TGD People and Eating Disorders:
Australian Human Rights Commission
Current and Emerging Threats to TGD Human Rights

Joint Submission from
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About the Contributors

Kai Schweizer (they/he) is an AuDHDer, researcher, sexologist, and PhD student with the University of Western Australia and the Telethon Kids Institute. Kai's core research focus is the eating and exercise behaviours of trans and gender diverse people. Their PhD project focuses on improving eating disorder treatment for trans and gender diverse people.

Lumen Gorrie (they/them) is a clinical psychologist in Naarm, supporting neurodivergent, queer, trans, chronically ill, and disabled community members navigating eating disorders or differences. Outside of this, Lumen is also involved in advocacy and education, focussed on increasing accessibility and inclusivity for marginalised individuals across healthcare, systemic, and broader community contexts. Lumen holds lived experience as a queer, nonbinary trans, autistic ADHDer, and has history of an eating disorder.

Hayden Moon (he/him, they/them) is a PhD candidate in Theatre and Performance Studies at the University of Sydney, an author and a well-known transgender advocate. Hayden's work has been published widely with Junkee, Archer Magazine and a recent Chapter in 'Nothing To Hide - Voices of Trans and Gender Diverse Australia'. Hayden frequently advocates for the LGBTQIA+ community and has performed Keynote speeches at the Australasian Reproductive and Sexual Health Conference and the Australian Youth Futures Summit. In 2020, he was named 'Student of the Year' in Out for Australia's 30 under 30 Awards and received the Charles Perkins Memorial Prize for Academic Achievement at the University of Sydney. Hayden is also Autistic and has lived experience of an eating disorder.

Majella Jones (they/them) is an Accredited Practising Dietitian and PhD Student at Monash University based in Naarm. Their clinical practice and professional education workshops involve advocating for, and supporting those who are trans and gender diverse, neurodivergent, chronically ill and disabled, and experiencing an eating disorder or navigating eating difficulties and differences. Their research is exploring trans and gender diverse health and nutrition towards improving education and standards of practice in healthcare. Majella has lived experience as a nonbinary bipolar autistic person with a history of an eating disorder.

Positionality of Contributors

Our personal and professional values are grounded in approaches central to identity-affirming and accessible support, including depathologising, intersectional, trauma-informed, harm reductionist, anti-oppressive, anti-ableist, and weight/body-inclusive approaches.

Acknowledgement of Country

We acknowledge the traditional custodians of the lands on which we live and work/where this research was conducted. This includes the lands of the Cadigal people, the Whadjuk Noongar people, and the Wurrundjeri people. We pay our respects to Elders past and present. We recognise that sovereignty was never ceded and that decolonisation is an ongoing project. This always was and always will be Aboriginal Land.

We 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. We 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.

Terminology Within This Paper

Transgender and gender diverse (TGD) encompasses people of all experiences and expressions of people and communities whose gender differs from what was socially attributed to the sex assumed to them at birth. It includes all culturally specific and/or language-specific experiences, identities and expressions of gender; it is not limited to a Westernised or Eurocentric understanding or conceptualisation of gender or the language used to describe it.

Included Abbreviations Within This Paper

Abbreviation	Meaning
TGD	Transgender and Gender Diverse, Trans*
ED	Eating Disorder
DEBs	Disordered Eating Behaviours
MH	Mental Health
HCP	Healthcare Professionals
GAC	Gender Affirming Care
GAHT	Gender-Affirming Hormone Therapy
GAS	Gender-Affirming Surgery

1.0 Introduction

1.1 Eating Disorders

Eating disorders (EDs) are mental health (MH) issues that result in substantial physical and cognitive harm[1]. These include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder (ARFID), other specified feeding or eating disorder (OSFED), and unspecified feeding or eating disorder (UFED)[2]. In 2023, over one million Australians were living with an ED and the social and economic cost was estimated to be $66.9 billion[3]. Mortality rates associated with EDs are alarmingly high, with people afflicted by EDs facing up to 12 times the risk of death compared to those without[4]. Moreover, the risk of suicide among people with EDs is up to 57 times greater than that of the general population[5].

1.2 Gender Diversity and Eating Disorders

TGD people are disproportionately affected by EDs compared to their cisgender counterparts[6]. In one study of Australian TGD youth, 22.7% had been diagnosed with an ED and two-thirds had disordered eating behaviours (DEBs)[7]. Similarly, research from the Inside Out Institute for Eating Disorders has indicated that more than one-third of TGD adults met the criteria for an ED and over 99% of TGD adults had reported DEBs within the past three months[8].

1.3 Role of Gender Dysphoria in Eating Disorders

Gender dysphoria refers to the distress or disconnect that can occur from the incongruence between a TGD person's gender identity and their sex assumed at birth. This can result in substantial psychological distress and impair daily functioning. Within the field of EDs, it is essential to delineate between gender dysphoria and other body image concerns, such as body dysmorphia. Unlike body dysmorphia, which involves a distorted perception of one's body or preoccupation with perceived flaws, gender dysphoria reflects an accurate perception of the incongruence between one's gender identity and physical appearance. This distinction is not only recognised within psychological discourse but also corroborated by neuroimaging studies.

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[1] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).
[2] Ibid.
[3] Butterfly Foundation. (2024). Paying the Price: The Economic and Social Impact of Eating Disorders in Australia (2nd ed.)..
[4] Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. *Archives of General Psychiatry*, *68*(7), 724. https://doi.org/10.1001/archgenpsychiatry.2011.74
[5] Ibid.
[6] Jones, B. A., Haycraft, E., Murjan, S., & Arcelus, J. (2015). Body dissatisfaction and disordered eating in trans people: A systematic review of the literature. *International Review of Psychiatry*, *28*(1), 81–94. https://doi.org/10.3109/09540261.2015.1089217
[7] Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Lin, A. (2019). Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: Findings from Trans Pathways. *Psychological Medicine*, *50*(5), 808–817. https://doi.org/10.1017/s0033291719000643
[8] Schweizer, K., Kim, M., Aouad, P., Vatter, S., Miskovic-Wheatley, J. (2024) Trans and gender diverse experiences of eating disorder treatment. [manuscript in preparation].

Research mapping gender dysphoria has revealed hyperactivation of specific brain regions; the left occipital cortex and precuneus cortex[9]. In contrast, studies of body dysmorphia have reported hypoactivation of the left occipital cortex[10].

DEBs are often consciously utilised as coping mechanisms to alter physical characteristics associated with one's sex assumed at birth and affirm one's gender identity. For instance, people may engage in restrictive eating patterns to suppress the onset of puberty or reduce the appearance of gendered traits such as breasts or hips. For example, one TGD Australian explained, "*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"*[9]. Healthcare professionals (HCPs) have observed instances of TGD adolescents employing DEBs to delay pubertal changes and alleviate gender dysphoria concerns. One Australian HCP said, "*They're trying to delay the pubertal changes that their bodies are undergoing. A lot of them stop eating to delay those [pubertal changes], particularly the trans masculine patients. I think they get very concerned about breast development and having a feminine figure"*[11].

It is evident from both research and lived experience of TGD people with EDs, that traditional approaches aimed at addressing body dysmorphia, such as talk therapy, are inadequate for alleviating gender dysphoria. Instead, gender-affirming care (GAC) - encompassing gender affirming hormone therapy (GAHT), gender-affirming surgery (GAS), and social and legal transition - emerges as the sole evidence-based approach to mitigate gender dysphoria and enhance TGD peoples' well-being. Therefore, understanding the nuanced interplay between gender dysphoria and EDs is imperative for tailoring effective interventions and promoting holistic recovery among TGD people struggling with both conditions.

1.4 Purpose of Submission

This submission aims to elucidate the human rights threats confronting TGD people in Australia, with emphasis on how these challenges intersect with the prevention, development, and treatment of EDs within this population. We assert that current ED treatment in Australia not only fails to meet the needs of TGD people but also poses a threat to TGD human rights. Furthermore, we argue that restrictions to gender-affirming medical care will increase the prevalence and severity of EDs amongst TGD people in Australia.

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[9] Fisher, A. D., Ristori, J., Castellini, G., Cocchetti, C., Cassioli, E., Orsolini, S., Sensi, C., Romani, A., Mazzoli, F., Cipriani, A., Ricca, V., Vignozzi, L., Viggiano, M. P., Mascalchi, M., Maggi, M., & Gavazzi, G. (2020). Neural correlates of gender face perception in transgender people. *Journal of Clinical Medicine*, *9*(6), 1731. https://doi.org/10.3390/jcm9061731

[10] Feusner, J. D., Moody, T., Hembacher, E., Townsend, J., McKinley, M., Moller, H., & Bookheimer, S. (2010). Abnormalities of visual processing and frontostriatal systems in body dysmorphic disorder. *Archives of General Psychiatry*, *67*(2), 197. https://doi.org/10.1001/archgenpsychiatry.2009.190

[11] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke,J., Furzer, B. (2024). Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication].

2.0 Threats to Trans and Gender Diverse Human Rights in Eating Disorder Treatment

Despite the elevated prevalence of EDs among TGD people, treatment accessibility and efficacy remain concerningly low. A recent study found that 82.89% of TGD people diagnosed with an ED never accessed treatment[12]. Furthermore, among the TGD people who accessed treatment, 62.67% did not find it helpful[10].

2.1. Misgendering, Abuse, and Gaslighting of Trans and Gender Diverse People in Eating Disorder Treatment

Such statistics are consistent with the limited qualitative research describing the experiences of TGD people with ED treatment. In one study of 84 TGD people, none reported positive experiences of ED treatment[13]. Most commonly, studies have described misgendering and invalidation of patients' trans identities[11, 14, 13]. Such experiences led 1to acute gender dysphoria and distress for TGD people and ruptured the therapeutic alliance between patients and HCPs[11, 15, 13]. Whilst these experiences occur in other MH care treatments, they are especially damaging during inpatient ED treatment, where patients are often stripped of all bodily autonomy. One participant in an Australian study said, *"I said I was non-binary and he [HCP] was just like 'No, that's not a thing'. At this point, I had a feeding tube. I was bedbound. What am I going to do? I can't walk away from the situation"*[12]. These harms appear to be systemic, as explained by one HCP, *"The hospital doesn't have the capability to allow for aliases or preferred names to be used…they [young people] come to hospital, and we are often misgendering and dead naming them six to eight times a day; every time they have a medication, every time they have their blood pressure checked, every meal. I think that we actively harm gender variant people even as we are treating their eating disorder"*[13].

Gaslighting refers to a psychological manipulation tactic involving the deliberate invalidation of a person's reality, emotions, and experiences[16]. This can cause significant distress and lead an individual to doubt their reality and sanity[17]. In mainstream ED treatment, patients are often encouraged to externalise their ED (sometimes referred to as an "ED voice") and attribute their thoughts and feelings to said "voice" rather than acknowledging their own agency and autonomy. As explained by one Australian TGD person, *"When you have an eating disorder, you are gaslighted into believing none of your thoughts or emotions are real or worthy"*[18].

This gaslighting in ED treatment is especially harmful to TGD people, for whom these tactics are often used to invalidate their gender identity and attribute it as a symptom of their ED.

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[12] Schweizer, K., Kim, M., Aouad, P., Vatter, S., Miskovic-Wheatley, J. (2024) Trans and gender diverse experiences of eating disorder treatment. [manuscript in preparation].
[13] Duffy, M. E., Henkel, K. E., & Earnshaw, V. A. (2016). Transgender clients' experiences of eating disorder treatment. *Journal of LGBT Issues in Counseling*, *10*(3), 136–149. https://doi.org/10.1080/15538605.2016.1177806
[14] Bowman, M. (2018). The lived experience of transgender individuals with eating disorders (Doctor of Nursing Practice). DePaul University.
[15] Schweizer, K. (2021). *"A lot of people put me in the too hard basket": Experiences of Australian Trans and Gender Diverse People Presumed Female at Birth Living with Eating Disorders* [unpublished master's thesis]. Curtin University.
[16] Sarkis, S. (2021). *Gaslighting: Recognize manipulative and emotionally abusive people - and break free*. Hatchette Go.
[17] Ibid.
[18] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke,J., Furzer, B. (2024). Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication].

A TGD client of the authors explained, *"I've been told that it's just the eating disorder trying to convince me I'm trans, because in treatment they say that everything to do with your body and appearance and shape is the ED"*. These experiences not only erode trust in the healthcare system, but also exacerbate gender dysphoria by further alienating TGD people from their bodies and sense of selves.

Overall, these negative experiences of ED treatment have led to avoidance of future care and/or avoiding disclosure of one's TGD identity[19, 20, 21]. Unfortunately, given the role of TGD-specific factors such as gender dysphoria and gender minority stress in ED development and maintenance, non-disclosure of a patient's TGD identity may also limit treatment efficacy[22].

2.2 Gender Identity Change Efforts/Conversion Practices in Eating Disorder Treatment

Conversion practices (colloquially referred to as conversion "therapy") refer to "any practice or treatment that seeks to change, suppress, or eliminate an individual's sexual orientation or gender identity"[23]. Based upon the available literature, and the authors' professional and lived experience, contemporary treatment modalities and frameworks of ED treatment frequently (intentionally or unintentionally) seek to a) change, suppress, or eliminate TGD people's gender identity; and/or b) facilitate engagement in conversion practices by parents, guardians, and other caregivers.

2.2.1 Body Acceptance Approaches

Body acceptance is the process of acknowledging and embracing one's body without seeking to change it[24]. This serves as a foundational principle in numerous treatment modalities for EDs[19]. Of the nine outpatient psychological treatments for EDs recommended by the National Eating Disorder Collaboration (NEDC), all treatments either have body acceptance as a core component or commonly integrate a body acceptance framework[25].

Among these modalities, enhanced cognitive behavioural therapy (CBT-E) is notable as the widely endorsed 'gold standard' treatment approach for adults with EDs[26]. Central to CBT-E is the cultivation of body acceptance through challenging body image distortions and accepting one's body without seeking to change it through DEBs[27]. However, when applied to TGD

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[19] Bowman, M. (2018). The lived experience of transgender individuals with eating disorders (Doctor of Nursing Practice). DePaul University.
[20] Duffy, M. E., Henkel, K. E., & Earnshaw, V. A. (2016). Transgender clients' experiences of eating disorder treatment. *Journal of LGBT Issues in Counseling*, *10*(3), 136–149. https://doi.org/10.1080/15538605.2016.1177806.
[21] Schweizer, K. (2021). *"A lot of people put me in the too hard basket": Experiences of Australian Trans and Gender Diverse People Presumed Female at Birth Living with Eating Disorders* [unpublished master's thesis]. Curtin University.
[22] McGregor, K., McKenna, J. L., Barrera, E. P., Williams, C. R., Hartman-Munick, S. M., & Guss, C. E. (2023). Disordered eating and considerations for the Transgender Community: A review of the literature and clinical guidance for assessment and treatment. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00793-0
[23] SOGICE. (2020, July). *The SOGICE survivor statement*. The SOGICE Survivor Statement. https://www.sogicesurvivors.com.au/
[24] Griffiths, S. (2017). Body Acceptance. In V. Zeigler-Hill & T. K. Shackelford (Eds.), *Encyclopedia of Personality and Individual Differences* (pp. 1–3). Springer International Publishing. https://doi.org/10.1007/978-3-319-28099-8_486-1
[25] NEDC. (n.d.). *Treatment Options*. The National Eating Disorders Collaboration. https://nedc.com.au/eating-disorders/treatment-and-recovery/treatment-options
[26] Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. Guilford Press
[27] Ibid.

people, this approach can cause significant harm by invalidating the distress of gender and attempting to suppress or change a TGD patient's gender identity[28, 29, 30].

Many of the body acceptance exercises involved in CBT-E, such as somatic work and mirror exposure, are inappropriate for TGD patients and cause undue distress without therapeutic benefit[20, 21, 22]. The experiences of TGD people in ED treatment emphasise this[20, 21, 22], with one TGD person describing their experience with mirror exposure, *"There is one thing they had me do which was to stare into a mirror for half an hour. The way they try to describe it was to try to normalise seeing yourself in the mirror. It seems okay if you're just dealing with body dysmorphia, regular body dysmorphia, but with gender dysphoria as well that's also very triggering. I was basically fighting back a panic attack during that"*[22]. Body acceptance also underpins the talk therapy component of CBT-E, such as the normalising of body parts that trigger gender dysphoria[20]. For example, when speaking with a TGD person, one HCP said, "*It's normal for women to have breasts and hips, you should embrace that!*"[20].

It is our position that treatment modalities advocating body acceptance inadvertently engage in conversion practices by coercing TGD people into living with the acute distress of gender dysphoria and discouraging GAC.

2.2.2 Facilitation of Conversion Practices via Family Based Therapy

Family based therapy (FBT) (also known as Maudsley FBT or the Maudsley approach) is considered the 'gold standard' approach to treating anorexia nervosa and bulimia nervosa in adolescents who are well enough for outpatient treatment[31]. This approach involves parents or guardians (henceforth: caregivers) having full responsibility for and control over their child's eating and exercise behaviours[32]. This approach can be problematic and/or harmful when supporting TGD young people with EDs. If caregivers are unsupportive of their child's gender diversity, this approach may empower said caregivers to not only take control of a young person's eating behaviours, but also of their gender expression and access to gender affirmation. The authors of this submission have heard countless anecdotes of FBT being weaponised by caregivers to invalidate, abuse, or detransition young trans people. This is consistent with one quote from a young trans person with an ED, who said, "*It's [FBT] 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*

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[28] Cusack, C. E., Levenson, N. H., & Galupo, M. P. (2022). "Anorexia wants to kill me, dysphoria wants me to live": Centering transgender and nonbinary experiences in eating disorder treatment. *Journal of LGBTQ Issues in Counseling*, *16*(3), 265–284. https://doi.org/10.1080/26924951.2022.2054492

[29] Hartman-Munick, S. M., Silverstein, S., Guss, C. E., Lopez, E., Calzo, J. P., & Gordon, A. R. (2021). Eating disorder screening and treatment experiences in transgender and gender diverse young adults. *Eating Behaviors*, *41*, 101517. https://doi.org/10.1016/j.eatbeh.2021.101517

[30] Joy, P., White, M., & Jones, S. (2022). Exploring the influence of gender dysphoria in eating disorders among gender diverse individuals. *Nutrition & Dietetics*, *79*(3), 390–399. https://doi.org/10.1111/1747-0080.12727

[31] Rienecke, R. (2017). Family-based treatment of eating disorders in adolescents: Current insights. *Adolescent Health, Medicine and Therapeutics*, *Volume 8*, 69–79. https://doi.org/10.2147/ahmt.s115775

[32] Ibid.

have control over who you are as a person, which extends to the gender you are and how you're allowed to present yourself"[33]. Furthermore, to our knowledge, no study has ever demonstrated the efficacy of FBT in a sample of trans young people with EDs.

2.3 Importance of Gender Affirming Care in Eating Disorder Prevention and Treatment

The importance of GAC in the recovery process of people with EDs cannot be overstated. There are significant positive outcomes of increased access to GAC for TGD people with EDs [34]. TGD people accessing GAC commonly experience a significant decrease in ED symptoms and severity[35-36]. For example, one study reported that TGD people on GAH were half as likely to have BN and 27% less likely to have a drive for thinness compared to TGD people not on GAH[37]. Some TGD Australians have described rapid and sustained ED recovery trajectories after accessing GAHT. For instance, one TGD Australian with severe and enduring AN expressed, "*I started on testosterone. It was just like 'Oh. That's fixed it [the ED]*"[38]. Another TGD Australian with BN shared, "*Now I feel that I am the right gender, it [purging] doesn't happen anymore*"[26]. Such care is essential to treating EDs in TGD people, particularly when the ED is driven by a desire to align one's appearance with their gender identity and alleviate gender dysphoria.

Conversely, delays in accessing GAC often occur throughout receiving ED treatment, further complicating recovery efforts. This underscores the interplay between gender-affirming care and ED recovery, emphasising the need for integrated treatment approaches that address both concerns simultaneously. Despite this evidence, TGD Australians have described delays in access to GAC due to having an ED. One TGD Australian said, "*I find that with me, a lot of the time, it's 'let's wait, let's make you put up with this dysphoria until you've solved your eating disorder', but really to solve the eating disorder, other issues need to be addressed in my life.*"[39].

There is an absence of plausible evidence supporting any negative outcomes associated with increasing access to gender-affirming care for TGD people. Much of the opposition to the provision and expansion of GAC is rooted in discrimination and stigma towards TGD people.

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[33] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke,J., Furzer, B. (2024) Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication].

[34] McGregor, K., McKenna, J. L., Barrera, E. P., Williams, C. R., Hartman-Munick, S. M., & Guss, C. E. (2023). Disordered eating and considerations for the Transgender Community: A review of the literature and clinical guidance for assessment and treatment. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00793-0

[35] Bhatt, N., Cannella, J., & Gentile, J. P. (2022). Gender-affirming care for transgender patients. *Innovations in Clinical Neuroscience*, *19*(4-6), 23–32

[36] Heiden-Rootes, K., Linsenmeyer, W., Levine, S., Oliveras, M., & Joseph, M. (2023). A scoping review of research literature on eating and body image for transgender and nonbinary youth. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00853-5

[37] Jones, B. A., Haycraft, E., Bouman, W. P., Brewin, N., Claes, L., & Arcelus, J. (2018). Risk factors for eating disorder psychopathology within the treatment seeking transgender population: The role of cross-sex hormone treatment. *European Eating Disorders Review*, *26*(2), 120–128. https://doi.org/10.1002/erv.2576

[38] Schweizer, K. (2021). *"A lot of people put me in the too hard basket": Experiences of Australian Trans and Gender Diverse People Presumed Female at Birth Living with Eating Disorders* [unpublished master's thesis]. Curtin University.

[39] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke,J., Furzer, B. (2024) Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication].

Conversely, significant and sufficient evidence has advocated for the continued and augmented provision of GAC to all TGD people, both adults and young people seeking it[40-41].

3.0 Restrictions and Barriers to Gender Affirming Care as a Risk for Eating Disorder Development

3.1 Weight Limits for Gender-Affirming Surgery

The pathologisation of weight and body size continues to be a significant barrier to many areas of healthcare and is an unethical and discriminatory practice within healthcare. The World Professional Association for Transgender Health (WPATH) standards of care do not specify body mass index (BMI) limits for GAS[42]. This is consistent with a recent study, which determined that BMI requirements for GAS were not empirically supported[43]. Despite this, many Australian surgeons provide BMI requirements as part of their eligibility criteria for GAS. Given the urgency of such medical care in alleviating gender dysphoria, such requirements have been described by Australian TGD people and HCPs as the impetus for the development of an ED [44].

3.2 Financial and Waitlist Barriers to Gender-Affirming Care

Low income and lengthy waitlists pose significant challenges for TGD people seeking comprehensive healthcare and can contribute to the development of EDs in TGD people[45]. Financial barriers constitute a primary impediment to accessing GAS, encompassing costs associated with surgery, recovery support, and related healthcare. Many TGD people face financial hardship, exacerbated by loss of income during post-surgery recovery periods, and the absence of gender-affirming leave. Additionally, limited coverage by private health insurance further contributes to financial strain. One Australian HCP expressed the complexity of this financial strain, stating, *“The process of actually making their true body a reality is so expensive. And so, you've got people who are very low income, faced with this insurmountable burden…And it's like, where does the money come from for all this?”*[46].

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[40] Bhatt, N., Cannella, J., & Gentile, J. P. (2022). Gender-affirming care for transgender patients. *Innovations in Clinical Neuroscience*, *19*(4-6), 23–32

[41] Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022a). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*, *5*(2). https://doi.org/10.1001/jamanetworkopen.2022.0978

[42] Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health*, *23*(sup1). https://doi.org/10.1080/26895269.2022.2100644

[43] Brownstone, L. M., DeRieux, J., Kelly, D. A., Sumlin, L. J., & Gaudiani, J. L. (2021). Body mass index requirements for gender-affirming surgeries are not empirically based. *Transgender Health*, *6*(3), 121–124. https://doi.org/10.1089/trgh.2020.0068

[44] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke, J., Furzer, B. (2024) Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication].

[45] McGregor, K., McKenna, J. L., Barrera, E. P., Williams, C. R., Hartman-Munick, S. M., & Guss, C. E. (2023). Disordered eating and considerations for the Transgender Community: A review of the literature and clinical guidance for assessment and treatment. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00793-0

[46] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke,J., Furzer, B. (2024) Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication].

Additionally, TGD people often encounter extended wait times at various stages of care. Delays in accessing MH services, specialist providers, and surgical consultations prolong the pathway to GAC, exacerbating psychological distress increasing the risk of EDs, and compromising overall well-being. One Australian TGD person reported that the only clinic in their state offering GAHT was "*backed up for multiple years at this point*"[34]. Moreover, geographical disparities and misinformation among HCPs compound these challenges, leaving many TGD people without adequate information or support.

The limited availability of GAC can compel some TGD people to resort to DEBs to alleviate gender dysphoria, which increases the risk of developing an ED. One participant shared their experience, revealing, *"I didn't know about top surgery or hormone replacement therapy. 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"*[47]. Additionally, the medico-legal barriers to accessing GAH and puberty suppressant medications under 18 years of age exacerbate distress and perpetuate reliance on DEBs to cope with gender dysphoria. One Australian HCP highlighted this challenge, expressing frustration at the inability to provide necessary care: *"There's not necessarily a drive from them to just stop the behaviours that they're doing. Also, when you know that potentially starting them on hormones could be incredibly beneficial. And you just can't…it's horrible"*[48].

Addressing systemic barriers to accessing GAC services is paramount for promoting the holistic well-being of TGD people and mitigating ED risk. Efforts to enhance accessibility to GAC must prioritise reducing financial burdens, streamlining waitlist processes, and improving HCP education, to ensure equitable access to comprehensive and affirming healthcare for all TGD people.

4.0 Weaponisation of Eating Disorders in Anti-Trans Rhetoric as a Threat to Trans and Gender Diverse Human Rights

Anti-trans discourse has increasingly weaponised the high prevalence of EDs in TGD people to argue for restrictions to GAC. This rhetoric draws parallels between being TGD, positing that gender dysphoria is a form of body dysmorphia and therefore should be treated with psychotherapy. This disinformation perpetuates harmful misconceptions and has the potential to limit access to GAC in Australia.

[47] Schweizer, K. (2021). *"A lot of people put me in the too hard basket": Experiences of Australian Trans and Gender Diverse People Presumed Female at Birth Living with Eating Disorders* [unpublished master's thesis]. Curtin University.
[48] Schweizer, K., Austin, A., Lin, A., Jackson, B., Wright, K., Strauss, P., Bickendorf, X., Luke,J., Furzer, B. (2024). Qualitative experience of eating and exercise behaviours in trans and gender diverse adults. [manuscript submitted for publication]

4.1 Trans-Exclusionary Radical Feminism

Trans-exclusionary radical feminists (TERFs) represent a subset of feminists who harbour exclusionary attitudes towards TGD people. Recently, prominent TERFs such as Lionel Shriver, Abigail Shrier, and Hadley Freeman have propagated a misleading comparison between EDs and TGD identity, labelling TGD identity as "the new anorexia" [49, 50,51]. They argue that TGD identity stems from an underlying desire to evade the challenges associated with womanhood[52]. Furthermore, they posit that TGD identity may be influenced by social contagion, likening it to the glorification of physical harm by pro-anorexia influencers[53]. Through these arguments, they advocate for bans on gender-affirming care (GAC) and propose a psychotherapy and body acceptance approach[54]. However, as this submission outlines, this perspective lacks valid empirical evidence.

4.2 The Cass Review

The Cass Review was commissioned by the United Kingdom's (UK) National Health Service (NHS) to evaluate the care provided to TGD patients at the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust[55]. This review expressed apprehensions regarding the notable rise in referrals to gender identity services within the UK, particularly among young people assumed female at birth (AFAB). Given that AFAB people are 3.8 times more likely to experience an ED than those assumed male at birth[56], the review considered the possible role of EDs in explaining these trends. Within the review, two explanations related to EDs are proposed: 1) the presence of an ED may cause TGD identity, and 2) TGD identity is a mental illness similar to body dysmorphic disorder or EDs and is caused by exposure to social media and other online stressors[47]. The review's recommendations stressed the importance of addressing co-occurring MH concerns, including EDs. Despite widespread concerns about the quality of evidence of the review, the findings played a role in the NHS's decision to cease provision of puberty blockers as part of their gender services. In response, there have been calls for similar limitations and bans on provision of GAC to TGD young people in Australia. As outlined by our submission, any such restrictions will likely result in increased prevalence and severity of EDs amongst TGD young people.

[49] Freeman, H. (2023). *Good girls: A story and study of anorexia*. Simon & Schuster.
[50] Shrier, A. (2020). *Irreversible damage: The transgender craze seducing our daughters*. Regnery Publishing, a division of Salem Media Group.
[51] Shriver, L. (2023, April 27). *Is trans the new anorexia?*. UnHerd. https://unherd.com/2023/04/is-trans-the-new-anorexia/
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Cass, H. (2024). (rep.). *Independent review of gender identity services for children and young people: Final report*. National Health Service
[56] Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000–2018 period: A systematic literature review. *The American Journal of Clinical Nutrition*, *109*(5), 1402–1413. https://doi.org/10.1093/ajcn/nqy342

5.0 Recommendations and Conclusion

In summary of this discussion and supporting evidence, several recommendations emerge to address the complex human rights threats affecting TGD people in relation to EDs:

(1) There is an urgent need for research initiatives focused on elucidating the nuanced experiences of TGD people with EDs and developing novel treatment approaches tailored to their specific needs. These initiatives should prioritise intersectional perspectives and incorporate the voices and experiences of TGD people throughout the research process.

(2) Efforts must be made to increase access to GAC for TGD people with EDs. This includes ensuring that GAC services are available, accessible, and affordable for all TGD people seeking such care.

(3) HCPs must receive comprehensive education and training on GAC and its intersection with EDs. This education should encompass culturally competent and affirming care practices, as well as trauma-informed approaches to addressing the unique needs of TGD people with EDs.

(4) TGD people must be actively involved in research, treatment, and policy development related to EDs and GAC. Their perspectives and experiences are invaluable in informing culturally competent and affirming approaches to care delivery and policy formulation.

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