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Clinician and Patient Perspectives on Nutrition Counseling: Exploring Nutrition Counseling for the Gender-Diverse Community

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Abstract

The nutritional standards that currently guide care in the U.S. work on a male-female sex binary. This system generalizes the nutritional needs of humans to averages based on sex when many other factors are in play. Standards of transgender health also lack, focusing on hormone replacement therapy and surgery, barely, if at all, mentioning nutritional considerations. This is especially important for this population, so practitioners can support transition goals, changes that occur during medical transitions, and the prevalence of eating disorders. Literature suggests that this population does not have access to this information, but seeks it out often, resulting in misinformation and potential harm. Through semi-structured multi-site interviews and immersive participant observation through food-based methods, this research explored the perceptions of nutrition counseling specific for the trans and gender-diverse community (TGD) from both the clinician and TGD patient perspectives to identify opportunities for education and intervention. The results were coded and put into common themes. The results suggest that TGD patients do not have the information available to them and believe that this would

be especially valuable in the beginning stages of a medical transition. Additionally, clinicians believe that a multidisciplinary and individualized approach to nutrition care for this population would be beneficial. The researcher suggests future research and advocacy focus on gender-inclusive, multidisciplinary, and individualized nutrition counseling for the TGD population.

Introduction

The standards that currently guide nutritional care in the U.S. work on a male-female sex binary, meaning that some of the guidelines on what individuals should eat is sex-based. This system generalizes the nutritional needs of humans to averages based on sex when many other factors are at play. These standards do not account for other factors such as existing conditions, body composition, food access, taste, and more. Standards of transgender health also lack, focusing on hormone replacement therapy and surgery, often not mentioning nutritional considerations. This is especially important for this population, so practitioners can support transition goals, changes that occur during medical transitions, and the prevalence of eating disorders (Yesildemir & Akbulut, 2023). This project explored the perspectives of clinicians who work with transgender and gender diverse (TGD) patients, as well as the patients themselves, on nutrition considerations for TGD individuals. The researcher investigated what the current picture is of nutrition care for people who are transitioning (either medically or socially) and how we can make nutrition more accessible to this population. By asking both groups, we can gain the perspective of clinicians on what they have been trained on, how they approach patients, and what considerations are the most important. We can also gain the perspective of TGD individuals on their experiences with doctors, how nutrition could possibly empower them and their transition, and what information would be the most important for their needs. In taking these perspectives into account, the researcher proposes solutions to the current gap through more research, training, and adjusting current practices.

Sample and Methods

This study was conducted through ethnographic interviews with clinicians and transgender and gender-diverse individuals (TGD). For the clinician group, the interviews focused on what they know about this population's nutrition needs, how they think nutrition could be more accessible to TGD patients, and whether this would be something they would integrate into their care. These interviews were conducted over Zoom and recorded so the researcher could transcribe as much information accurately as possible. Clinicians were recruited through cold-emailing and snowball sampling. However, this method of recruitment for clinicians had benefits and drawbacks that may have impacted the conclusions of this research. For example, there may be fields (e.g., endocrinologist, gender therapist, and gender-affirming personal trainers) that would benefit this research that were not included due to relying on snowball sampling where people were recommended by other clinicians. This aside, a benefit of this recruitment was that it gave

me access to clinicians that work with TGD individuals, especially those who work with nutrition-related topics that are not as common. Inclusion criteria for interviewees were that the clinician worked with TGD patients and were in the United States but was open to all fields. This study didn't just focus on nutritionists and dietitians for two reasons: one, that there are not a lot of gender-affirming nutritionists and dietitians, and two, the researcher wanted to discuss with multiple fields to see if practitioners that work with TGD patients discuss nutrition at all. Of the seven clinician participants, two identified as transgender or gender non-binary and five identified as cis women. Participants represented several different positions in the medical field including registered dietitian with a focus in eating disorders (n=2), registered dietitian with a focus in gastrointestinal issues (n=1), a general health care practitioner (n=1), infectious disease specialist with a focus in HIV prevention and treatment as well as gender-affirming care (n=1), and a nutritionist educator (n=1). This study lacked racial and ethnic diversity with all but one clinician identifying as a person of color, the rest being non-Hispanic white. This is likely due to the low diversity in the medical field, and specifically the nutrition and dietetics field. Informed consent was gained before or during each interview, and a total of nine questions with additional sub-questions and occasionally follow-up questions were asked. Interviews were also tailored to if the interviewee prescribes hormone replacement therapy (HRT) or not.

For the TGD group, these interviews were conducted over a meal and were focused on their relationship with food, the consultation process (if applicable), how/if they seek out nutritional information, and what would help them the most when it comes to nutrition. This was done through a process called "Kitchen Table Ethnography" (Perez, R. L., 2019) in which interviews were conducted over a meal. These interviews were conducted carefully so as not to be insensitive about possible eating disorders, with EDs only being brought up if TGD participants wanted to discuss it. This method was used for TGD participants only as clinician participants were often too busy to meet for longer periods of time. Participants were recruited through word of mouth and flyers posted in queer-friendly places. Inclusion criteria for interviewees were that participants had to identify as TGD, be over 18 years old, available for a food-based interview, and on HRT, planning to be, or had specific physical transition goals. Of the six TGD participants, two self-identified as trans-masculine (n=2), one self-identified as trans-masculine non-binary (n=1), one self-identified as non-binary (n=1), and two self-identified as women (n=2). Racial and ethnic diversity was low, possibly due to the overwhelming amount of queer spaces dominated by non-Hispanic white individuals. Both groups lacked body diversity, likely due to the stigma placed on plus-size bodies. These interviews were conducted in person or over Zoom depending on the preferences of the participants. They were also asked to sign a consent form before or during the interview process, similar to those the clinicians signed. These individuals were also asked a total of nine questions with sub-questions and follow-up questions as necessary. Both groups were given the option to not answer or strike answers from the record as necessary throughout the research process, though only one clinician took this option. No one from the TGD group did.

Positionality Statement

Before discussing the results of this study, it is important to acknowledge my positionality as a researcher. This study was conducted by a researcher who identifies as trans-masculine and identified as such to his participants with the hope of making participants more comfortable in sharing their experiences. Additionally, many of the TGD participants were acquainted with the researcher. While there are benefits to a community member doing research with and for their community, it is important to acknowledge the possible impact this had on the willingness of participants to share their answers and the way the researcher interpreted the data. Efforts were taken to ensure the data was interpreted through an unbiased lens through continuous questions to further understand what participants meant and be able to represent them effectively, as well as practicing reflexivity. Additionally, some other demographics may have influenced what both groups shared. First, the researcher observed some hesitancy around his age when it came to talking to older participants. This could have influenced the trust participants had of a younger, potentially less-experienced individual conducting this research. Additionally, with the clinician group, there may have been hesitancy on how much the researcher knew about medical knowledge, especially as a non-medical student. These categories may have skewed what was shared, so it is important to acknowledge that more research should be done. While this research is exploratory, the data does not represent the entire TGD community. The researcher's goal is to encourage conversation around this topic and support the community's needs.

Relevant Theory

Michel Foucault laid the foundation for the Biomedical Model through the Medical Gaze in *Birth of The Clinic*. In his work, he highlighted that the medical gaze makes clinicians hone in on just the organ systems and pathophysiology of patients than the whole picture (Foucault, 1973). For example, clinicians may see trans patients with the lens of just fixing their gender dysphoria through prescribing HRT, rather than addressing the other factors of health that impact their lives like nutritional needs. The biomedical model has continued to be criticized by other scholars such as Kleinman, Hahn, Singer, Engel, Spade, and Mehta. Kleinman and Hahn (1983) criticized this model, similar to Foucault, for its reductionism of patients to their bodies and disease as well as the ways in which medical students are socialized into the biomedical model. This socialization and way of thinking may play into the ways clinicians think of their TGD patients, thinking of quick solutions to gender dysphoria instead of the many factors at play. Singer (1995) and Engel (1977) both argue about the need for physicians to go beyond the physical and recognize those other factors that play a role in individual health. Likewise, the argument of this paper argues the need for individualization in the sense that every patient's needs and goals are different but should not be taken out of the social context that influences those needs and the ability to meet them. Mehta discusses biomedicine and mind-body dualism in how they have led to sciences' "obsession with measurement and quantification" (Mehta, 2011). This becomes relevant when thinking about how the nutrition standards discussed in this paper focus on

binary ranges for nutritional levels, ignoring other factors that can impact a person's needs. Similarly, Spade (2003) argues that the reliance on medical evidence that exists in our medical and legal spheres pushes TGD folks to conform and play a role for clinicians just to meet their goals. This plays into a power imbalance which may impact the clinician-patient relationship.

Results and Discussion

Transgender and Gender-Diverse Participants

When seeking a medical transition, trans and gender-diverse patients often have to first do a consultation. In this first appointment, it is common for doctors to ask about the patient's medical history, mental health, and transition goals to gauge where the patient is at and where the patient wants to be and what steps would be most appropriate to accomplish those goals. Additionally, in these sessions, doctors will address any risks associated with HRT and will take blood samples to obtain base levels of hormones and certain measures such as complete blood count, metabolic panel, lipid panel, certain vitamins, hemoglobin, and others as needed. When talking to my TGD informants, I questioned whether nutritional aspects were ever mentioned in these consultations, specifically wondering if there was any discussion of risk for certain diseases that have a higher prevalence in the TGD community such as diabetes or cardiovascular issues (Buonaiuto, K., Dodge, E., & Aboul-Enein, B., 2023). The answers varied in terms of small things that might have been mentioned but shared the common theme that there was never really a conversation on what changes to expect or how one could eat for their transition goals. Further, the common advice patients got was unspecific and general: "your family has a history of high cholesterol, so avoid foods with high cholesterol" or "your appetite will change," not covering the ways one should address those potential changes. El, a transmasculine individual, experienced this directly. When asked if they were informed about nutritional or diet changes when going on HRT, they explained the following:

> "Not really. I was told that, or, I don't know if it's on that pamphlet or, like, verbally, that I was probably gonna have an increase in appetite... I was warned about cardiovascular risks. I don't, don't think I was informed of anything else that you listed there [obesity, diabetes, eating disorders]. Okay, we, I have a family history of both high and low blood pressure, as well as some other cardiovascular stuff. So that was probably, you know, we talked about that a little bit, because I am theoretically at a slight risk." - El (trans-masculine)

This is an example of these considerations only coming up in certain circumstances, in this case due to a patient having a family history of cardiovascular issues. The lack of discussion during these consultations is especially harmful considering in my research and in the literature (Schier, H., et al., 2024) it has been found that many TGD individuals often do not know what to look for or how to look for nutritional information and resources

or how to determine what information is true. This was not true for every TGD participant I talked to, there were two outliers who knew what to look for, mainly because of specific circumstances: one has health issues they need to eat for and a partner with food restrictions, and the other was a bodybuilder before transitioning. However, for most participants, there was a lack of knowledge when it came to knowing what to search for.

> "It's hard, because I do feel like there's just not a lot unless you're looking for it right, like it's not something that just kind of like shows up." -Kevin (non-binary trans masculine)

Kevin brings up that unless you are looking for that information or something specific, it is likely you will not get that information. This is especially important if patients do not know much about nutritional knowledge or if they have certain physical goals but are unsure how to address those goals. Thus, clinicians can intervene by becoming a resource for patients on how to find information, gain support, and what information is most applicable to their goals.

Clinicians

In trying to understand their perspectives on nutrition care for transgender patients, I interviewed eight practitioners of different fields: one nutrition educator, one healthcare professional, one infectious disease specialist who also works in gender-affirming care, two mental health professionals, and three registered dieticians. Two practitioners were part of the TGD community and one who is a researcher on this topic. I asked each clinician about what they know and how they feel about nutrition counseling for the TGD community. Additionally, I asked them how they would feel exploring this with their patients in the future, as well as how we could make nutrition more accessible to patients now. These interviews unlocked central themes like not being able to provide guidance to TGD patients because they have not received such education and guidance, not knowing how to approach patients if they do have this information, and trying to care for patients with the resources they do have through harm reduction practices.

Many clinicians I spoke to mentioned that they don't know how to direct their patients due to the lack of guidance they have received in their training. This issue ranged from nutritionists and dieticians saying that they believe their nutrition training rarely covered transgender patients to clinicians of various fields discussing that the current male-female nutrition standards do not work for anyone.

For the purposes of this research, 'nutritional standards' are the dietary recommendations and resources usually used in care in the United States, often seen published by *My Plate* or *Eat Right*. These standards often generalize nutritional advice based on demographics such as sex, weight, age, or other categories. Which seems individualized, but doesn't consider the many other factors such as hormones, personal goals, food access, preferences, dietary restrictions, and allergies, to name a few. Further, the information may not be accessible due to the overwhelming nature of finding nutritional information. *My Plate,* created by the United States Department of Agriculture, is used often in doctors' offices or as a simple tool for nutrition education but it doesn't

have the impact intended (Restrepo, B., 2025). According to an article by Restrepo, only around 15% of Americans use *My Plate* with about a third knowing about it. This indicates that it is not reaching as many as it has been intended for, suggesting that either not enough clinicians are recommending it in their care practices or that patients may not know how to use this tool (Restrepo, B., 2025). While *My Plate* is a governmental tool for educating Americans about nutrition, *Eat Right* is an organization dedicated to educating and advocating for improved nutrition made by registered dietitians and nutrition professionals, backed by up-to-date research. *Eat Right* addresses the LGBTQ+ population, specifically addressing the TGD, but only has a few articles currently, with most addressing cardiometabolic concerns. National organizations addressing this community is valuable, however the small amount speaks volumes about the need for more education and guidance on how to address this population beyond cardiometabolic concerns.

In addition to the national nutrition standards lacking information for this population, guidelines for transgender health lack information about nutrition. For this project, I examined eight different care standards published by organizations for promoting transgender health: WPATH, Fenway Health, Transline, Callen-Lorde, APA, Endocrine Society, Rainbow Health, and UCSF. Many of these standards were mentioned by clinicians I talked to or are known for being the standards that clinicians use, especially WPATH, Fenway, and Endocrine Society. These standards often include how physicians should address this population, information around hormone therapy and surgery, and potential risks, mostly focused on cardiometabolic risks for this population, similar to the MyPlate articles for transgender patients.

Nutrition training in the United States currently does not heavily cover topics related to transgender health. All clinician participants, aside from one, recognized this and their lack of knowledge as related to transgender folks. Riley, a nutritionist educator and researcher in this topic, tries to fight this lack of knowledge in the next generation of nutrition professionals. She finds that including the TGD population in the curriculum for future nutrition professionals is vital to transgender health and nutritional care. She has developed resources about this topic, hosted conferences, and addressed the TGD community specifically in her nutrition curriculum. This kind of action seems to be uncommon based on my conversations with clinicians. Other clinicians I spoke to can attest that this community was barely a part of their curriculum at all, but this doesn't mean they aren't interested in this information. Every single clinician I spoke to identified this as an important issue they would want to explore with their patients if they had the proper resources to do so.

When thinking of what 'proper resources' are, there might be a certain idea that clinicians have in mind. Specifically, they might rely on resources only from medical institutions, which at first does not seem like an issue as that is where our medical information generally comes from. However, this may in fact become an issue as research is behind about this population's needs, and clinicians may not be open to the perspectives of patients themselves. This ties heavily into the biomedical model as

clinicians may be trained to think information from patients is not 'medical' enough to guide care (Kleinman & Hahn, 1983; Spade, 2003). This is especially relevant because the current medicalized standards clinicians rely on focusing on an exclusionary, binary system.

Billie, a registered dietitian focused on eating disorders and conditions such as diabetes and PCOS, and I discussed the current standards for nutritional care and whether they work for anyone:

> "I feel like the standards that exist for like, men and women probably are not, have nothing to do with actual sex and a lot to do with hormones and muscle mass and bone density and other things. It's like a shorthand for that. But individual humans may not align with either, whether they're cis or trans or not, just because of individual variations in, hormone levels and muscle and bone density and activity levels and all kinds of stuff...I don't typically follow a gendered binary standard for diets, so I would recommend that nobody does...It's often inaccurate for cis people too, and it is much less accurate for cis people when they're, pre puberty or very old..." Billie, RD (she/her)

The idea that the current standards are not effective for anybody is something that was mentioned quite often. The main reason: they're too generalized. As Billie mentioned, everyone has different biological and lifestyle factors that impact their nutritional needs. The current standards focus on nutritional needs based on the male-female binary, ignoring the many other factors at play such as physical activity, mobility, access to nutritional food, hormone levels, and physical goals. With those factors in mind, it is not surprising that almost all of the clinicians I talked to stated that individualized and multidisciplinary care is the key to supporting the TGD community and everyone in their healthcare journeys, something that will be discussed in the future recommendations section.

"I want to talk to patients about it if they want to talk about it" is what one clinician, Bailey, answered when asked if she would explore nutritional counseling for her gender-diverse patients or if she believes nutritional considerations are important to discuss as related to a hormonal transition. Bailey is an infectious disease specialist who used to be a gender-affirming clinician. She is currently working with patients on HIV prevention and treatment as well as HRT. During our interview, Bailey discussed how she fears causing more gender-related and/or body-related stress to her patients by being the first to bring up diets. This fear is not unfounded. Transgender and gender-diverse individuals are more at risk of developing eating disorders (EDs) (Send; Savio et al; Scheinman et al; Kirby & Linde; Ferguson et al; Hayden; Linsenmeyer et al). Five of the clinicians I interviewed brought up the role of EDs in TGD care. As one described, EDs often appear in the TGD community as a way to connect the outer appearance of bodies to the gender identity the individual wants to express. This is very prevalent amongst trans-femmes as a way to slim down and present a "feminine figure." Further, there may be 'ideal bodies' that TGD individuals have based on their own feelings as well as societal influences such as thinness being associated with femininity or androgyny in some cases (Galupo et al, 2021). Due to this, those body types become ideal and desirable which may lead to disordered or controlling eating behaviors or other types of harm. However, long-term, disordered eating causes

extreme harm to the body, over several body systems such as cardiovascular issues, gastrointestinal issues to endocrine and neuropsychiatric conditions (Carlson & Lemly, 2024). Therefore, there needs to be careful and healthy intervention done to ensure the patient reaches their gender expression goals in the least harmful way.

> "How can we have you feel more connected to yourself, to your gender, to the way that you hope the world sees you that isn't harmful to you?" Jordan, LCMHC, CRC (they/them)

This practice, also known as harm reduction, is very important to working with a vulnerable community such as the TGD community. This is just one of the many strategies that multiple clinicians have used to approach their patients due to the current lack of guidance. Harm reduction, often associated with substance use, is the practice of reducing consequences and harm of risky behaviors that patients may be engaging in (Oregon Health, 2024). This practice approaches patients with empathy rather than shame and judgement in hopes of reducing risky behaviors in a supportive manner. In this context, approaching trans and gender-diverse patients who are dealing with an eating disorder by telling them "don't restrict your eating" will not work or may even cause more harm. Instead, approaching patients with understanding and empathy towards their experiences and their goals and preparing them with the tools necessary to meet those goals safely is more beneficial and a form of harm reduction. As seen in Jordan's quote, clinicians should approach their patients by equipping them with the knowledge and choice in taking care of themselves.

Another method of approaching patients mentioned by most of my clinicians was the Health at Every Size model. HAES is a model focused on compassionate care and not equating every problem a fat person experiences to their weight. This model was brought up in my first interview with a health professional, Judy, and would continue to be a common theme in these interviews.

> "My conversations around nutrition probably didn't happen until more recently, and the reason for that is, right, I'm a 'Health at Every Size' provider, and we think of, you know, 'all bodies are good bodies'… So when you're adding in testosterone or masculinizing therapy to somebody who was assigned female at birth, right? We're focusing on a lot of muscle, a lot of changes with adipose body composition, trying to minimize viscera, adipose tissue, to decrease the comorbidities that could occur with that, we see an increase of diabetes in that population, high cholesterol, you know, can happen. And so I really talk to them about, like I said, increasing protein, how much movement they're doing, what their goals are…The majority of the time, what I hear from my patients is changes in body composition." - Judy

This model played a role in harm reduction as clinicians tried to approach patients in the least harmful way possible, especially when it comes to eating disorders or controlling eating behaviors. The HAES model emphasizes bodily autonomy, informed consent, and moving patients away from a focus on weight and the guilt around body image and towards holistic health (Association for Size Diversity and Health). Comparatively to the biomedical approach that tends to focus on weight loss first as a solution for disease, HAES focuses on bettering a patient's relationship to food and their body with the hopes to promote intuitive eating and positive relationships with food, eating, and body image (Suarez, et al., 2024). In promoting intuitive eating, a practice in which patients listen to hunger and full

cues from their body, this model has seen a decrease in emotional eating and eating disorders, and an increase in positive eating behaviors (Suarez, et al., 2024). Research into this model as applied to TGD patients has not been done yet. However, current results show a possibility for positive application to this population.

The HAES model may also have unintended consequences that may overtake the positives of its use. For example, one TGD participant discussed that their practice is a HAES clinic, so there was not much of a discussion around diet or nutritional changes which may end up harming this patient due to the lack of information given. Another example is Lydia, who discussed how she believes that maybe the reason her provider did not mention anything about diet or nutrition is because she is thin. She explained that maybe the provider believed she was healthy and did not need that discussion because of her size. This could also be harmful to Lydia if she wanted or needed nutritional support.

These practices are ones clinicians are currently trying to use as a way to approach their patients because they have no guidance specific to approaching their trans and gender diverse patients about nutritional concerns. They mentioned implementing practices like these because they do not feel equipped enough to provide actual information or comfortable to inform patients/clients about how they should eat or exercise.

Another common theme among all clinicians I interviewed was the desire to help patients, but facing barriers in doing so, such as an education gap either in themselves or patients, burnout, and not being paid enough.

> "And I think what has happened is that I have a lot of academic privilege in the fact that you have a master's degree because of that I have-I know how to research things. I know how to find information. I know how to read literature in a way that is not academia- is not accessible for many people. And so what I have been able to do is use that knowledge that I have, in order to be like, Okay, let's-what are the questions that we should be figuring out together. And some therapists are weird about that. You know, they're like, though, "this isn't within our scope of care", which I think is kind of bullshit, like, I do genuinely think it is both our ethical and moral responsibility to do what we can to provide our clients with the services that we can, even if that means that it is not necessarily something that we were trained to do, right? And so I have sat down with clients and been like, "All right, let's like, let's put this in Google Scholar. Let's access whatever articles I can, and let's read through them together. This is what I'm gathering from them. How does that sit with you? What are you thinking?" Jordan, LCMHC, CRC (they/them)

Jordan, a licensed clinical mental health counselor, takes the time to make sure their patients can reach their goals through using their experience. However, they discussed how this is something they are not sure will continue as they go on in their career due to the burnout they have observed in their colleagues.

> "Yeah, I think, you know, therapists are often very overworked and frequently very underpaid, and so I, I really do get why... But I think one, I'm very early in my career, and so I'm not fully burnt out, like a lot of my colleagues are, but I think the other thing too, is I am a first gen student, right? My parents didn't finish high school, my grandmother didn't know how to write, right? Like, there are, I think that provides me a very unique perspective of,

> like, how inaccessible information is. And I think that is what allows me to, I think that is sometimes the driving force that, like, even if I'm tired, I'm like, “Okay, we're going to do this together, right?” Because I think, I think so often, you know, many therapists that I know are, their parents were therapists. Their parents were doctors, right? Like, they had these things, examples accessible to them, because grad school is fucking expensive and so they like, it's just not something they consider, which is, which is a disservice. And also, like, I understand how it would not be something that comes to mind for them, yeah, and so I, I am grateful that the experiences that I have had have allowed me to then provide better care for my clients. And I also understand why it is so challenging for other therapists to find the time to do so or to feel comfortable doing so, I think, right? Also, in a sense, it is a liability that you're taking on, right? Because you could, it could be interpreted as you giving medical advice, or it could be interpreted as you like, guiding your client, whatever that means, right, which are things that we're not supposed to do. But for me, that feels like a risk worth taking, at least for now.” -Jordan, LCMHC, CRC (they/them)

Due to personal experiences, Jordan makes sure to do this for their patients because they recognize what a privilege it is to access information such as scientific articles. But as they discussed, there is a deeper need that requires addressing: patient education. Unfortunately, due to the model of medicine we have right now, doctors and other healthcare professionals do not have the time or bandwidth or even the resources to help their patients access everything they need to reach their goals. Therefore, solutions need to go further than just clinicians giving information, especially when they do not have it to begin with.

DIY Research as a Consequence

This lack of support from clinicians has consequences. One of the biggest was DIY research. Without proper access to nutritional information from trusted care teams, it seems many in the TGD community turn to finding the information on their own. This is true of finding nutritional information as well as just information on transitioning. While doing your own research is never a bad thing, it can lead to some negative outcomes such as becoming misinformed, encountering dangerous relationships, feeling like we don’t have a trusted practitioner to go to, and ultimately not getting enough of what we need nutritionally.

Addressing these outcomes may be achievable without reinforcing the medical gaze that we are currently in. In doing so, clinicians need to approach patients with an individualistic lens and autonomy. This can be done through patient education or pointing patients to the resources available to address concerns and goals they have. This means patients would be able to take a more holistic approach to their health and clinicians would be focusing on the entire patient, rather than just ‘solving their gender dysphoria.’ Equipping patients with information may help with dispelling misinformation that is a common occurrence in this community and generally.

A big issue within online communities is the spread of misinformation. We see this in every single community we encounter on the internet. For the TGD community, a common example is soy. Unfortunately, this piece of misinformation is so common in the

transmasculine community to the point that quite a few of the transmasculine folks I talked to either mentioned it or had heard of it at some point in their transition. Even clinicians knew about it! The misinformation stated that soy was to be avoided by transmasculine folks if they wanted to avoid estrogen because soy contains estrogen. The problem with this blanket statement is not unlike the standards from earlier; it's too generalized. Soy does indeed have estrogen in it, but for the estrogen to make that much of a difference in our hormone levels an individual would need to be eating pounds of tofu every single day. Additionally, the estrogen found in soy (phytoestrogen) is not the same as estrogen found in animal bodies, so it is not absorbed in the same way. This means estrogen levels will also not increase. Although it should be noted that too much soy is not good either and can cause possible reproductive issues in those assigned female at birth. Further, in the research done so far, it has been found that tofu does not alter the bioavailability of testosterone in individuals assigned male at birth, so this research also dispels possible misinformation around using soy to decrease testosterone and/or increase estrogen in transfemmes (Messina, 2021). This reflects a larger trend in the broader culture of concern about feminization with even articles directed at cisgender men, telling them not to eat soy through creating fear about developing breasts or 'becoming a woman' (Messina, 2021). The big issue with this is the fear it has generated over certain foods, creating a 'good' or 'bad' food for parts of the community. This may result in restricted eating behaviors when in fact foods like tofu are considered a healthy food option. Further, some of this information is prevalent in online eating disorder communities where many TGD individuals may be finding a majority of their nutrition information, causing even more harm. This is far from the only misinformation spread within our community about certain foods. Supplements have also become a dangerous tool of misinformation.

"I do know that there are supplements that folks might read about or take to especially those that have phytoestrogens, and so I have done a little bit of research and seen a number of folks who are taking an over the counter supplement, which can lead to increases in estrogen or testosterone, because those are not regulated and can sometimes have negative effects on like liver enzymes in the example of testosterone, or concern for like blood clot risk or something, and they for estrogen, we generally recommend folks don't take over the counter supplements that are for that reason." Bailey, IDS (she/her)

In order to meet the goals of TGD patients, nutritional assessments were a commonly agreed upon solution. Specifically, trans and clinician participants alike agreed that these would be most beneficial at the beginning of their medical transition care in order to understand a baseline of goals, food access, preferences, and lab results to better support patients.

> "I think nutritional assessment and support around transition makes a ton of sense, just as risk reduction, like, "hey, a lot of people are experiencing disordered eating prior to this, related to depression, dysphoria, all kinds of other things that may be happening this so this is a, this is an at risk population. If people aren't already getting support and service, it would be a great time to offer it, because starting a medical transition doesn't necessarily

> guarantee that it's all gonna just get better and go away"...Certainly, any time our bodies change, whether it's like changes that we're excited about and really want or changes that we don't want, it's complicated. It brings up really complicated stuff around... body image and weight and food and eating behavior definitely gets touched by that. So, yes, I feel like it's an important time for people to have weight inclusive, gender expansive support with their nutrition care." -Billie, RD (she/her)

Beyond the professional opinions of clinicians, some of my TGD participants brought up that they believed these assessments would definitely be more effective at the beginning of transitions to set them up for success later. This could be due to the forming of habits or to get a more individualized approach to their care.

Another issue of DIY research is the communities TGD individuals might find themselves in. A big example of this is eating disorder forums. One of my informants discussed his experiences with online eating disorder communities and how a lot of his nutrition information came from there.

> "Okay, basically, the only thing that I know about nutrition. So, this is where we're going to get into eating disorders. When I relapse because I'm still actively in an issue with it. I often go onto forums for people with eating disorders, and that is where I've gotten the majority of the nutrition information for my whole life. It's not accurate. I'm not saying it's accurate, but it's like, "here's the minimum things you need to survive." And so that's the information I know. Yeah. So, I know, maybe the most negative appearance of food ever...Yeah, my dad, who never explained how these meals worked, and after I started refusing a couple, he just stopped making them. So, I never really learned nutrition that way. Nutrition wasn't taught in my school, any of them...I, frankly, okay, let's say the eating disorder forums are not the place [to get nutrition information]." -John, trans man

As John said in his interview, these forums are not the best place to get nutrition information that is beneficial for TGD health, but these forums provide community. John further explained that these forums were even "instrumental to understanding [his] identity" and that they are turning towards harm reduction. As explained in the clinician section, it is important to approach patients that have a history of or risk for eating disorders with a harm reduction lens so as to not cause further harm and treat patients with dignity. Providing accessible nutritional information and adjusting the care guidelines we currently have could help support this community as it deals with the fallout of not having those resources such as the ED forums and DIY research.

Future Recommendations

When discussing potential solutions and accessibility in these interviews, a few common themes came up: improving general accessibility, addressing the educational gap between patients and clinicians, additional research and updates to the current standards, and multidisciplinary, individualized care. These recommendations come from both clinicians and TGD participants that I interviewed and from the broader literature surrounding nutritional ranges, educational methods, and representation in the medical field.

General Accessibility

Food and nutritious food in particular, seemed to be inaccessible in some way to almost all of my trans and gender-diverse participants. Food insecurity is very common in the TGD community (Kirby & Linde, 2020; Linsenmeyer, 2023). Addressing this issue is important to supporting the nutritional considerations for this population so that patients are able to access the food that meets their needs and preferences after receiving care. It is vital that there is not just access to food in general, but food that meets their individual needs, wants, and is culturally appropriate. Further, patients should be provided with the means necessary to afford these foods, ways to prepare them, and enough education to have autonomy over choices that will support them. This seems to be especially relevant to younger adults in college as they make their own food choices perhaps for the first time (Kirby & Linde, 2020). This seemed evident in the TGD participants I talked to through patterns between those in college and on the meal plan and those who were older or not on a meal plan. For those on a meal plan and in college, it seemed they often were not sure how to eat in a way that supported their goals. For those off the meal plan and/or older, they often were established in a routine of what to eat and knew a little bit more about nutrition. This makes me believe that earlier educational interventions would be appropriate to supporting the needs of TGD patients, so they are equipped with the knowledge to support their needs and goals.

Providing researched and supported food options is additionally crucial to addressing the common issue of patients not knowing what information to trust and combating the common misinformation about foods.

> "Understanding more of what food will fuel me in the way that I need…I just feel like there's always so many different fads out there, right, and things like that, so it's hard to know what is actually good information." -Kevin, non-binary transmasculine

This is especially relevant as online communities may fuel misinformation about eating behaviors, and they are commonly where TGD individuals look for this information. In studies by Schier et al (2024) and Schier and Linsenmeyer (2019), they found that many TGD individuals look to online sources such as communities on Reddit and YouTube videos which may have positive and negative effects. On one hand, these forums are beneficial as they may provide community and a place to share experiences. However, these forums contain much misinformation that can harm patients such as promoting risky eating behaviors or just incorrect information. Clinicians can combat this spread of misinformation by providing their patients and communities with evidence-based resources and participating in already existing channels where this information is shared.

Closing the Education Gap

As mentioned before, there is an education gap with clinicians as well as patients. Clinicians often aren't taught this information, the trans community not being a part of the curriculum.

> "There's a lot of folks who just don't, we don't know much, and don't get much training about nutrition in general. So it'll be interesting to explore, like, Okay, are there really simple things that you know can be written into the guidelines that then, like, the non-nutritionist, non-dietitian, person, can rely in the clinic, and then kind of a separate like, Okay, are there in depth studies and things that nutritionists and or dieticians...but get trained in so they can give more detailed information."-Bailey, IDS (she/her)

> "So I graduated in 2024 so hopefully getting the most like, up to date information too, and it was something I'd say pretty like, grazed over, if talked about at all, probably more like that somebody in my class, like, if we wanted to know more information, it would have been on, like, independent research projects, rather than something necessarily talked about often"-Molly, RD (she/her)

Inclusion of the TGD community in the curriculum for general health practitioners and more specifically, for nutritionists and dietitians is important so that these patients are supported holistically and that concerns such as the prevalence of EDs are appropriately considered. Further, because of the gap of education between patients and clinicians, it is important that clinicians know how to approach their patients with information that is accessible. One way this can be done is through patient-friendly resources. Many TGD and clinician participants alike mentioned the need for different types of resources such as asynchronous video-based learning, one-on-one counseling, and written resources. It is important that a variety of resources are available as well as ensuring that the information is presented in a way that is accessible to patients (i.e., reduced jargon).

> "Honestly, like videos, videos, anything that I could go to in my own time, I guess talks are good, but I think that...Personally, the most accessible things for me are asynchronous, especially for information transfer." -John, trans man

> "So I think that, like I said, some asynchronous learning, you know, that they could go you would have to make it accessible in terms of costs, which is going to be difficult, because we know that, from a financial, economic standpoint, that the those individuals in that community are with our, within our gender diverse populations, are in a lower socio-economic, right, status. So cost is always a big issue. I think a lot of people forget that insurance can, you know, help to offset some of the nutrition counseling. So I tend to refer to nutritionists or dieticians that take insurance. I know that that's far and few between, but it's helpful, and not all insurance plans cover nutrition counseling." -Judy, health care practitioner (she/her)

> "I think the first part is definitely, you know, having that conversation in a public space, if you can, if you have the opportunity to. I also think that so that can be through culturally competent training. So training dieticians training or nutritionists in trans or gender non-conforming health to reduce stigma and ensure affirming care, including education on HRT, the metabolic effects of HRT disordered eating, risks in this population, and also related body image issues, doing things this is a really big one, actually, that I feel like is really important using on intake forms and When communicating using gender neutral and inclusive language, especially on forms, because that is like, that is a big one...I also think, as a practitioner, it's important to work to develop community partnerships. So, you know, working with LGBTQ organizations, maybe clinics to offer maybe mobile or even sliding scale nutrition counseling, and then creating resources for those communities, for the tailored to the community's needs. So if they're like, you know, within your practice creating

like educational materials on hormone friendly nutrition tips, like affordable food planning, eating disorder support, like that type of thing, in terms of adapting nutrition guidelines, I think it's important to recognize that a lot of these are kind of male female averages, so they're not necessarily reflecting changes in body composition due to HRT. You know, the effects of HRT. So I think it's important to be mindful when applying male or female BMR ranges, caloric ranges, protein needs, etc, so that we're just prioritizing, not necessarily the male or female part, but I try to prioritize the individualized assessment of that individual, of that person." -Bowen, RD (he/him)

The most common theme of what patients would find most helpful is education. It seems that having options for education would be the most beneficial as stated above, and patients should have the autonomy to pick what resources or mix of resources would be the most beneficial for them. Clinicians should be open to supporting patients in whatever option(s) they choose.

Diversity in the Nutrition and Dietetics Field

The nutrition and dietetics field, like many medical fields, has a lack of diverse practitioners as well as a lack of diverse teachers guiding the next generation of medical professionals. Currently this impacts patients who are part of minority communities, including TGD individuals (The Sullivan Commission, 2004). This is even seen in this research where most of my nutritionist and dietitian participants were white cisgender women.

"If somebody did want to see a nutrition professional as well, I'm always going to be a proponent of increasing that access. And I Hmm, I think also within, just like generally within the dietetics community, I would say we need to be able to expand the folks that come in and want to become dietitians, I would say for the most part, people look a lot like me. It's a lot of white, female, cisgendered folks. I think that that is changing. I'm hopeful that it is, but it is a lot to do with the amount of schooling that it takes, and there's a lot of unpaid internships associated to and then, unfortunately, we don't end up getting paid too much by the end of it" -Molly, RD (she/her)

Having clinicians that are part of the community is important as it may make patients more comfortable and because those practitioners would have the personal experience that informs their work (The Sullivan Commission, 2004). Two of my clinician participants for this research were part of the community, one of which was a dietitian.

"I specialize in gastrointestinal conditions, but I see individuals who want to lose weight, who want to learn more about nutrition, just for themselves to improve their life, and I see a lot of members of the LGBTQ community, which I find to be very empowering for myself, but also for them. I think it's helpful to talk to someone who you feel you can relate to...Obviously, as a trans person myself, I felt that it was very important that I enter this space to create that platform in a way, not that's, I don't mean it like, you know, this is my platform. I just mean, like I felt a need to be present for people who were looking for that, because when I transitioned, I did not have that, and I didn't know how to approach my nutrition, which is part of why I got invested in it myself." - Bowen, RD (he/him)

This is an important perspective as this clinician emphasized the importance of empowering people with the information they did not even have access to when they began their transition.

Research and Updating/Adding to the Standards

The current standards, as we have seen with this research, do not sufficiently address individual needs. Clinicians even felt that traditional sex-segregated nutritional standards have nothing to do with sex, but rather individual measures such as one's hormone levels and muscle mass.

"So I think we actually have to take binary out of it. Because everybody comes in different shapes and sizes. So the fact that you're putting, you know, women and men into these categories, like not all men are 6'2 and weigh 250 pounds...And we have to remember that when those standards got put into place, that the thought was that women lived in smaller bodies and that men lived in larger bodies. We know that that is not the case. And I think if we actually can take that out of it and put it into more of an individual body composition, like maybe start looking at percent muscle, percent fat, right? You could take weight into consideration, but we are so skewed by BMI that I hate weight... And I don't think that you can, necessarily use binary constructs in this space to do that, because some of these goals, even as a trans femme like I have lots of folks who are like, "I have a very demanding job, and I want to be able to do my landscaping job and lift and I love lifting heavy things, so I don't want to give that up, but I love more of a feminine shape or a feminine body composition." So again, I think it's just meeting that person where they're at in terms of goals. And I think that that's the problem with the world, is that we want to put people into boxes and recognizing that we are very unique individuals, that, yes, there's going to be some, I think, similar themes throughout, but when you start limiting people's abilities into boxes like that, in a binary box, you-you miss the point." - Judy, general health practitioner (she/her)

So, when thinking of whether the current standards address the needs of anyone, maybe individualization would be the most appropriate option for addressing nutritional concerns as genetics and hormones are not the end all be all. All of this is not to say that HRT does not make a difference; we still do not know all of the information on what nutritional needs may be changed when a person goes on HRT. However, it is important for clinicians to look at the entire patient to make any changes as needed.

> "So from a dietary perspective, it does depend on the individual person's goals. So for example, if I see someone on HRT that has elevated blood glucose levels, that's the primary thing that I work towards addressing, or maybe it's, you know, a weight related question that they have regarding how to, you know, and that can be based on any hormonal related changes that they experience, like you kind of listed Here, metabolic changes, etc. I don't change things too drastically. From a dietary perspective, a lot of the baseline foundations and principles of nutrition remain the same, regardless of whether or not they are on HRT, keeping in mind, though, that HRT obviously does have some things that it changes, but not in such a way where I would drastically change their diet, you know, too much, but I really

> try to take an individualized approach to each person. So I think that, again, it depends on the individual's person's goals. But I have not experienced a case where I've had to even with, with all the kind of metabolic effects of, you know, potentially a slower metabolism, potentially changes in red blood cell count, potentially changes in cholesterol levels. I have not had, you know, if there is an instance where that is occurring, we can address those through the diet, so, but I have not, it's not this sort of case where someone goes on HRT and now all of a sudden we have to do like, an overhaul of their diet. Does that make sense? I make individualized changes based on their presentation, with the incorporation of like lab work, looking at maybe their protein intake isn't high enough for their needs. Maybe they're needing more of a heart health focus, a muscle maintenance focus, cholesterol management, that type of thing, so I look more at how they are presenting to me, rather than this sort of generalized approach" -Bowen, RD (he/him)

My clinician group, like Bowen above, often stressed that there should be no preliminary change in diet for trans patients going on HRT, that is taking too much of a generalized approach to their care, but instead discussing the goals of the patient, their medical and family history, and taking their lab work into consideration to support patients in their transition.

In research done by Whitney Linsenmeyer, Theresa Drallmeier, and Michael Thomure, they recommend basing the standards a clinician uses off of where patients are in their medical transition. For example, if a female to male patient is taking testosterone and has been on testosterone for one year or more, a clinician could choose to switch from the nutritional ranges for females to those for males and vice versa. The clinician may also choose to do a range of male and female nutritional values if that works best with the patient's needs which may be especially relevant for non-binary patients (Linsenmeyer, W., et al., 2020). We need to continue the research, such as this study, being done and use those results to inform the guidelines/standards that address nutrition and the needs of this community to appropriately care for this population.

Multidisciplinary and Individualization

The biggest theme in this research and what I argue would be the most beneficial to this care is multidisciplinary, individualized care. What this means is the collaboration between different fields (e.g., nutrition, gender-affirming care, personal training, and mental health) that focuses on the individualized needs of a patient. This could be constructed in a strong-referral based practice where if a patient wants certain support, they could be referred to trusted practices or even in-house resources like having dietitians or nutritionists in gender-affirming care practices.

> "I think it would make a lot of sense to me for providers who are helping people with medical transition to have like, strong referral relationships with dietitians who are well informed about eating disorders and trans healthcare, and to have that be a sort of standard part of it that it is offered that people have at least an assessment, like a nutrition assessment at some point in there, just to see where things are at and give them some basic information and let them know that there's somebody they can reach out to if they're having trouble along the way." -Billie, RD (she/her)

This would be especially helpful in the face of insurance and cost barriers that may prevent patients from accessing care.

Conclusion

These findings serve as an interesting addition to the current research out there through both clinician and patient perspectives. The findings of this study suggest that more research is needed to identify the most effective dissemination strategies of nutritional information to TGD patients as well as the most appropriate information to be disseminated. This work identified current issues with the standards that exist to guide the care of this population in hopes of advocating for more individualized care for patients. Due to its small sample size, this work should be used as a jumping off point to understand the potential areas of intervention. The researcher hopes to continue this work in the future, advocating for a multidisciplinary and individualized approach to the care of TGD patients.

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Appendix A: Interview Guide for Clinicians

1. First and foremost, how would you describe your gender identity?

2. What is your position in the medical field? How do you help patients/What services do you provide?

3. [If you provide HRT]: When you have prescribed patients with HRT or guided hormonal transitions, have you discussed changes in diet? (Meaning metabolism changes, needing to eat more, foods to help meet transition goals, etc.)

4. [If you provide nutrition services]:When you have seen patients on HRT, how have you discussed nutrition in relation to hormone changes? (e.g., metabolism changes, binary-standards of nutrition, foods to help meet transition goals, etc.)

5. Have you heard of nutrition counseling services for trans/GNC individuals? If so, what are your thoughts or understanding of this topic?

6. Do you believe this is something you would like to explore with patients or that you think is important to consider when guiding a hormonal transition?

7. How do you suggest we can make nutrition more accessible to trans/GNC patients? How would you recommend following the current binary-gendered standards for diets?
   a. E.g., FTM who's planning to go on HRT following "male" guidelines.

8. Do you have anybody else that you think I should discuss this with? (This is helpful to gain as many perspectives and as much information as possible to represent a larger population–called snowball sampling) AND/OR Do you have any topic or other questions I haven't addressed that you think I should look into?

9. I am creating a zine off of this project with the goal to inform trans community members on how to advocate for themselves in the nutrition/care space as well as what resources are out there. Do you have any suggestions for how I should organize this, what information you find most helpful and important, etc?

Appendix B: Interview Guide for TGD

1. First and foremost, how would you describe your gender identity?
   b. Do you consider yourself as a person with gender dysphoria?
2. How would you describe your transition? Are you currently on or planning to go on hormone replacement therapy?
   a. If yes, what has this looked like for you? If you're comfortable, please describe the consultation process with your doctor (what information did you receive about HRT)
   b. If on HRT: how long have you been on HRT?
   c. Did your doctor talk to you about nutrition or diet changes for HRT?
   d. Were you informed about potential risks for the following conditions?
      i. Obesity
      ii. Diabetes
      iii. Cardiovascular disease and other risks
      iv. Eating disorders
   e. If you have had any surgery:
      i. Did you take any supporting eating measures or even know about any that would assist you in the healing process?
3. What is your relationship with food? (This is broad, but ideally getting an idea of what role food plays in their life)
   a. What role does food play in your life?
   b. Do you think, with the proper resources, food could be empowering to you and/or support your gender identity?
   c. How do you currently seek nutrition information and/or information that helps with your transition?
   d. Do you follow any guidelines currently or eat sex-related foods/vitamins (i.e., "for men's/women's health" food items)?
   e. For those on campus: Do you eat through a meal plan? Do you feel the meal plan provides options for you to reach your goals?
      i. How do you make choices on what to eat?
      ii. Do your transition goals impact these choices?
   f. For those off campus: How do you make a choice about what you make/eat on a daily basis?
      i. Do your transition goals impact these choices?
4. Gen Health
   a. How balanced are your eating habits? (fruits, veggies, protein, etc)
   b. Do you drink enough water?

5. What barriers exist for you when accessing food and/or nutritional resources? What about facilities–gyms, clinics, trans spaces, nutritionists, etc?
    a. What about accessing cooking, grocery shopping, or other food-related activities?
6. Have you heard of nutrition counseling services for trans/GNC individuals? If so, what are your thoughts or understanding of this topic?
    a. Are you interested in both medical and non-medical transition strategies?
7. What are ways you think nutrition could be more accessible to you and other trans/GNC individuals?
    a. What topics would you be interested in within nutrition education?
    b. Do you have any concerns involving food or nutritional intakes that have developed since the beginning of your transition?
    c. How could a practitioner approach you about nutrition?
8. Do you have anybody else that you think I should discuss this with? AND/OR Do you have any topic or other questions I haven't addressed that you think I should look into? (This is helpful to gain as many perspectives and as much information as possible to represent a larger population–called snowball sampling)
9. I am creating a zine off of this project with the goal to inform trans community members on how to advocate for themselves in the nutrition/care space as well as what resources are out there. Do you have any suggestions for how I should organize this, what information you find most helpful and important, etc?

Appendix C: Recruitment Flyer