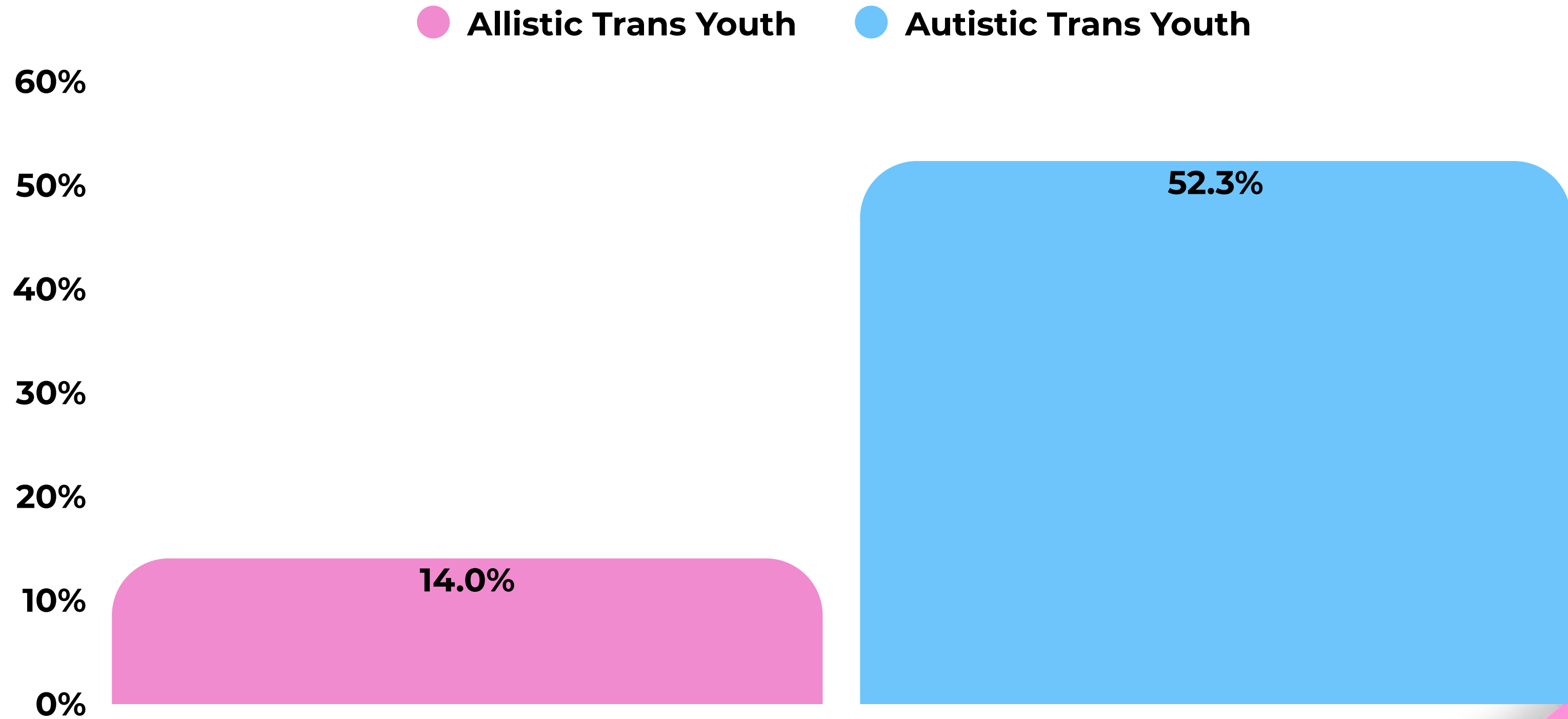
# DIFFERENCES IN DYSPHORIA



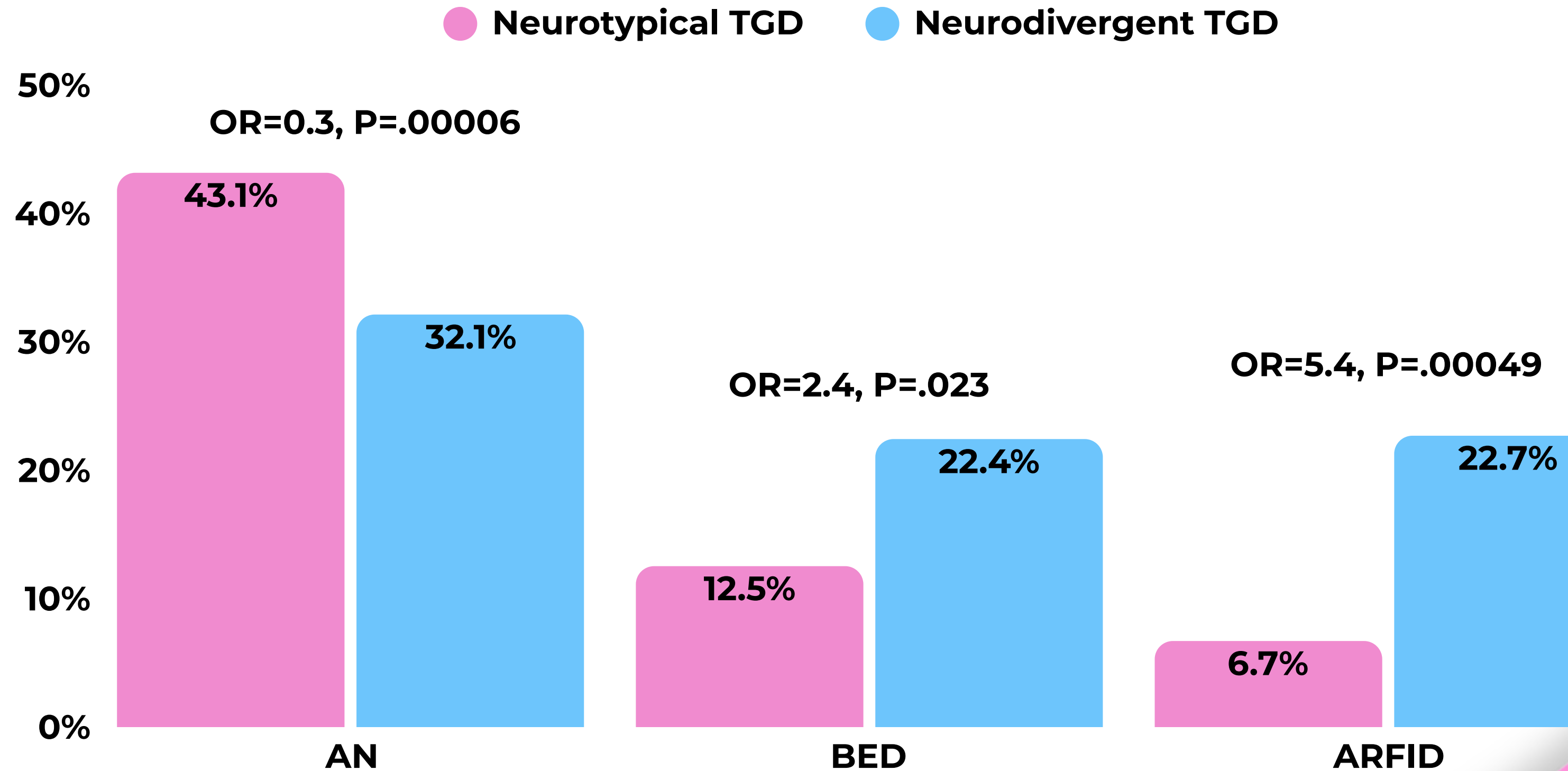
# ED DIAGNOSIS



# ED DIAGNOSES



# ED DIAGNOSES





# **SUPPORTING TRANS FOLKS WITH EATING DISORDERS**



# TREATMENT TYPES & PATHWAYS

## Psychological

- Adolescent Focused Therapy (AFT)
- Cognitive Behavioural Therapy Guided Self Help (CBT-GSH)
- Enhanced Cognitive Behavioural Therapy (CBT-E)
- Family Based Treatment (FBT)
- Focal Psychodynamic Therapy (FPT)
- Interpersonal Psychotherapy (IPT)
- Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA)
- Specialist Supportive Clinical Management (SSCM)

## Pharmacological

- Brexpiprazole
- Fluoxetine
- Ketamine
- Lisdexamfetamine
- Metreleptin
- Olanzapine
- Psilocybin
- Zinc supplementation

## Emerging

- Deep Brain Stimulation (DBS)
- Faecal Microbiota Transplant (FMT)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Transcranial Direct Current Stimulation (tDCS)
- Virtual Reality Therapies

## Psychological

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# MULTI-DISCIPLINARY TEAM

## Medical

- GP
- Specialists (for co-occurring conditions)

## Mental Health

- Psychologist
- Psychiatrist
- Counsellor

## Support Services

- Peer navigator/peer support worker
- Local area coordinator (NDIS)
- NDIS / support workers

## Allied Health

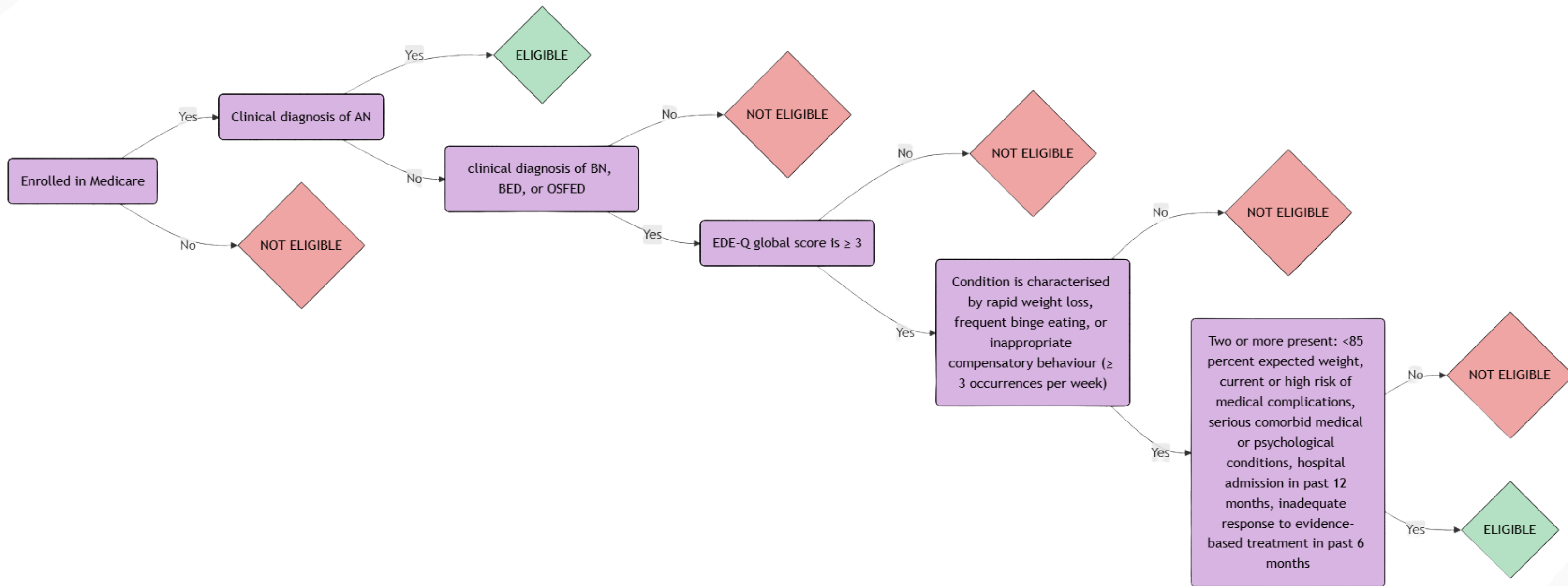
- Dietitian
- Occupational Therapist
- Physiotherapist

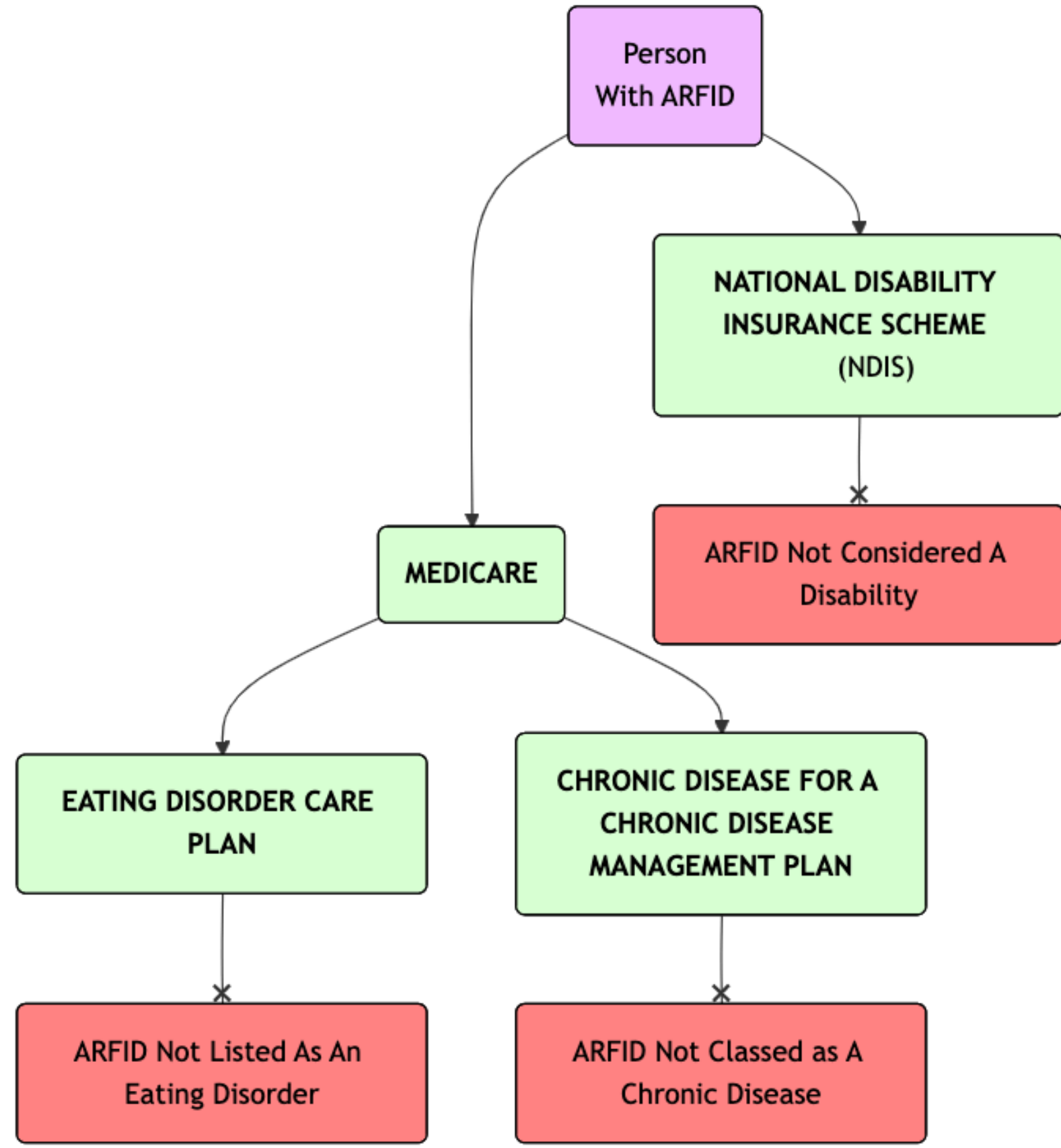


Eating Disorder Treatment  
and Management Plan  
(EDP)

Mental Health Care Plan  
(MHCP)

Chronic Disease  
Management Plan (CDMP)





EDP Criterion	Barriers and Harms for Trans and Gender Diverse (TGD) People
<b>Clinical diagnosis of anorexia nervosa</b>	<ul style="list-style-type: none"> <li>• TGD people are less likely to be diagnosed with anorexia nervosa due to weight-based, gendered, and biased diagnostic schemas.</li> <li>• Atypical anorexia nervosa is more common and less likely to trigger care eligibility.</li> </ul>
<b>Clinical diagnosis of bulimia nervosa, binge-eating disorder, or OSFED</b>	<ul style="list-style-type: none"> <li>• ARFID is highly prevalent in TGD populations, yet is not included in EDP eligibility criteria, excluding a large portion of those needing care.</li> </ul>
<b>Reliance on EDE-Q global score <math>\geq 3</math></b>	<ul style="list-style-type: none"> <li>• The EDE-Q has not been validated in TGD people.</li> </ul>
<b>Behaviour frequency <math>\geq 3</math> times per week</b>	<ul style="list-style-type: none"> <li>• TGD people often present with restrictive patterns, chaotic eating, or compensatory behaviours that do not map to these weekly frequency thresholds.</li> </ul>
<b>Weight indicator: &lt;85 percent expected weight</b>	<ul style="list-style-type: none"> <li>• Trans adolescents reach medical instability at higher weights.</li> <li>• BMI and “expected weight” calculations are poor fit for trans bodies</li> </ul>
<b>Current or high risk of medical complications</b>	<ul style="list-style-type: none"> <li>• Complications may be misattributed to gender-affirming medical care rather than the ED (trans broken arm syndrome)</li> </ul>
<b>Hospital admission in past 12 months</b>	<ul style="list-style-type: none"> <li>• TGD people are less likely to seek or access hospital care due to discrimination, gatekeeping, trauma history, and non-affirming environments</li> </ul>
<b>Inadequate response to evidence-based treatment in past 6 months</b>	<ul style="list-style-type: none"> <li>• “Evidence-based” treatments are rarely designed for or tested with TGD people. Lack of response reflects treatment inappropriateness rather than patient failure.</li> </ul>



# SCREENING

# SCREENING

*Most tools don't capture TGD experiences. They misclassify or miss symptoms, and rely on harmful metrics like BMI.*

**Used tools  
validated in  
gender diverse  
populations**

**Avoid gendered  
cut-offs and  
thresholds (e.g.  
BMI)**

**Use DEXA,  
serology, and  
other measures of  
health wherever  
possible**

*“The first time I spoke to a doctor and said I think I might have disordered eating, they're like, ‘You can't be diagnosed with that because you're overweight.’ I'm like, thank you. That has just made it worse.”*

# ED SCREENING TOOLS

**Nine-Item  
Avoidant/Restrictive  
Food Intake Disorder  
Screen (NIAS)**

**The Sick, Control,  
One Stone, Fat, Food  
(SCOFF)** \*

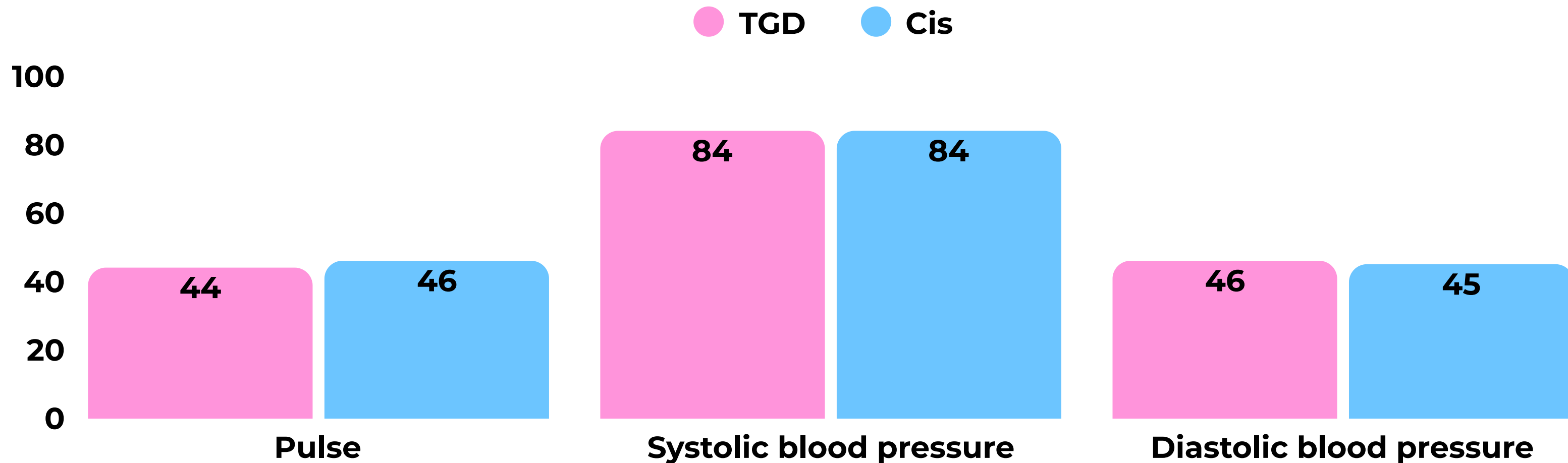
**Adolescent Binge  
Eating Disorder  
Measure (ADO-BED)**

**Eating Disorder  
Examination  
Questionnaire Short  
Form (EDE-QS)**

*\*I would not recommend the use of the SCOFF*

## BMI is a poor measure of risk in trans people

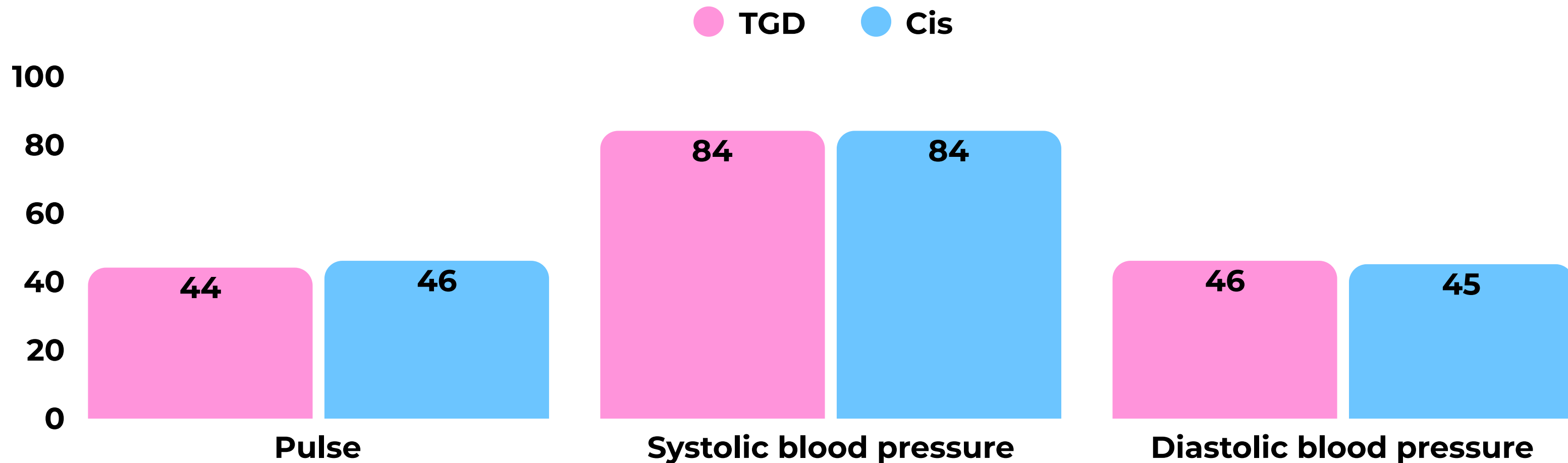
Trans teens with EDs require hospitalisation at **higher BMI percentiles** than cis peers.



At a higher BMI, they have **equally severe** bradycardia, systolic hypotension, and diastolic hypotension.

## BMI is a poor measure of risk in trans people

Trans teens with EDs require hospitalisation at **higher BMI percentiles** than cis peers.



At a higher BMI, they have **equally severe** bradycardia, systolic hypotension, and diastolic hypotension.

# TRANS DISORDERED EATING SCALE



Question
1. I wore clothes that hid the shape of my body.
2. I was uncomfortable with the shape of my body because it did not fit with my gender.
3. I would experience negative changes to my mood (for example, anxiety or shame) if I had to skip a planned workout.
4. My dissatisfaction with my body is more related to gender than my weight.
5. I exercised with the goal of losing weight, losing fat, or becoming leaner.
6. I wanted to change the way I exercised after getting comments about my weight or size.
7. I was uncomfortable seeing my body.
8. I exercised to try to make my body more aligned with my gender.
9. I did not like specific parts of my body that did not align with my gender.
10. Losing or controlling my weight has allowed me to dress in ways that feel more in line with my gender.
11. I did a lot of cardio to try to lose body fat and make my body more aligned with my gender.
12. I wanted to change the way I ate after getting comments about my gender or gender expression.
13. Changing my weight would help me feel more comfortable expressing my gender.
14. I wanted to change the way I ate after getting comments about my weight or size.
15. I exercised to look smaller to more closely align my body with my gender identity.
16. I would be happy with the size of my body if the shape of my body was more aligned with my gender.
17. My dissatisfaction with my body is more related to my weight or shape than my gender.
18. Changing my weight would help me feel more gender euphoria.

# INPATIENT ADMISSION

Indicator	Medical Admission Criteria	Trans-Specific Considerations
<b>Weight and BMI</b>	BMI <12	<ul style="list-style-type: none"> <li>GAHT can alter body composition. BMI can therefore misclassify severity in some trans people.</li> </ul>
<b>Systolic BP</b>	<80 mmHg	<ul style="list-style-type: none"> <li>Spironolactone can lower BP. Testosterone caused mean systolic BP increase of 1.7 mmHg in trans men. Chest binding may restrict comfort during vitals.</li> </ul>
<b>Postural BP</b>	>20 mmHg drop with standing	<ul style="list-style-type: none"> <li>See above regarding spironolactone</li> </ul>
<b>Heart rate</b>	≤40 bpm or >120 bpm or PT >20 per minute	<ul style="list-style-type: none"> <li>Testosterone therapy improves postural tachycardia in trans masculine adolescents with POTS. May mask severity.</li> </ul>
<b>12 lead ECG</b>	Any arrhythmia including QTc prolongation, non-specific ST or T wave changes including inversion or biphasic waves	<ul style="list-style-type: none"> <li>cyproterone acetate and spironolactone both cause average of 19/1 ms prolongation of QTc interval</li> </ul>
<b>Potassium</b>	<3.0 mmol per L	<ul style="list-style-type: none"> <li>Purging usually lowers potassium, but spironolactone can mask or reverse hypokalaemia.</li> </ul>
<b>Other (not in criteria)</b>	Hypophosphataemia	<ul style="list-style-type: none"> <li>Potential side effect of oestrogen dose being too high.</li> </ul>

# BONE MINERAL DENSITY

- Trans feminine people have lower BMD pre-HRT than cis men.
- GnRHAs can also decrease BMD.
- People who have had an orchiectomy or oophorectomy, who take low-dose HRT or inconsistent administration, are at elevated risk of low BMD.
- Can be compounded by restrictive eating.
- More frequent monitoring may be necessary.
- DEXA scans should compare Z-scores to gender identity, not sex presumed at birth.



**TREATMENT**

# CONFIDENTIALITY

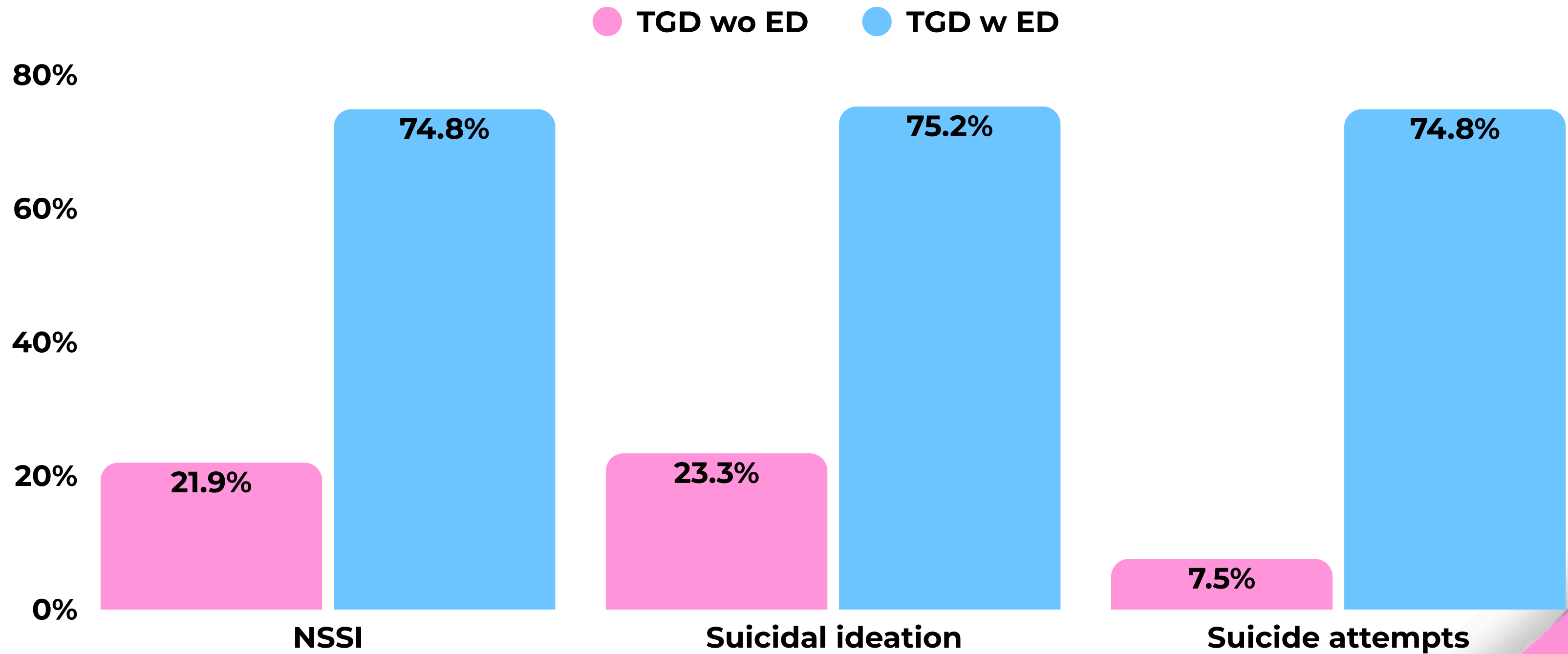
- Carefully consider with whom the person's identity and pronouns can be shared (E.g., family, other professionals, future referrals)
- Ensure that you explain all privacy and confidentiality limitations

Are there different contexts where you use one pronoun over the other?

How can staff support you if misgendering occurs?

If we have to use your birthname and different pronouns in family sessions, would you like to check in before and after to process how you feel?

# SUICIDE RISK



“working with [TGD] patients at risk for suicide necessitates cultivating a sense of hopefulness and envisioning a life worth living”



Sharing stories of adult TGD people who are thriving



Connecting them with peers



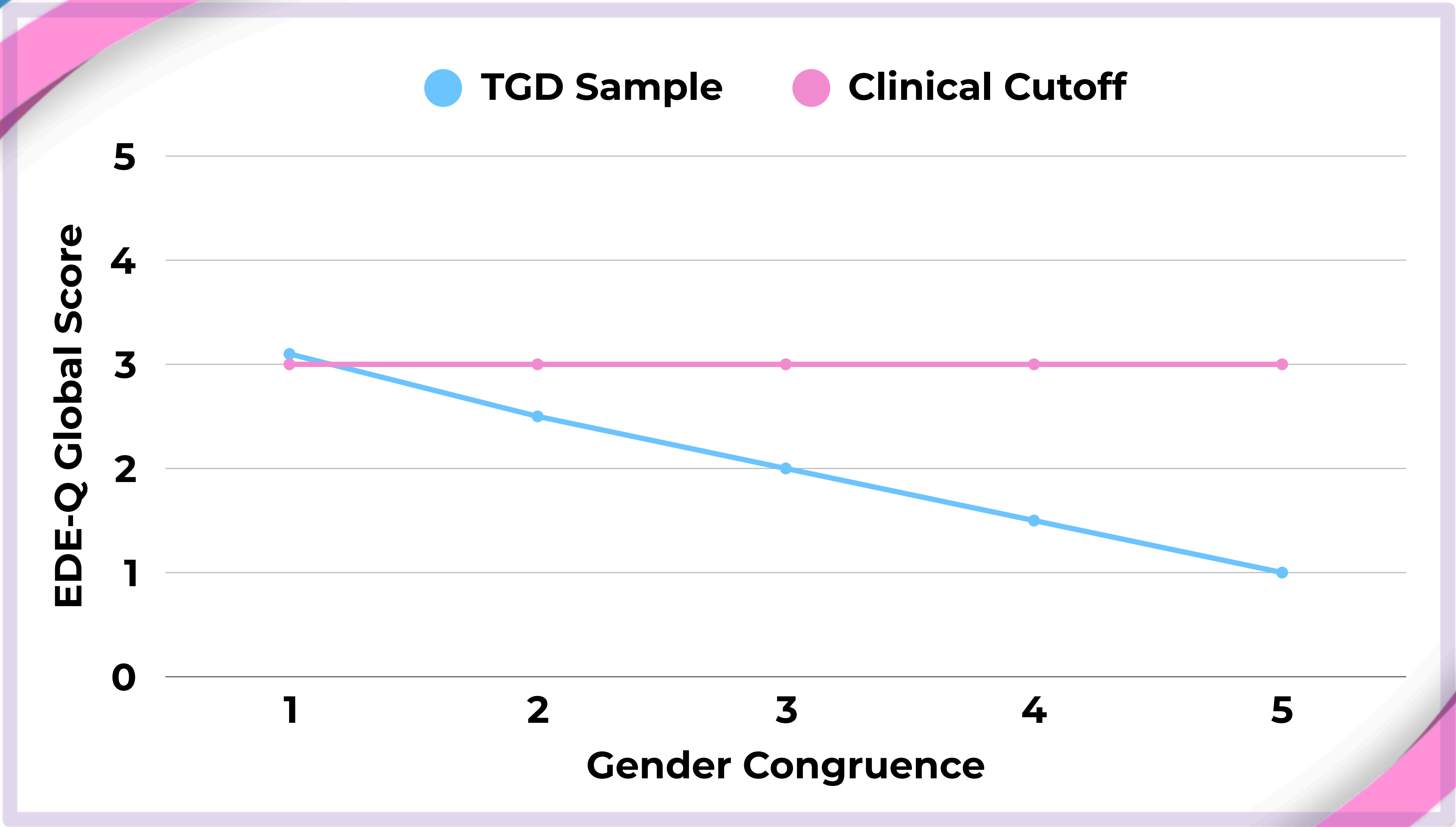
Validating trauma and exploring survival and resilience narratives

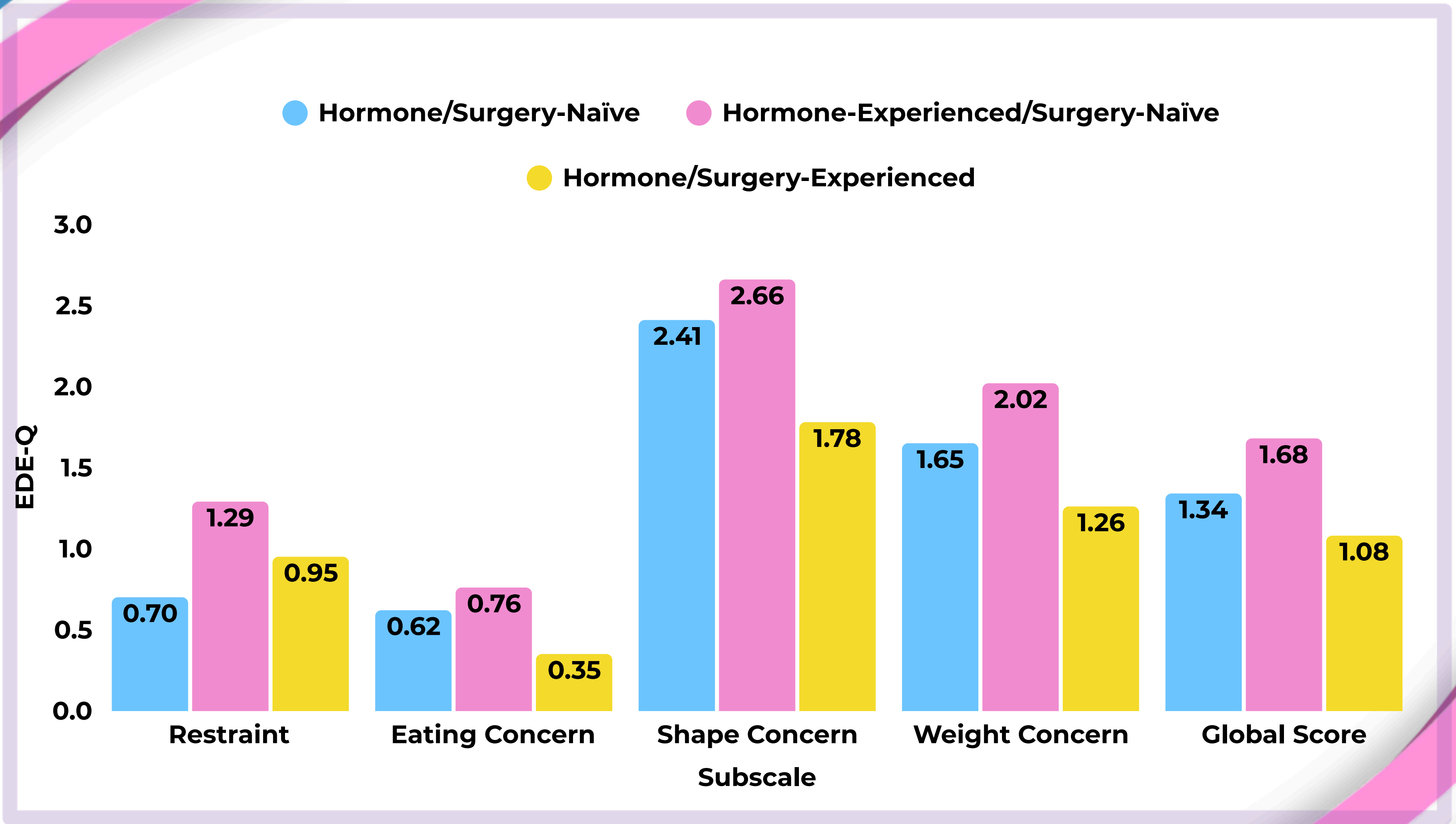


Making a plan to alleviate suffering from dysphoria and co-occurring mental health concerns

# ADDRESSING GENDER DYSPHORIA

<b>Function of ED</b>	<b>Treatment/Support</b>
<b>Pubertal Suppression</b>	Provide information about the psychosocial benefits and potential side effects of pubertal suppression. Engage with family/guardians/patient to explore GnRHAs as potential option. This can require a referral to a children's gender diversity service in some states.
<b>Reducing Appearance of Gendered Traits</b>	Discuss safe binding, safe tucking, and gender-affirming medical care options. Explain thoroughly what HRT and surgery will and won't change to provide realistic expectations. Conduct WPATH assessment if necessary. Provide any relevant referrals for doctors, surgeons, specialists.
<b>Menstrual Suppression</b>	Discuss options such as OCP and Tranexamic acid with the patient, explain potential menstrual suppression effect of testosterone. Refer to GP for access to these options.
<b>Compensatory Restrictive Eating for Lack of Exercise</b>	Provide some harm minimisation information regarding binding and exercise (no data to support it being dangerous). Allow patient to make informed decision weighing the risks and benefits of binding whilst exercising. Ongoingly monitor for any negative effects of binding. Collaborate with dietitians and exercise physiologists.





(Nowaskie et al., 2021)



# PSYCHOTHERAPIES

# CORE PRINCIPLES

- Should prioritise exploring what aspects of gendered embodiment could be euphoric, and try to manifest these sources
- Categorising thoughts, feelings, and experiences with their gender and body
- Developing an individualised plan for both gender-affirming and ED care
- Focus on distress tolerance and adaptive coping strategies drawn from DBT, ACT, and mindfulness

# FBT

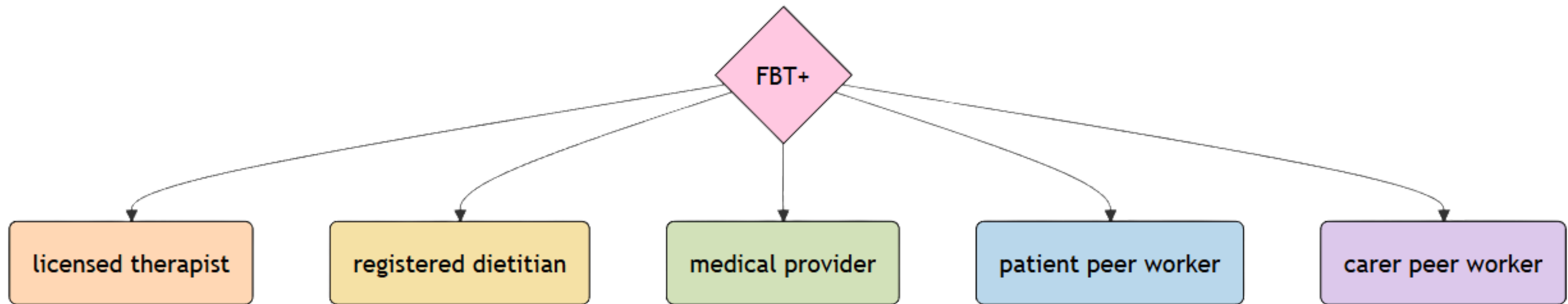
“it’s all about giving your parents the control you have, which can often mean...if they’re homophobic, or transphobic, or whatnot, your identity is sort of persecuted as well, because they’re the ones who now get to have control over who you are as a person, which extends to the gender you are, how you’re allowed to present yourself”

we know that the gold standard for that [eating disorder treatment]...is family-based therapy, but for many of my clients, their experience has been that their relationship with the parent or parents has become quite fractured.



(Schweizer et al., 2025)

# FBT



# CBT-E

**“Exposure doesn't help if it's not a symptom of a disease.”**

- Focuses on eliminating body avoidance and promoting body acceptance, which inherently does not work for TGD people
- Guided body exposure (E.g., mirror exposure) does not alleviate body distress due to gender dysphoria
- Body avoidance can be adaptive in TGD people
- Generally not considered appropriate for trans people, but if required adaptations needed.

# USING A TA-CBT APPROACH

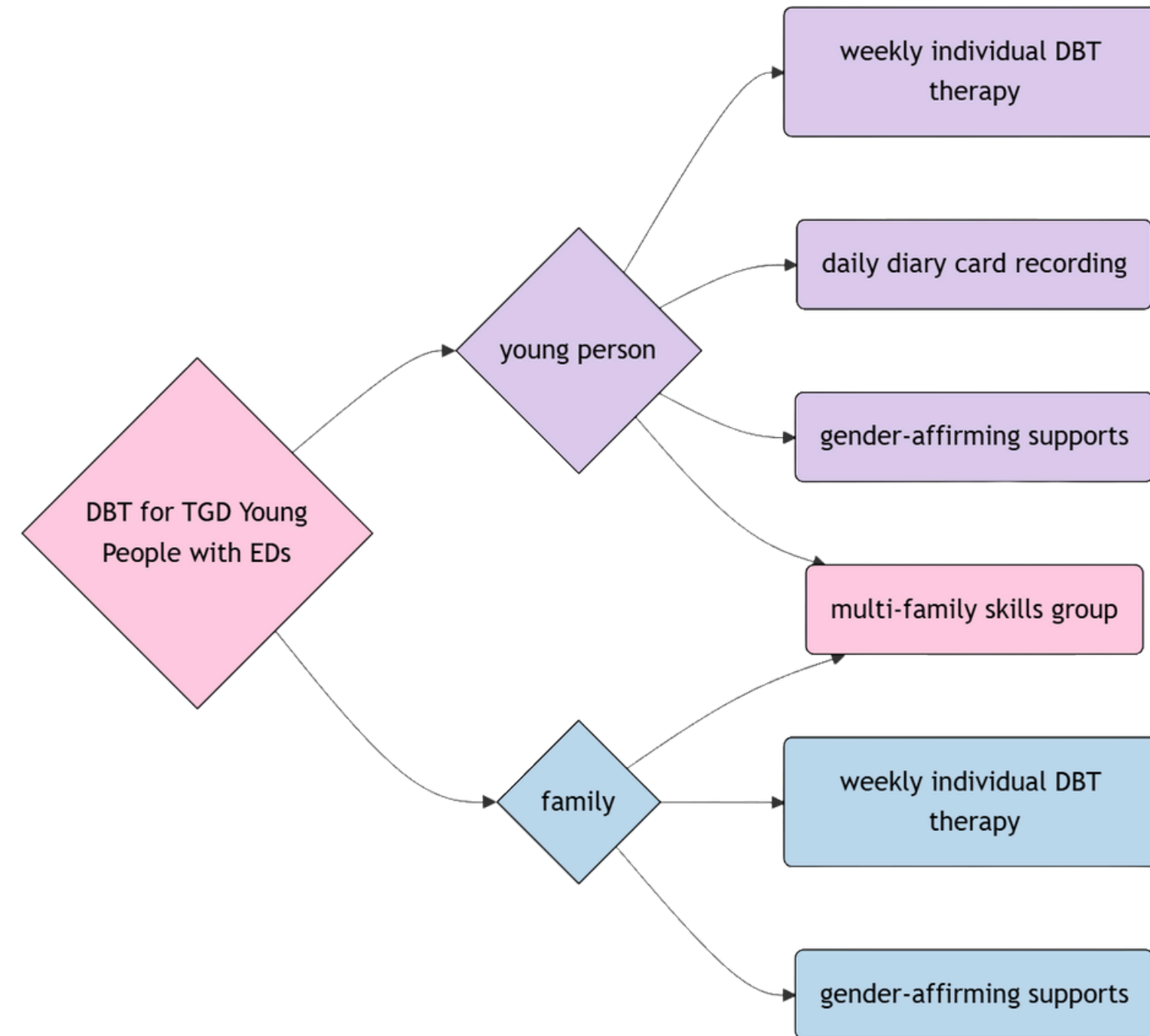
<b>Situation</b>	<b>Example Response</b>
<b>Support the client's reality that their current body does not conform with their internal gender identity or body ideals</b>	"What you are seeing in the mirror is different from what you would ideally like to see. Are there more adaptive ways to cope than restricting?"
<b>Validate feelings surrounding body incongruence</b>	"It is true that most women do not need to shave. That does not feel good."
<b>Challenge dysfunctional coping skills (such as restricting, binging, or purging)</b>	"It must have been hard that the server commented on your appetite, and I can see why you coped by restricting. Was there another way you could have responded?"
<b>Support effective, safe practices for changing the body</b>	"You are doing what you can and it's hard to wait. Hormones take time to work in the way you are seeking."

# USING A TA-CBT APPROACH

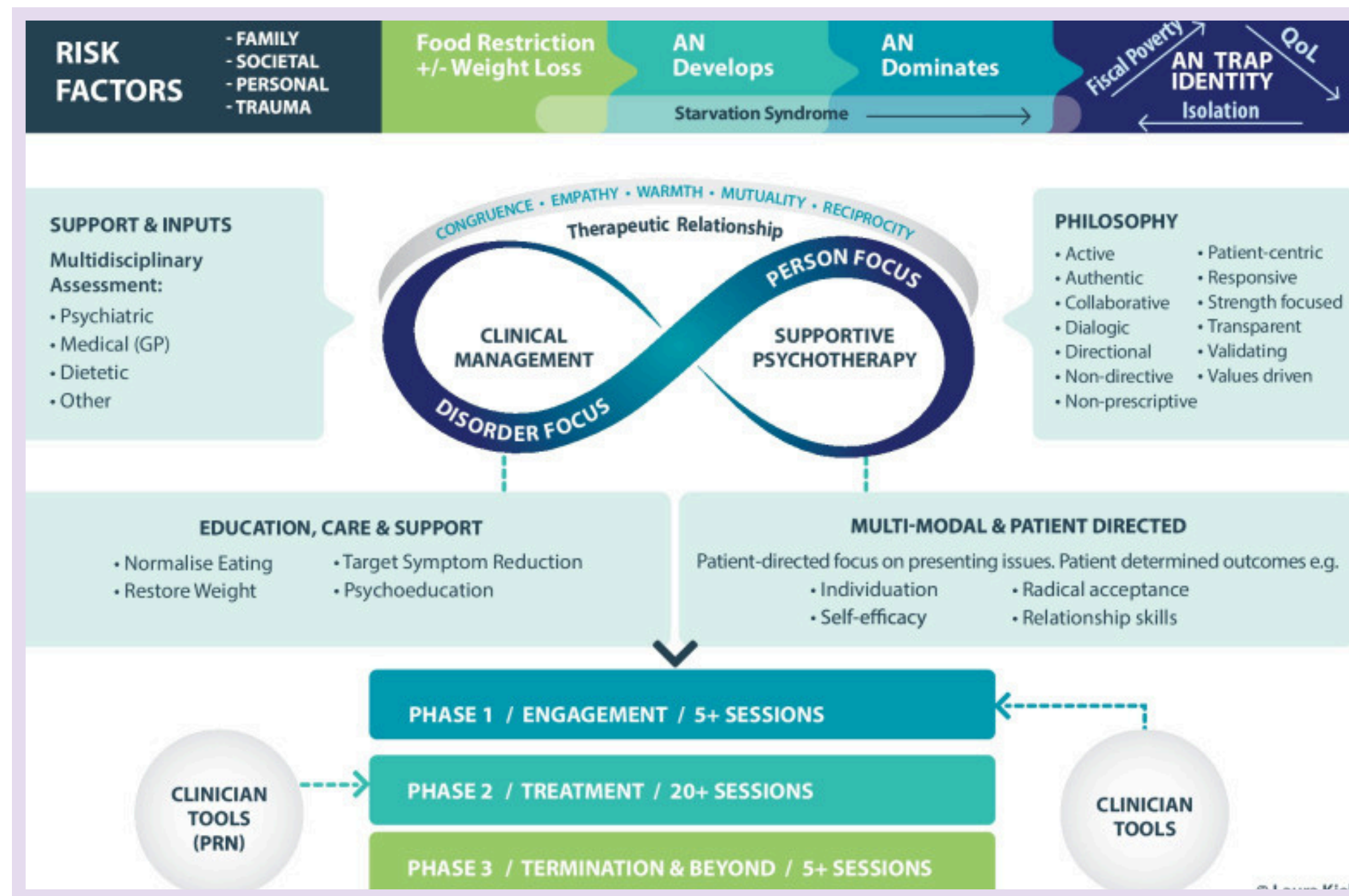
<b>Situation</b>	<b>Example Response</b>
<b>Facilitate supportive relationships and decrease avoidance behaviours</b>	“It is hard to go into a context where you are unsure about acceptance. I’ve had other trans clients attend this meeting and they have had great experiences.”
<b>Acknowledge transphobic policies</b>	“That situation did feel very isolating. Are you handling it in the most effective way you can?”
<b>Support assertive behaviors</b>	“It is frustrating that that program does not take trans men. Perhaps you could call your insurance company to seek support from a program that does.”

# DBT

- Maladaptive behaviours are seen as attempts to solve real problems
- Clinicians validate patients' experience of pain while teaching them new skills to solve those problems

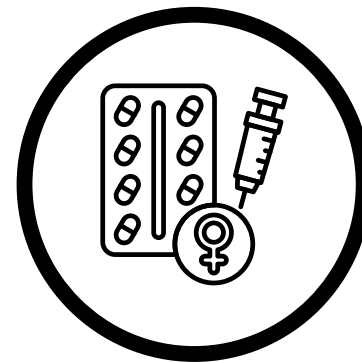


# SPECIALIST SUPPORTIVE CLINICAL MANAGEMENT

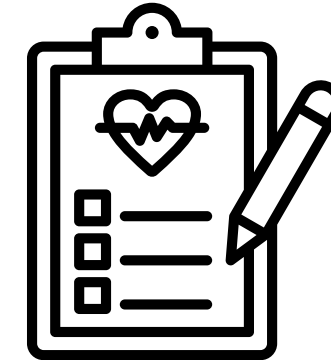




**Affirm names  
and pronouns**



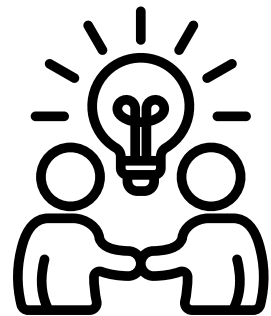
**Integrate GAMC**



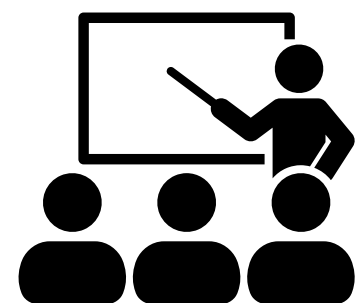
**Use validated  
screening tools**



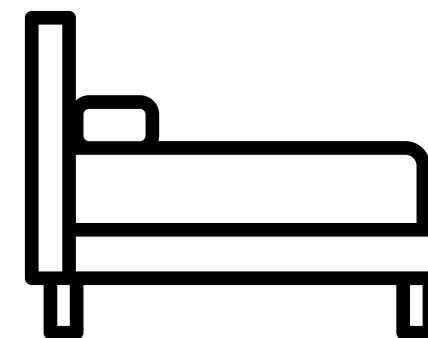
**Replace BMI  
with inclusive  
measures**



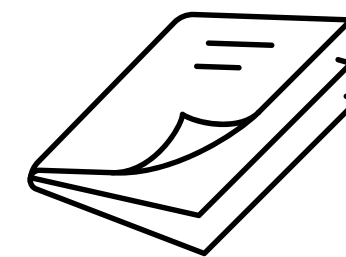
**Co-design services  
with TGD people**



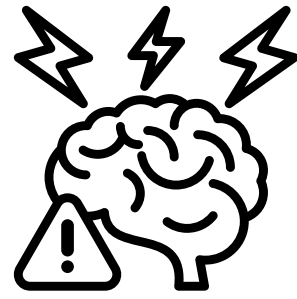
**Train clinicians  
continuously**



**Provide gender  
inclusive facilities**



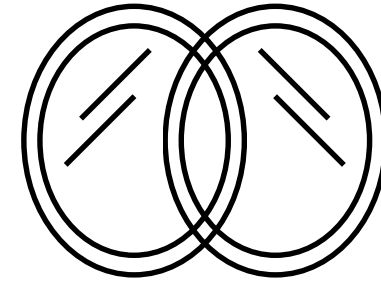
**Gender-neutral  
patient materials**



**Address  
minority  
stress**



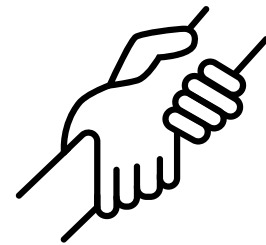
**Avoid harmful  
exposure tasks**



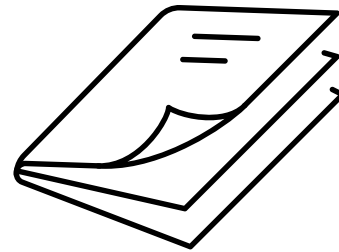
**Differentiate  
between dysphoria  
& dysmorphia**



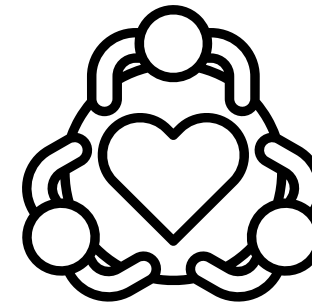
**Explore gender  
euphoria**



**Hire patient &  
carer peer  
workers**



**Gender-neutral  
patient materials**



**Host a TGD  
recovery group**



**1**

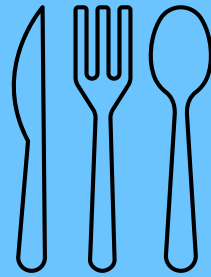
What are the disordered eating behaviours?

**2**

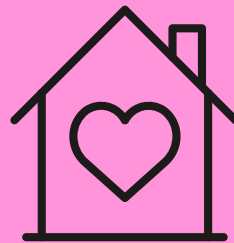
What function do the behaviours serve?  
What need is being met?

**3**

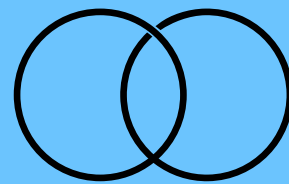
What healthier ways can these needs  
be met?



## DIFFERENTIATING GENDER DYSPHORIA AND BODY DYSMORPHIC DISORDER



## SUPPORTING YOUR TRANS CHILD WITH DISORDERED EATING

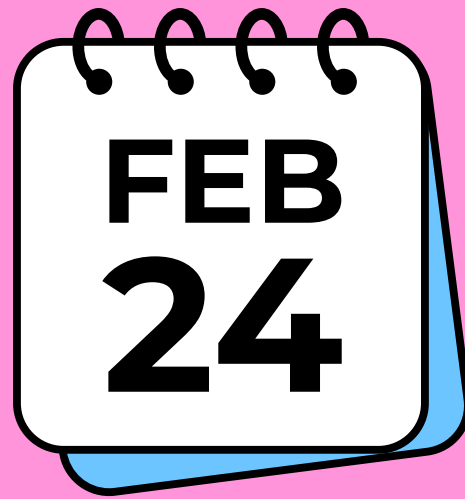


## NEURODIVERGENCE, GENDER DIVERSITY, AND EATING DISORDERS



## SUPPORTING AUTISTIC TRANS AND GENDER DIVERSE PEOPLE





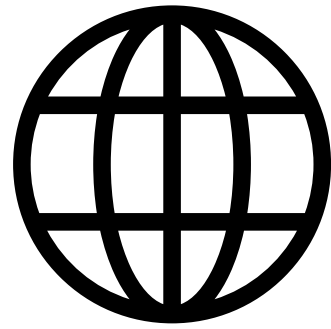
## Differentiating Gender Dysphoria and Body Dysmorphic Disorder

 9:30-11:30 AWST/12:30-2:30 AEDT

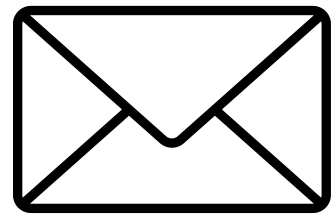


# QUESTIONS?

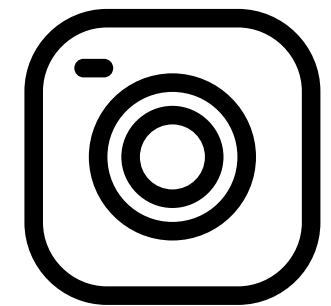
Contact me!



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[@kai.schweizer](https://www.instagram.com/kai.schweizer)