Caring for Transgender Patients and Clients: Nutrition-Related Clinical and Psychosocial Considerations

DISEASE PREVENTION AND health promotion in the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community has gained significant momentum in the past 3 decades. Prior research has demonstrated marked health disparities among the LGBTQ population, such as elevated rates of cancer, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome, and mental health disorders, compounded by limited access to quality health care. Studies investigating cancer incidence specifically in the transgender population have been limited in size and scope, making it difficult to draw conclusions; however, increased incidence and mortality from cancer have been reported in LGBTQ communities. As a result, in October 2016, the National Institutes of Health formally designated sexual and gender minorities as a health-disparate population.

In the nutrition and dietetics literature, differences in gender-specific diet- and nutrition-related considerations have traditionally been framed as occurring between cisgender, heterosexual males vs cisgender, heterosexual females. However, emerging research has indicated distinct nutrition-related considerations for sexual minorities of the LGBTQ population. A landmark study identified significant variations in health risk behaviors within each subcategory of sexual orientation, indicating a need to investigate the dietary considerations of sexual minorities that have historically been grouped into one category.

The transgender population is of particular importance to the nutrition profession, given the medical interventions undertaken to make the transition from one gender to another. An estimated 0.6% of adults in the United States, or 1.4 million, identify as transgender. This figure has approximately doubled in the last decade. Historic advancements in legal equality and increased cultural acceptance have likely contributed to an increasing number of individuals openly and more willingly describing themselves as transgender. Furthermore, increased media visibility, access to the internet, and greater support resources for this community have resulted in greater awareness of LGBTQ issues and a reduction in the stigma and some of the previously held stereotypes that often lead to discrimination.

The following key terms are defined throughout this paper.

Transgender: an adjective that is an umbrella term to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term transgender is common, not all transgender and gender-nonconforming people self-identify as transgender.

Cisgender: an adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth; a person who is not transgender and gender-nonconforming.

Male to Female (MtF): individuals whose assigned sex at birth was male and who have changed, are changing, or wish to change their body and/or gender role to a more feminized body or gender role. MtF persons are also often referred to as transgender women, transwomen, or trans women.

Female to Male (FtM): individuals assigned a female sex at birth who have changed, are changing, or wish to change their body and/or gender identity to a more masculine body or gender identity. FtM persons are also often referred to as transgender men, transmen, or trans men.
### Strategies for Provision of Care, Treatment and Services

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<tr>
<td>- Prominently post the hospital’s nondiscrimination policy or patient bill of rights.</td>
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<td>- Waiting rooms and other common areas should reflect and be inclusive of LGBT patients and families. (For example, LGBT-relevant magazines and posters and information about local LGBT resources should be available.)</td>
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<td>- Décor and images depicting couples and families should include same-sex partners, same-sex patients, and LGBT families.</td>
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<td>- LGBT-friendly symbols such as the rainbow flag can be displayed in waiting areas, on placards and forms, and on staff badges. This can immediately signal a culture of acceptance.</td>
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<td>- Create or designate unisex or single-stall restrooms. (Although making a unisex restroom is an important signal of acceptance, patients should be permitted to use restrooms that comport with their gender identity and should not be required to use the unisex restroom.)</td>
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<th>Foster an environment that supports and nurtures all patients and families.</th>
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<td>- Ensure that visitation policies are implemented in a fair and nondiscriminatory manner.</td>
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<td>- Refrain from making assumptions about a person’s sexual orientation or gender identity based on appearance. (For example, a patient wearing a wedding ring may be partnered with another man or woman; someone whose appearance is typically masculine or feminine may have transitioned from another gender.)</td>
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<td>- Be aware of misconceptions, biases, stereotypes, and other communication barriers.</td>
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<td>- Be aware that visible discomfort on the part of staff or other patients in the presence of displays of affection or support can exacerbate an already difficulty situation for LGBT families.</td>
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<td>- Determine mechanisms for handling patient-to-patient discrimination while preserving the dignity of all involved.</td>
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<th>Facilitate disclosure of sexual orientation and gender identity while remaining aware that such disclosure (“coming out”) is an individual process.</th>
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<td>- Honor and respect the patient’s decision and timing with regard to coming out.</td>
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<td>- Ensure that all forms contain inclusive, gender-neutral language that allows for self-identification. (For example, under “relationship status”, provide options such as “partnered”. For parents, use terminology such as “parent/guardian” that is inclusive of same-sex parents who may or may not be biologically related to the child.)</td>
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<th>Advance effective communication.</th>
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<td>- Keep in mind that patient information is protected by privacy and confidentiality laws.</td>
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<td>- Use neutral and inclusive language in interviews and when talking with all patients.</td>
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<td>- Listen to and reflect patients’ choice of language when describing their sexual orientation and how a patient refers to his or her relationship or partner.</td>
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<td>- If you are unsure of a person’s gender identity, ask gender-neutral questions for clarification (such as “How would you like to be addressed?” or “What name would you like to be called?”).</td>
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<td>- Be aware of language or questions that assume heterosexuality (such as “Are you married?”). When asking about family relationships ask “Who are the important people in your life?” or “Who is family to you?”</td>
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Gender-nonconforming: an adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned birth sex.

Genderqueer: a term used to describe a person whose gender identity does not align with a binary understanding of gender (ie, a person who does not identify fully as either a man or a woman).

Hormone therapy (gender-affirming hormone therapy, hormone replacement therapy): the use of hormones to masculinize or feminize a person’s body to better align that person’s physical characteristics with his or her gender identity. People wishing to feminize their bodies receive antian- drogens and/or estrogens; people wishing to masculinize their bodies receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

**DIETARY CONSIDERATIONS FOR TRANSGENDER PATIENTS AND CLIENTS**

Based on the current evidence, dietary considerations for transgender patients and clients are both clinical and psychosocial in nature. Individuals seeking to medically transition may undergo gender-affirming medical interventions of masculinizing or feminizing hormone therapy, as well as surgical reassignment. In adolescents, treatment may also include suppression of puberty. Specific side effects of hormonal therapy may be within the scope of practice of registered dietitian nutritionists (RDNs). These side effects include weight gain, changes in body composition, altered lipid profiles, and changes in bone composition and other metabolic factors. As a result, the World Professional Association for Transgender Health has identified specific risks associated with hormone therapy. Specifically, transgender FtM individuals receiving testosterone therapy may exhibit weight gain, increased lean body mass, decreased fat mass, increased low-density lipoprotein levels, decreased high-density lipoprotein levels, delayed prothrombin time, increased hemoglobin and hematocrit, and increased creatinine levels. The World Professional Association for Transgender Health identifies transgender males as having a likely increased risk for polycythemia; a possible increased risk for hyperlipidemia; and a possible increased risk for cardiovascular disease, hypertension, and type 2 diabetes when other risk factors are present. The World Professional Association for Transgender Health identifies transgender females as having a likely increased risk for venous thromboembolic disease and hypertriglyceridemia, a possible increased risk for hypertension, and a possible increased risk for type 2 diabetes when other risk factors are present.17

Dietary considerations for the transgender population are not only clinical but also psychosocial in nature. Existing research points to a higher prevalence of disordered eating, unhealthy weight control behaviors, weight misperception, and body dissatisfaction among sexual minorities.14,18-22 Within the adolescent population, heterosexual males with prior same-sex partners and bisexual males were more likely to consider themselves overweight, despite being at a healthy weight or underweight, whereas sexual-minority males and females were significantly more likely to engage in unhealthy weight control behaviors compared with exclusively heterosexual individuals.23 Within the college student population, transgender and cisgender sexual minorities reported elevated rates of eating disorders and compensatory behaviors that included use of diet pills, use of laxatives, and induced vomiting.21

**THE ROLE OF THE RDN**

The increased demand for medical treatment by transgender individuals, in conjunction with evidence that this population is health disparate and underserved, supports the need for

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**Strategies for Provision of Care, Treatment and Services**

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<td>• Provide information and guidance about specific health concerns faced by various LGBT subgroups.</td>
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<td>• Become familiar with online and local resources available for LGBT health topics.</td>
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<td>• Be prepared with appropriate information and referrals, and help patients find respectful providers.</td>
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<td>• Be an advocate for vulnerable LGBT subgroups such as the frail elderly, disenfranchised youth, those who are homeless or uninsured, those who have been victims of violence or bullying, and those with no legal status.</td>
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*LGBT = lesbian, gay, bisexual, transgender.

highly trained health care providers with expertise in this area.\textsuperscript{24,25} RDNs are in a position to provide appropriate, patient-centered, and compassionate care for this health-disparate population.

**Eating Disorders**

Although the precise etiology of eating disorders in the transgender population has not been clearly explicated, it is evident that the relationships among sexuality, gender identity, body image, and eating disorders are complex. The higher incidence and multifactorial nature of eating disorders in this population requires a collaborative treatment approach by an interdisciplinary team of experts, including an RDN. Nutrition interventions provided by an RDN have demonstrated improvements in behaviors related to binge eating, increased caloric intake, and purging and significant increases in weight and the amount and variety of foods consumed.\textsuperscript{26-28}

**Weight Gain**

Weight gain is a documented side effect in the transgender population among those undergoing hormone therapy. Although weight gain has been noted in both MtF and FtM individuals, the composition of the gained weight varies. Typically, in MtF transitions, body weight changes reflect an increase in body fat and decrease in lean body mass owing to feminizing hormones, whereas masculinizing hormones in FtM transitions appear to have the opposite effect.\textsuperscript{29} Within the literature, there exists a dearth of evidence identifying best practices to estimate nutrient needs in the transgender population. Further research investigating the impact of hormone therapy on the calorie needs of transitioning individuals would allow RDNs to work effectively on weight management strategies with their clients. Further research in this area is needed to optimize weight loss efforts and weight management strategies within this specific population. Although successful and lasting treatment interventions for overweight and obesity remain somewhat elusive, evidence suggests that incremental, discrete, and practical lifestyle changes that are implemented with the support of a multidisciplinary team can be sustainable and effective.\textsuperscript{30} In addition, existing research has established the effectiveness of nutrition counseling by an RDN on weight loss when compared with counseling provided by other health care professionals.\textsuperscript{31-35}

**Chronic Conditions**

Although limited, evidence suggests that transgender adults are more likely to have chronic conditions such as cardiovascular disease, type 2 diabetes mellitus, HIV, cancer, obesity, depression, asthma, chronic obstructive pulmonary disease, and chronic kidney disease.\textsuperscript{36,37} Substantial evidence links dietary factors to increased risk and incidence of chronic disease. However, the elevated prevalence of chronic conditions among the transgender population cannot be attributed to nutrition-related factors alone. The etiology of chronic conditions among the transgender population is multifactorial and complex. Stigmatization of transgender individuals has been implicated as an underlying contributor to adverse health outcomes in this population.\textsuperscript{37} Although limited research exists on the effects of stigmatization on health outcomes in the transgender population specifically, studies from other stigmatized groups show links between stigma, stress, and negative health effects such as hypertension, diabetes, and cardiometabolic disturbances.\textsuperscript{37} Furthermore, limitations in access to and utilization of health care services remain a substantial impediment to transgender individuals receiving the care they need, further increasing their risk for chronic disease.\textsuperscript{17} Regardless of the etiology of chronic disease in this population, dietary modifications, implemented with the guidance of an RDN, have been shown to improve biomarkers of chronic disease.\textsuperscript{38} Nutrition counseling in the adult population has been effective in improving overall diet quality, blood glucose levels and glycated hemoglobin values, blood pressure, and lipid levels and in reducing weight and waist circumference,\textsuperscript{38} thereby reducing overall risk of chronic disease.

**APPROPRIATE AFFIRMATIVE PATIENT CARE FOR TRANSGENDER INDIVIDUALS**

Although some strides have been made in societal understanding and acceptance of transgender individuals, access to culturally competent, gender-affirming health care remains limited and contributes to troubling health inequities.\textsuperscript{39} Research has demonstrated that these disparities are made evident in the prevalence of physical and mental health conditions and are exacerbated by stigma and the inexperience and insensitivity of health care providers. In a follow-up to the 2011 National Transgender Discrimination Survey, the National Center for Transgender Equality, conducted the National Transgender Discrimination Survey and found that discrimination and disparities were evident in the workplace, educational system, community, family structures, and the health care system.\textsuperscript{40,41} Social and economic marginalization have devastating effects on health outcomes for the transgender population. One-third of respondents to the US Transgender Survey reported having at least one negative experience with a health care provider in the past year, including denial of care; verbal, physical, or sexual harassment; and the need to educate the provider about transgender health issues in order to receive appropriate care. In addition, 23% of respondents avoided necessary medical care because of fear of discrimination and mistreatment, as compared with 28% of respondents to the National Transgender Discrimination Survey.\textsuperscript{41,42}

With the staggering consequences of inadequate treatment, it is incumbent upon health care providers and agencies to adopt culturally competent, gender-affirming practices to ensure optimal health care access and provision. Health care providers can take a number of positive steps to eliminate barriers that compromise access to and provision of culturally sensitive care. The Joint Commission has outlined best practices guidelines designed to promote patient-centered and inclusive care for the LGBTQ community (Figure).\textsuperscript{41,42}

**Education of Health Care Students**

The best practices identified in the Figure are important strategies for providing appropriate affirmative care for transgender individuals. However, increasing transgender cultural
competence during health care training may provide an opportunity to reduce these biases before health care practitioners are working in their respective fields. Although there is evidence that explicit bias against the transgender population is on the decline, implicit bias within the health care system remains pervasive and creates barriers to individuals seeking and receiving appropriate care.\textsuperscript{43,44} In addition to barriers to access and utilization of health care created by stigmatization and discrimination, transgender individuals often cite providers’ lack of knowledge about trans health and health care issues as an obstacle.\textsuperscript{45} The Institute of Medicine, the US Department of Health and Human Services, the American Association of Medical Colleges, and the American College of Physicians have all described gaps in training and education related to LGBTQ issues among health care students and practitioners.\textsuperscript{3,46-48} The widespread prevalence of bias against sexual minorities among health care providers suggests that health care curricula are inadequately addressing stigmatization, if at all. Research suggests that medical school curricula and residency training rarely include LGBTQ health issues.\textsuperscript{49,50}

More germane to the field of nutrition is the lack of research on the inclusion of LGBTQ health issues in nutrition and dietetics curricula. Although there is a dearth of research regarding LGBTQ health and transgender cultural competence training in nutrition and dietetics curricula, there is some evidence from other health care disciplines that introducing trans-specific curricula into students' training improves their knowledge regarding transgender health issues.\textsuperscript{45} However, an increase in knowledge does not always translate into fewer transphobic attitudes and behaviors.\textsuperscript{45} Therefore it is crucial for health care curricula to include bias reduction interventions in conjunction with teaching students how to address the specific health care needs of transgender individuals.

Although the full scope of the role of an RDN in treating transgender individuals has yet to be elucidated, it is clear that an RDN can play an important part in reducing health disparities and providing appropriate and inclusive care. Educational endeavors to increase health care providers' cultural and clinical competence in providing care to the transgender population is a critical first step in addressing these health inequities.

FUTURE NEEDS

Although certain dietary considerations for the transgender population are known, a marked gap exists in both research and nutrition care guidelines for this health-disparate population. A sound body of literature is needed to identify the nutritional considerations of transgender individuals during and after a medical transition. Given the lack of existing research in this area, exploratory studies may investigate the impact of diet on mitigating known effects of hormonal therapies, the psychosocial concerns of transgender patients and clients as they relate to food intake and behaviors, best practices for applying the nutrition care process to transgender individuals, and the role of the RDN in the health care team providing care to transgender patients and clients.

References


