Received: 12 March 2019 | Revised: 28 May 2019 | Accepted: 6 June 2019

DOI: 10.1002/ppi.1507

ARTICLE

WILEY

# The body politic: The changing face of psychotherapy and transgender

**Danielle Tanner**

Hebden Bridge, West Yorkshire, UK

**Correspondence**
Danielle Tanner, The Vicarage, Mytholm Bank, Hebden Bridge, West Yorkshire, UK, HX7 6DL.
Email: psychotherapydanielletanner@gmail.com

## Abstract

To support gender diversity in clinical practice, psychotherapists need to provide culturally competent, developmentally appropriate and trans-affirmative care with trans and gender nonconforming people. This article explores the trans body, the trans identity, and the issues that arise in psychotherapy. It examines psychological wellbeing within the trans population and offers a rationale for body psychotherapy approaches to these issues, before exploring the politicisation of the trans body in our culture and the ethical issues that surround trans youth. The increased political focus on the topic has bought about legislation affecting trans rights. Psychotherapists need to be at the forefront of engagement with these changes and their implications for this population. To achieve this, this paper concludes that therapists today must build political and personal self-awareness, taking care to examine their biases and avoid perpetuating unethical, harmful or limited perceptions of gender in the psychotherapy encounter.

**KEYWORDS**

gender identity, relational, trans

## 1 | THE TRANS BODY

Imagine being in a world where your physical appearance makes others uncomfortable, anxious or uncertain about themselves. Your very presence may be perceived as a threat to others' sense of self or sexual orientation. In relation to others, there may be little possibility for an unselfconscious moment in the world. Everywhere you go, people stare at you—sometimes discreetly, often blatantly. Nonetheless, these reactions you experience from others, while arising out of ignorance and sometimes "curiosity," can still cause harm, for you are perceived as "other." At times,

  

people's reactions are openly hostile, the result of conscious and unconscious fears about what it means to deviate from social norms. Indeed, there is the genuine possibility of verbal or physical violence (Nuttbrock et al., 2014a; 2014b; Nuttbrock et al., 2010). As a client (G), explained "people are upset by transsexuals, they are enraged, and, sometimes as a result of this, she is shunned, ostracised and punished by society; and also sometimes, meets with deadly violence—all as though transsexuality were a choice or a mental illness. As I have said, it is neither of those things." Kuiper and Cohen-Kettenis (1988) estimate that 40% of untreated trans people are either institutionalised or die prematurely, though the suicide statistics of treated trans people do not remarkably differ from non-trans populations (see also Kiesling, 2011)

Trans and gender nonconforming (TGNC) identities include, but are not limited to: transgender (TG), trans and gender diverse (TGD), female-to-male (FTM), male-to-female (MTF), transexual, transgirl or transboy, two-spirit, cross-dresser, girl/woman (assigned male at birth [AMAB]), boy/man (assigned female at birth [AFAB]), they/them, bigender, gender-variant, gender fluid, agender, drag king or queen, gender queer, transqueer, queer, androgynous. The terms FTM (female-to-male) and MTF (male-to-female) encompass a spectrum or continuum from those who identify as primarily female or male to those who identify somewhere in the middle or both (e.g. queer). Between these two posts or "extremes" (female and male) lie most gender non-conforming (GNC) individuals. The sexual orientation of GNC and transgender clients is a separate issue and should never be presumed or assumed; it refers to whom one is typically romantically and/or sexually attracted to (e.g. gay, heterosexual, bisexual/pansexual, polysexual, asexual).

Now imagine that the body you perceive yourself to have is not the one reflected back to you. A trans person going through "transition," must metamorphose, often over a period of years, in plain sight of everyone with whom they come into contact socially and professionally. This is what it is like to be a trans or GNC individual in today's world. Although there is increasing awareness and tolerance around gender issues in segments of British culture, the overwhelming level of prejudice that surrounds this group has created a mental health crisis. This is not to say that transgenderism is a psychological disease, although it is still presently classified as a medical condition. Nor is it a whim, as it is often presented by popular media. The trans identity and persons are not viewed here as inherently pathological. However psychological issues arise due to insufficient or harmful mirroring during developmental stages or periods of identity construction, as the trans self is often invisible to the outside world. Issues also arise as a consequence of the trans-self experiencing a body–mind mismatch. They may also experience stigma due to their gender variance in a binary world, which can result in tensions or issues between the individual's desire, authenticity and avoidance of stigma. Indeed, the issues that emerge in psychotherapy with transgender clients, as with all people, are about the self and self-in-relation, and how to negotiate identity with outer reality.

For many trans individuals, the very nature of their sense of self conflicts with society's gender identity ideals and social scripts. The resulting prejudice (transphobia and homophobia), whether explicit or covert, manifests through denial, invisibility, harassment, bullying or, in more extreme cases, assault and murder. These issues can be compounded if a trans person may be further marginalised by their ethnic and racial identity, economic status, physical abilities or age. Nor is the abuse or violence primarily from the outside world. Many are subjected to intimate partner violence, which is associated with anxiety and depression (Henry, Perrin, Coston, & Calton, 2018).

## 2 | PSYCHOLOGICAL WELL-BEING IN THE TRANS POPULATION

The distress experienced by trans and gender-variant people is not the fault of some individual pathology, but is instead the result of problems generated by a society that perpetuates ignorance, prejudice and bigotry. Research indicates trans individuals have a higher incidence of depression, anxiety, victimisation and discrimination. Body psychotherapy uses techniques like Somatic Experiencing ® that are resiliency-based treatments for autonomic nervous system (ANS) regulation. Therefore, body psychotherapy tools may support trans/GNC individuals to increase resilience in the face of discrimination and social injustice. Somatic or body psychotherapy focuses on re-establishing an

individual's innate capacity for ANS, physical and emotional regulation, and thus treating the underlying trauma that may be contributing to anxiety and depression. Emotionally, clients frequently take for granted that they have survived adversities with great courage and fortitude sometimes for a very long time. They often lose sight of the fact that there has been, and still is, support for them through their internal strengths. A felt sense of their body-based resources in the "here and now" has had, in my experience, a powerful stabilising and calming effect on traumatised trans clients. For my clients, focusing on increasing somatic awareness and mindfulness and the ability to regulate difficult emotions has a positive impact on their capacity to manage the many stressful events in their lives, their ongoing exposure to discrimination and the perpetual threat of community violence. By ensuring that I, as a body psychotherapist, am informed of the research literature and statistical analysis in this field, I feel better equipped to approach the emotional, and somatic issues that are prevalent in this minority group.

Trans individuals are particularly vulnerable to psychological distress (Murad et al., 2010; Nuttbrock, Rosenblum, & Blumenstein, 2002), as well as gender dysphoria (GD) or chronic minority stress. Minority stress describes persistently high levels of stress faced by members of stigmatised minority groups. It may be caused by a number of factors, including poor social support and low socioeconomic status. The most well-understood causes of minority stress are interpersonal prejudice and discrimination—specifically, misgendering is a unique minority stressor for trans people (McLemore, 2018). Trans people experience disproportionately high rates of adverse psychological health outcomes relative to both their gender-normative, heterosexual peers and their gender-normative lesbian, gay, and bisexual (LGB) peers (Carmel & Erickson-Schroth, 2016). Trans individuals report higher levels of anxiety and depression than the general population (Nemoto, Bodeker, & Iwamoto, 2011; Nuttbrock et al., 2010) and are at increased risk for substance use disorders, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting, Knudson, & Goldberg, 2006; Robinow, 2009). As mentioned previously, trans individuals are at a higher risk of eating disorders. Diemer, Grant, Munn-Chernoff, Patterson, and Duncan (2015) concluded that compared to cisgenderstudents, that is, students whose gender identity matches the sex that they were assigned at birth, transgender students are almost five times as likely to report an eating disorder and two times as likely to use unhealthy compensatory methods (e.g., vomiting) for weight control. Gordon, Austin, Krieger, Hughto, and Reisner (2016) found that transgender teenagers are almost three times as likely to restrict their eating, almost nine times as likely to take diet pills, and seven times as likely to take laxatives. This may be due to society's unrealistic standards of the "ideal" body type or to maladaptive coping mechanisms for stress arising from anti-trans stigma and discrimination. However, these explanations are not mutually exclusive and could simultaneously drive disordered eating among trans individuals (Diemer et al., 2015; Guss, Williams, Reisner, Austin, & Katz-Wise, 2017).

The trans population is at higher risk for psychiatric co-morbidities and life-threatening behaviours, such as suicide (Narang, Sarai, Aldrin, & Lippmann, 2018; Peterson, Matthews, Copps-Smith, & Conard, 2017), as well as non-suicidal self-injury (NSSI, see Arcelus, Claes, Witcomb, Marshall, & Bouman, 2016). Equality campaigning charity, Stonewall, concluded that nearly half of trans people in Britain had attempted suicide at least once (McNeil, Bailey, Ellis, Morton, & Regan, 2012). In 2017 Stonewall reported that trans youth had experienced death threats at school and high rates of self-harm and suicide attempts. These elevated rates of psychopathology are likely the result of the years of prejudice, discrimination, stigma, and abuse that trans individuals face, (Robles et al., 2016) as well as the conflict between one's appearance and stated identity (Grossman & D'Augelli, 2007). Social and familial rejections negatively impact the social support that is linked to improved mental health outcomes amongst trans adolescents and adults (Simons, Schrager, Clark, Belzer, & Olson, 2013). Stigma affects access to healthcare professionals, and creates social isolation, and can result in addiction and risk-taking behaviours, like unsafe sex (Kosenko, 2011; Operario, Nemoto, Moore, & Iwamoto, 2011; Williamson, 2010). These behaviours may affect overall health and sexual health status (Herbst et al., 2008). Marginalisation can lead to unemployment and re-victimisation (Lombardi, Wilchins, Priesing, & Malouf, 2002).

Although trans people attending healthcare services appear to have a higher risk of psychiatric morbidity, this improves with treatment (Dhejne, Van Vlerken, Heylens, & Arcelus, 2016). In the majority of cases, psychological issues disappear or significantly decrease after a change of gender role or physical characteristics (Heylens, Verroken,

De Cock, T'Sjoen, & De Cuypere, 2014; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Transitioning improves trans people's emotional health. Sexual functioning, self-esteem, body image, socio-economic functioning, family life, relationships, psychological status and general life satisfaction improve. Suicidal tendencies decrease during and following treatment (Pfäfflin & Junge, 1992, 1992). Treatment is successful in achieving the desired changes in areas of partnership and sexual experience (De Cuypere et al., 2006; Kuiper & Cohen-Kettenis, 1988; Murad et al., 2010). Transition marks not only a change in social status, but confirms the trans individual's core gender self-identity, by bringing their external anatomy, their hormonal profile and their social gender role more closely into alignment.

Individuals with gender identity issues who receive treatment are comparable with the general population in their daily functioning (Ainsworth & Spiegel, 2010; Murad et al., 2010). In recent decades many more have sought professional help and, despite the tabloids' macabre need to sensationalise transition regrets, “surgical regret” is very uncommon. With more proficient surgical procedures, surgical regret is further declining (Dhejne, Öberg, Arver, & Landén, 2014; Kuiper & Cohen-Kettenis, 1988; Pfäfflin, 1993; Pfäfflin & Junge, 1992, 1992; Smith et al., 2005; Wiepjes et al., 2018). However, the therapist needs to be aware that surgery, drug or hormone interventions will inform therapy and the body narrative. There are risks, complications, infections and contra-indications (for example ART drugs used in the management of HIV often interact with hormones).

## 3 | THE POLITICISATION OF THE TRANS BODY

The tabloid media have long used the trans body—perennially pulling it out across its spread—for profit and sensationalism. However, as the trend in media exposure has become more positive towards the trans body, a virtuous causal and reciprocal relationship has come into being between media exposure and political interest and political news (Stömbäck & Shehata, 2010). Recently the political world has directed its attention to the trans identity. Theresa May, speaking at the Pink News awards (2017), said;

> *We are determined to eradicate homophobic and transphobic bullying. We have laid out plans to reform the Gender Recognition Act, streamlining and de-medicalising the process for changing gender because being trans is not an illness and it should not be treated as such.”*

The Labour leader has supported this reform, including the removal of the need for medical diagnosis of GD and assessment preceding the often demeaning process of being awarded a Gender Recognition Certificate (GRC) by a gender recognition panel before someone can officially change gender. This move will allow trans people to self-identify their gender.

These proposed changes have led to dissension in certain circles. We have marked the one-hundred-year celebration of women rights and, at the same time, some women's groups and feminists are demanding the right to debate these reforms without being treated as a hate group. Some women have voiced their concern that trans issues are impinging on women rights and that self-declaration threatens women-only spaces, single-sex refuge centres, women's prisons, crisis centres and women's sport. The proposed reforms have created misunderstandings on all sides, and has contributed to the very public war between trans activists and so-called “TERFS” (trans-exclusionary radical feminists). These women see these proposed changes not as progressive, but as taking women back in time and reinforcing gender stereotypes and attitudes that existed in the nineteenth century. This silencing suggests to them gender fundamentalism which calls on women simply to acquiesce and be in silent submission. Both trans activists and women's groups are hostile, and the most vociferous should not be the only ones to be considered. This discord has created a situation that has led to threats and acts of physical violence with transactivists attacking “TERFS” and anti-trans lesbian activists protesting at the 2018 Pride in London march. In 2018, The Degenderettes Antifa art exhibition in the San Francisco Public Library displayed trans activists’ artefacts including a blood-stained T-shirt with the slogan “I punch terfs,” coloured baseball bats and axes.

Within a relatively short period, trans ideology has influenced school guidelines (Cannon & Best, 2015; Lancashire Children and Young People's Trust, 2014), NGOs, and youth mentality. However, if we look at this issue only through the lens of personal victimhood and neoliberalism, we may miss the unresolved conflicts between neoliberal and radical analyses of femininity, sexuality and freedom that characterise our current society's approach to "woman" and "women." Although the measures that Theresa May has called for make the government appear enlightened, they are in actuality deeply divisive, with language "policing" and black and white thinking which prohibits democratic debate and movement. There may be a need to return to an older ideal of politics and equality that moves beyond individual "choice," "agency" and of hyper-femininity as "empowerment." These rigid gender stereotypes embraced in modern society can be oppressive. Perhaps as society tolerates more diversity of gender expression, all of us will become freer to express ourselves as however masculine or feminine we feel or not, without being obligated to go to the extreme ends of the spectrum or cave in to stereotypes. In order to move beyond binaries and self, we may need to work collectively to create social conditions where gender is less concrete and exaggerated, more fluid and not directly mapped onto biological bodies. Within this "fluid" society, new modes of sexual identity and behaviour may have the opportunity to develop.

Tokenistic support of minority groups can be seen to fill an elitist "tick box" and not address the underlying social inclusion issues. A more thoughtful approach would address the need to mutually include women who were assigned female at birth (AFAB) and more of the trans community. Bridging projects, better education and supportive work to sensitively and collaboratively include trans women into women spaces may be more expensive and time-consuming, but it may be a more appropriate approach to a tinderbox situation. A better examination of the impact of self-identification, and a more in-depth exploration of the potential exploitation by predatory people may be more apt. Key support for the trans community during this societal shift should be a priority. Oppression and marginalised groups, require more care and attention than political hyperbole and politically correct "quick fixes." Which raises the question of who and where are the people to carry out this enlightened programme?

We can best equip ourselves for meeting our clients by making ourselves aware of the shifting political landscape. Within my practice, I have encountered women who are deeply affected by the proposed reforms to the Gender Recognition Act (2004). There are those who perceive self-declaration as a contravention of their inalienable rights to "safe spaces," which they view as "sacrosanct." Additionally, some trans women want a considered approach to self-identity without it being "at the expense of women." They are alarmed by a growing enmity from women whom they consider natural allies. In 2015 socialist trans woman Kristina Jayne Harrison outlined her concerns with proposed reforms in her article, "As a trans woman, this is the unity I want to see" in *Counterfire Opinion*. I have met trans women who do not identify as "women," but as a "transwomen," and feel that they should have their own spaces, as well as trans clients who are "as terrified of predatory men, as the next woman" and cannot imagine that they would not be included within women spaces. There has been misinformation that has not helped this division. The gender reforms are not seeking to change the exemptions in the Women's Equality Act, but within political groups, it is often raised as a moot point.

Despite popular discourse, there is no data to support the idea that those in the sexual or gender majority require protection from sexual or gender minority individuals (McKay, Lindquist, & Misra, 2017). Instead, research indicates that minorities are themselves at elevated risk. Most victimisation is not perpetrated by strangers or acquaintances, but often close family members. However, despite the perception that society is becoming more welcoming to trans people, victimisation disparities appear to be stable or widening since the 1990s (McKay et al., 2017).

Despite surgical regret being uncommon, there is a growing dialogue involving those who have detransitioned and lesbian groups that are voicing their concerns that young lesbians, driven by the media's attention to the trans "body," are moving towards transition rather than identifying as lesbians. There is also a growing number of reactionary groups (i.e. parents of rapid-onset GD or Transgendertrend) who are sceptical of the "Affirmative Care" model in regards to GD, but also publish school resources material within their website, which Stonewall describe as a "deeply damaging document, packed with factually inaccurate content" (Kibirige, 2018). Gender-affirmative health care refers to care that is sensitive, responsive, and affirming to trans patients' gender

identities and expressions. Therapists should be aware of reactionary groups that are questioning GD, which may undermine the trans identity of their clients.

With so much chaos surrounding this issue, the importance of political and self-awareness among therapists is magnified; they must examine their biases to avoid perpetuating pathological, limited, or stereotyped notions of gender in the psychotherapy encounter.

## 4 | THERE IS A STORM BREWING, OR "WHAT ABOUT THE CHILDREN?": THE ETHICAL CONSIDERATION OF TRANSGENDER CHILDREN

Currently, in the UK, there is a small but increasing number of children presenting with GD. Each year since 2010 the Gender Identity Development Service (GIDS) in London has reported a 50% increase in the number of children presenting with gender issues. This increase may be due to several factors, including increased visibility of transgendered people in the media and the wider availability of information on the Internet about transgender, which both probably contribute to a partial destigmatisation of GD and increased awareness of hormone treatments for adolescents to delay or suppress puberty (Cohen-Kettenis, Steensma, & de Vries, 2011; Zucker, Bradley, Owen-Anderson, Singh, & Blanchard, & Bain, 2011). Although there are clear biological links between hormone exposure and gender identity—Cakeworld (http://www.cakeworld.info/transsexualism/what-causes/hormone-exposure-humans) details ninety-three peer-reviewed articles on the influence of hormone exposure and its effect on gender identity and sexual orientation— the question of whether there is an innately transgender child is still being explored. With regards to hormonal suppression of puberty, GIDS support a thoughtful, "watchful waiting" approach, as studies have highlighted that the majority of children who are identified with body dysphoria will desist before adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). GIDS also have a considered, ethical approach to fertility preservation for their younger clients, given that hormone use has long-term implications, including possible irreversible impairment of future reproductive functioning.

Early use of puberty-suppressing hormones may avert negative social and emotional consequences of GD. However, neither puberty suppression nor allowing puberty to occur is a neutral act. Functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense GD. There are those that have suffered a distressing and alienating adolescence, who, having come out on the other side, have become a compelling voice determined to spare anyone else from going through what they experienced. However, there are concerns about adverse physical side effects of hormone use (GnRH analogue; see WPATH, 2011). Transition can entail lifelong medication (puberty blockers and then cross-sex hormones) and irrevocable surgery. Both sides of the argument can accuse the other of child abuse. Sadly, there will be casualties on this ideological battlefield.

At first glance, when exploring the online youth "'transgender narrative" it can seem that adolescent angst and confusion is being interpreted as deriving from an underlying transgender identity, and medical transition is the cure. Struggling with issues of identity, sexuality, bodily changes and relationships is the work of adolescence. Learning to cope with discomfort and uncertainty is essential to maturing into a healthy adult. So, there is a fear that developmental processes are being brought to a premature conclusion by uncritically affirming a child's self-diagnosis, gleaned from internet videos: being trans is the cause of these adolescent struggles, which makes transitioning seem like the solution. However, persistent GD will not be a passing "phase," and it would be ethically inadequate to adopt this dismissive stance.

Confusion can be a part of "coming out," and, as psychotherapists, we should be able to tolerate a period of uncertainty in our clients with unbiased compassion. The goal of therapy may not always be a medical transition, but we have a responsibility to listen to the client about their gender identity and gender expression. Trans-visibility is helping more people realise they are trans, and, as trans realities are increasingly known, clients may recognise their

inner turmoil. As therapists, we should not assume it is a social contagion or "psychic epidemic," or an expression of the desire to flee from the predatory forces of misogyny and hypersexualisation into the trans body.

A balanced approach is a prerequisite for the therapist. Gender nonconforming behaviours in children may continue into adulthood, but are not necessarily indicative of GD or a need for treatment. GD is not synonymous with diversity in gender expression. GD in childhood does not inevitably continue into adulthood, and only 6–23% of boys and 12–27% of girls treated in gender clinics showed the persistence of their GD into adulthood (WPATH, 2011). Further, in adulthood, most of the boys' GD desisted, and they identified as gay, rather than as transgender. Indeed, the most likely outcome of childhood GD seems to be homosexuality or bisexuality (Drescher & Pula, 2014). In contrast, GD in older adolescents and adults rarely desists, and so the treatment of choice is gender or sex reassignment.

However, for some clients there has never been a question surrounding their gender; while others have consciously rejected gender as a "social construct" (Butler, 2001). Some see it as "biology and genetics." One client described her natal gender as a "birth defect" that required corrective surgery, "like a cleft palate or a club foot." However hard it was to digest this, I was able to empathise with her view that surgery was not a lifestyle "choice," but a necessity.

## 5 | OUR SOCIAL RESPONSIBILITY IN THIS CHANGING WORLD: BOTH IN PRACTICE AND THE WORLD AT LARGE

Since the publication of *The Transsexual Phenomenon* (1966) trans individuals have sought psychotherapeutic help in increasing numbers. However, these individuals frequently report negative experiences with medical and mental health services, and psychotherapy. This includes discrimination, prejudice, offensive statements, dehumanising treatment and even outright refusal of care (Ellis, Bailey, & McNeil, 2015; Poteat, German, & Kerrigan, 2013; Shipherd, Green, & Abramovitz, 2010). Therapists need to recognise the potential vulnerability trans clients experience when seeking counselling and their own need to develop greater awareness, knowledge and competence regarding working with transgender clients.

## 6 | SUPPORTING GENDER DIVERSITY IN CLINICAL PRACTICE AND PROMOTING TRANS-AFFIRMATIVE CARE

Through ignorance, psychotherapists may commit a multitude of micro-aggressions, such as asking for multiple clarifications or using inappropriate language or restrictive gender conceptualisations (Mizock & Lundquist, 2016). Those with "gender narrowing" tendencies may further reify traditional notions of gender and impose their implicit attitudes about gender onto the client. Negative experiences in psychotherapy have been associated with worsening of trans client's mental health symptoms, diminishing treatment satisfaction, and interfering with future help-seeking (Bess & Stabb, 2009; Hunt, 2014; Willging, Salvador, & Kano, 2006). There is a need to address potentially unexplored negative countertransference between cisgender therapists and trans clients. Micro-aggressions can arise, especially in the consciously trans-friendly therapist, as a result of countertransference. Through our own expectations for gendered expression, a sense of protectiveness, fear of behaving in a transphobic manner, fear of incompetence, fear or grief for our client, or difficulties owning privilege we may deny the existence of heterosexism, heterosexual privilege and a culture of heteronormativity, because we find it an unpleasant reality.

Additionally, the focus of our work should not be solely on exploring gender and sexuality issues. Gender may not be the most salient aspect of a trans person's life. The gender inflation approach may dehumanise or "exoticise" the trans individual, interfering with addressing important aspects of their mental health and life experience. Clients may present with gender-specific issues, such as decision making around gender affirmation/process or family adjustment to one's gender, but may also present with problems such as depression, anxiety and substance abuse.

Our approach to the body needs to be holistic, with an emphasis upon continued education on trans issues and a connection with the transgender community.

There have been pervasive heterosexist and transphobic attitudes within the mental health field, including historical pathologisation of trans identifications and experiences within psychodynamic theory itself. Some therapists "wrap themselves in the mantle of science to justify their professional status, their control, and their fees" (Conover, 2002: p.149), while pathologising their trans clients. They operate out of sickness theories that do not draw their mandate from science, but rather from a defence of current cultural traditions and the pressures of gender norms. Trans people have been described as narcissistic, developmentally and emotionally immature, impulsive, obsessive, withdrawn, schizoid, and borderline (Lev, 2004). For example, Steiner (1990) prepares therapists "to see individuals who may present physically looking somewhat bizarre, either flamboyantly or inappropriately dressed, or looking like a man in drag" (p. 96) and asserts that they should "withstand transsexuals' demands to know why you have not surgically reassigned them yesterday" (pp. 95–96). Chiland, meanwhile, (2000) describes trans clients as being so enclosed "within their narcissistic shells, they do not care about their analyst's inner reactions to what they say" (p. 28).

Trans individuals reported their psychotherapists conducting sessions as if their transgender identity were a problem to be "fixed" or responsible for all their other problems. This process, known as gender repairing, inadvertently pathologised or stigmatised clients as mentally ill (Mizock & Lundquist, 2016). Reparative therapies have been used with LGBTI+ individuals in an attempt to change the person's gender or sexual orientation to the dominant, societal norm. Clients may have a history of encountering such therapeutic approaches (Bartlett, Smith, & King, 2009), which are ethically dubious and harmful. Although most psychotherapists do not practice gender repairing interventions, they may still hold beliefs that can alienate or harm trans clients. In October 2017, alongside other leading professions and Stonewall, the British Association of Counsellors and Psychotherapists (BACP) and the UK Council for Psychotherapy (UKCP) signed an updated memorandum of understanding (MoU) against conversion therapy which makes it clear that conversion therapy in relation to gender identity and sexual orientation (including asexuality) is unethical, potentially harmful and is not supported by evidence.

Misunderstandings arise from the body positivity movement, rooted in the belief that all human beings should hold a positive body image and move towards the social acceptance of the human form. People who suffer from dysmorphia perceive their bodies as being different from how they are. They hold a distorted image of how they look, mainly through the pervasive, idealised beauty standards ingrained in us by advertising. However, people who have GD do not have a distorted image, but feel a strong misalignment between mind and body. As a client elucidated, "you look at yourself and see yourself just as you are and can tell exactly how wrong it is." Unlike body dysmorphia, GD is the distress caused by the incongruence between one's gender identity and one's anatomy, along with the desire to have the characteristics of one's affirmed gender identity, and to align one's body with one's gender identity. (Sadly, this is not to say that these two, dysmorphia and dysphoria, cannot reside in the same body).

As body psychotherapists, I feel it imperative that we become well-versed in these issues, because much of our somatic work is about acceptance and love of the body that we have. How, therefore, as therapists can we talk about and explore our client's relationship with their body, indeed even discussing the possibility of becoming more comfortable with their natal body, without being accused of conversion therapy? Trans people are more likely to seek therapy due to demonstrably high levels of mental distress and self-harm, and so there is a distinct and immediate need for therapists to be able to provide skilled therapeutic support.

Therapists have to hold the tension between what Totton (2003) describes as "starry optimism or hard-bitten pessimism" (p. 140), viewpoints that can become two closed postures and be therapeutically destructive. That is, if we follow the vision of a "perfect"' body, unshackled by society's conventions, we can easily tread the path towards "a malignantly charismatic performance of cure" (p. 141). However, from the middle ground, we can find a place of "moments" where the trans body can acknowledge the impact of trauma and socialisation, and also contest it.

## 7 | PROMOTING GENDER SENSITIVITY IN BODY PSYCHOTHERAPY

As body psychotherapists, we need to become fluent in the same language of various gender-related issues, including transgenderism. Through education and active engagement, we can demonstrate the intention of promoting respectful communication that expresses an intricate set of thoughts, ideas and feelings associated with gender, sexuality and identity. This requires thoughtful engagement, as the language is still forming around the desire to articulate profound and complex notions of self and identity. We need to provide culturally competent, developmentally appropriate and trans-affirmative practice with TGNC people. Staying abreast of the current of change is an integral part of being not only competent, but an empathically attuned therapist, and also avoids the pitfall of over-burdening our clients with the task of educating us (Poteat et al., 2013).

## 8 | THE CHANGING FACE OF PSYCHIATRY

The Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-V) reclassified gender identity disorder (GID) to gender dysphoria (GD). While the DSM-V states that GD should not be viewed as a mental disorder and that the manual intends to avoid stigma, it perversely continues to categorise it as such. However, there are several positive changes. The diagnosis has been separated from sexual dysfunctions and paraphilic disorders, and is now positioned in its own chapter. Furthermore, subtyping regarding sexual orientation has been eliminated. The specific term, GD, assigns the pathology to the dysphoria rather than to the gender identity (Bouman & Richards, 2013). Gender nonconformity is not in itself a mental disorder, but GD is the presence of clinically significant distress associated with the condition. Gender dysphoric symptoms arise when self-concept and expressed gender in relation to ascribed gender is "incongruent." Language such as "incongruence" and "alternative gender" is chosen over "cross-gender identification" and "other sex," in order to recognise the variation in individuals' experiences. However, the turmoil suggested in the diagnosis seems to be reflected in the external world in the on-going debate over gender identity and self-identification. The social, political and medical climate in the trans field is continuously evolving, which is reflected in the changes to diagnostic criteria. How the experience of being trans is defined and diagnosed not only has political and social ramifications, but importantly affects how others perceive people and how people perceive themselves.

In order to be eligible for treatment (e.g. hormone therapy; gender confirmation surgery)on the UK National Health Service (NHS), trans people must undergo a psychiatric assessment and be diagnosed with GD. Consequently, a trans person wanting gender reassignment treatment through the NHS will come under the jurisdiction of mental health services. In the past, when therapists were the gatekeepers of gender recognition, this position of power could lead to serious power asymmetry that resulted in abuse. The de-medicalisation of GD will change the face of transgenderism. It may take many more decades, but the evolutionary process of moving away from labelling the trans body as pathological has begun.

Trans clients are typically more educated about gender identity development than most therapists, and I have found that they have both been invaluable educators and highlighted the need that some have to conform to the narratives outlined in the DSM in order to gain their gender recognition. For example, the narrative "the girl trapped in the boy's body," was not one that a client felt she had until late adulthood. Yet, she explained, "God help me, I am not going to let *them* know that." As her body narrative had not followed the "rules"' of the intelligible transsexual narrative endorsed by the DSM—a temporal ordering of events (i.e. cross-gender identity since early childhood, persistent desire to be the opposite sex), causal linkings (i.e. continued desires throughout adolescence and early adulthood), demarcation signs (childhood cross-dressing, lack of genital pleasure in adult sexuality), and a "valued endpoint" (genital reassignment surgery) (Lev, 2004, p. 216)—she had concealed it.

## 9 | THE TRANSFORMATION OF THE BODY

It is an extraordinary fact that, within the UK, the "mayhem" laws were used by the legal systems until the 1970s to prevent the performance of gender confirmation surgery. As a subject of the crown we did not own our own bodies, and the removal of any body part qualified as "mayhem" under the Coventry Act (see https://thelawdictionary.org/coventry-act/).

While "transmedicalists," believe that only those who experience GD are transsexual/transgender, and that GD is a medical conditionthat requires corrective surgery, for many trans is an identity. Trans is a sense of self, in relation to socially constructed ideas of gender, which cannot be solely defined through surgical procedures and hormones. Some trans people either do not want to pursue a medical transition or are unable to access it due to financial barriers, relationship constraints, work challenges or health issues.

## 10 | CLINICAL EXPERIENCE OF THE TRANS BODY

It was as a teenager that I first, knowingly, encountered the transgender community. I lived in a shared house with someone who was going through their transition. I was curious about the silk scarves that they wore to cover their burgeoning facial hair, as they prepared for electrolysis. I listened intently to their description of their forthcoming procedures and surgery with a mixture of fascination and silent horror. I studiously avoided the lurid yellow sharps box in our shared bathroom, feeling a mixture of shame at my morbid fascination and a horror of daily injections. Since then, I have come to know many women and men who have chosen to tread this path, both personally and professionally. I have worked with clients before, during and after their transition, and I have also worked alongside parents, siblings, partners and children of those that have taken this path.

Jason was 24 when we began therapy. They had been diagnosed with schizophrenia before we met. One day, we were sitting together on the floor, the room was warm and the lighting had been dimmed. In the cocoon of light from a lamp, we began our body journey together. They slowly traced out lines on their body with a felt tip pen. We were mapping the regions of their body that belonged to "he," and "she." The lines were uneven and unsymmetrical over the body. However, they never once hesitated in their roadmap. Once they had completed their handiwork, we surveyed the lay of the land. Much of their terrain had been marked "she." We were beginning to talk about their transition from their identification as a male schizophrenic to their self-identity as a trans woman. Significant challenges had marred their process of self-realisation. Jason continued to reflect on the ways that their gender identity and pathology had become competing narratives. Fortunately, their mental healthcare support believes that they are recovering from their schizophrenic episode, and their journey has been clarified with their diagnosis of GD. There has been a significant transformation of social, physical and emotional selves, as Jason moves towards identification as Jade and establishes a different relationship with the outside world. By holding a trans-affirmative stance, within the context and meaning of gender variance, I have been able to support Jade as she examines the impact of her gender transition on self and her relational life, whilst remaining mindful of the co-morbidity of severe mental illness, such as schizophrenia, with GD (Rajkumar, 2014).

## 11 | CONCLUSION

*'and all there is, is love and the body,*
*nothing to give but this moment,*
*and this moment and this moment,'*

*John Siddique, (2011). Love and the Body*

The trans body has entered into public consciousness, and the therapy room. The therapeutic field is rapidly changing in terms of knowledge about gender, identity and sexual minority groups. Language and concepts are continuously shifting, especially in regard to trans issues. Terminologies for trans identifications continue to evolve and intersect in complex relationships with race and socioeconomic status. With the recent political focus on legislation affecting trans rights, therapists need to be at the forefront of these changes and their implications for this population. Our responsibility is to keep up, to continue to question our self-beliefs, to be curious about our unfolding somatic resonance and to evolve alongside our trans clients fluidly.

Working with trans clients calls for specialised knowledge, and appropriate supervision for providing care to gender-variant people. Current training programmes for psychotherapists provide little or no education on gender variance. If any education is provided at all, it is usually theoretical or an aside to LGB issues. With inadequate training around gender, sexual and relationship diverse clients, it can prove challenging to provide competent and ethical care. As psychotherapists we are expected to investigate the field, and I hope that this article will be informative to many, particularly those who are not directly experiencing these cases but for whom the reminder may still be useful—of what our responsibilities are and how to be mindful of them. Our next client may not announce their gender presentation before arrival. Trans clients may present with specific mental health care needs, within a sociocultural context in which minority discrimination stress and micro-aggressions have contributed to significantly higher rates of depression, suicide and self-harm. Adequate training should be given to addressing these issues as well as fostering the emergence of an authentic gendered (including non-binary) self, helping to restore cohesion of self, and modelling acceptance and empathy in order to restore relational integrity (Ehrensaft, 2009, Fraser, 2009, Lev, 2004). Trans-affirmative practice is the provision of care that is respectful, aware, and supportive of the identities and life experiences of trans people. We need to implement culturally responsive trans-affirmative psychotherapy, TGNC-sensitive psychotherapy training, and to concentrate our efforts toward social-justice-oriented research.

Various expressions of gender may not necessitate psychological, hormonal, or surgical treatments. Some clients will have made significant, self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or GD. Only some trans people experience GD at some point in their life; most are "quietly getting on with ordinary life." To truly support trans people in healing their relationship with the body, we must educate ourselves on their unique experiences and needs, whether they are in transition or not, by politically joining the struggle for their rights, and by becoming an ally and educating others. Myths regarding transition and trans are creating an environment biased against trans people, which may increase transphobia. In 2015–2016 in the UK, 858 transphobic hate crimes occurred. Globally murder of trans people has increased exponentially (Balzer/LaGata & Berredo, 2016). As professionals, we have a duty of care to remain informed, and to dispel misinformation actively. We have a social responsibility to advocate for trans rights to dignity and wellbeing, whether that involves gender confirmation surgery or other procedures or not.

As psychotherapists, we must avoid insensitive questioning, avoid enforcing gender norms, avoid assuming a source of trauma as the underpinning cause of dysphoria. Our assumptions can be ill-received and can perpetuate detrimental ideas, such as the concept that a trans identity is a form of repressed homosexuality, or that trans people require gender-reparative therapy. It can be all too easy to overfocus on issues of gender when the topic is not relevant to the care being provided, or to inadvertently discourage gender confirmation procedures due to our own judgments about our client's body.

As body psychotherapists how do we react when a client is on a journey in which they have removed or will be endeavouring to remove parts of their physical body in order to feel more themselves? How do we react both externally and internally? Trans clients often desire bodily change not only to feel more congruent with their internal self, but with the hope of being experienced relationally as they truly are. How do we support them and ourselves if we are not responding in the way that they need? Can we support our clients when they aspire to be more "themselves," rather than just a composite of gendered parts?

I wish to view my client as a whole being, offering respect not solely to the trans aspect of the client but to the whole person. Society's persistent herding of diversities into labels can perpetuate a separatist environment, which

can create distress because it causes people to be viewed as "other." However, can we also support those clients that wish to be "other"?

As a body psychotherapist, the locus of my treatment has become a deeper exploration of the nature of the client's relationship to their body, of how they value their body, take care of it or take pleasure in it. Or their resilience to other people's perceptions of them, and what they themselves see or what they wish they could see: does that change if they can change their body to look like the body they believe they were supposed to have? With more experience of their body, have their expectations or perceptions of their body changed? How do they feel about their changed and changing body as it ages? How is their perception of their body affected by the changing perceptions of the wider world to their body? I believe in the fundamental healing value of acceptance and understanding of human experience. By engaging in this relational approach, I may get closer to an understanding that can allow me to mirror a person's inner view of themselves, whatever their identity. In this way, I can strengthen the sense of self and self-worth of a person, whilst working to emphasise the importance of the functionality, pleasures and joys of the body, not just the physical appearance. Through exploration and a commitment to loving self-care, I hope that we can fluidly support all our clients toward a better relationship to their body.

## ORCID

*Danielle Tanner* https://orcid.org/0000-0003-0200-1165

## REFERENCES

Ainsworth, T. A., & Spiegel, J. H. (2010). Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research*, *19*(7), 1019–1024. https://doi.org/10.1007/s11136-010-9668-7

Arcelus, J., Claes, L., Witcomb, G. L., Marshall, E., & Bouman, W. P. (2016). Risk factors for non-suicidal self-injury among trans youth. *The Journal of Sexual Medicine*, *13*(3), 402–412. https://doi.org/10.1016/j.jsxm.2016.01.003

Balzer, C./LaGata, C., & Berredo, L. (2016). An introduction to the Trans Murdering Monitoring Project: TMM annual report 2016. Transrespect Versus Transphobia Worldwide (TvT) Publication Series. 14. Retrieved from https://transrespect.org/wp-content/uploads/2016/11/TvT-PS-Vol14-2016.pdf

Bartlett, A., Smith, G., & King, M. (2009). The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation. *BMC Psychiatry*, *9*(1), 11. https://doi.org/10.1186/1471-244X-9-11

Bess, J., & Stabb, S. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling*, *31*(3), 264–282. https://doi.org/10.17744/mehc.31.3.f62415468l133w50

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, *9*(3–4), 35–82. https://doi.org/10.1300/J485v09n03_03

Bouman, W. P., & Richards, C. (2013). Diagnostic and treatment issues for people with gender dysphoria in the United Kingdom. *Sexual and Relationship Therapy*, *28*(3), 165–171. https://doi.org/10.1080/14681994.2013.819222

Butler, J. (2001). Doing justice to someone: Sex reassignment and allegories of transsexuality. *GLQ: A Journal of Lesbian and Gay Studies*, *7*(4), 621–636. https://doi.org/10.1215/10642684-7-4-621

Cannon, S., & Best, T. (Eds.) (2015). *Schools transgender guidance*. The Intercom Trust and Devon and Cornwall Police. Retrieved from. https://www.cornwall.gov.uk/media/13620644/schools-transgender_guidance_booklet-2015.pdf

Carmel, T. C., & Erickson-Schroth, L. (2016). Mental health and the transgender population. *Psychiatric Annals*, *46*(6), 346–349. https://doi.org/10.3928/00485713-20160419-02

Chiland, C. (2000). The psychoanalyst and the transsexual patient. *The International Journal of Psycho-Analysis*, *81*(1), 21–35. https://doi.org/10.1516/0020757001599483

Cohen-Kettenis, P. T., Steensma, T. D., & de Vries, A. L. (2011). Treatment of adolescents with gender dysphoria in the Netherlands. *Child and Adolescent Psychiatric Clinics*, *20*(4), 689–700. https://doi.org/10.1016/j.chc.2011.08.001

Conover, P. (2002). *Transgender good news*. Silver Springs, MD: New Wineskins Press.

De Cuypere, G., Elaut, E., Heylens, G., Van Maele, G., Selvaggi, G., T'Sjoen, G., … Monstrey, S. (2006). Long-term follow-up: psychosocial outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies*, *15*(2), 126–133. https://doi.org/10.1016/j.sexol.2006.04.002

Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, *43*(8), 1535–1545. https://doi.org/10.1007/s10508-014-0300-8

Dhejne, C., Van Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, *28*(1), 44–57. https://doi.org/10.3109/09540261.2015.1115753

Diemer, E. W., Grant, J. D., Munn-Chernoff, M. A., Patterson, D. A., & Duncan, A. E. (2015). Gender identity, sexual orientation, and eating-related pathology in a national sample of college students. *Journal of Adolescent Health*, *57*(2), 144–149. https://doi.org/10.1016/j.jadohealth.2015.03.003

Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant prepubescent children. *Hastings Center Report*, *44*(s4), S17–S22. https://doi.org/10.1002/hast.365

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, *44*(1), 34–45. https://doi.org/10.1037/0012-1649.44.1.34

Ehrensaft, D. (2009). One pill makes you boy, one pill makes you girl. *International Journal of Applied Psychoanalytic Studies*, *6*(1), 12–24. https://doi.org/10.1002/aps.185

Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people's experiences of mental health and gender identity services: A UK study. *Journal of Gay & Lesbian Mental Health*, *19*(1), 4–20. https://doi.org/10.1080/19359705.2014.960990

Fraser, L. (2009). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy*, *24*:2,126–142. https://doi.org/10.1080/14681990903003878

Gordon, A. R., Austin, S. B., Krieger, N., Hughto, J. M. W., & Reisner, S. L. (2016). "I have to constantly prove to myself, to people, that I fit the bill": Perspectives on weight and shape control behaviors among low-income, ethnically diverse young transgender women. *Social Science & Medicine*, *165*, 141–149. https://doi.org/10.1016/j.socscimed.2016.07.038

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-threatening Behavior*, *37*(5), 527–537. https://doi.org/10.1521/suli.2007.37.5.527

Guss, C. E., Williams, D. N., Reisner, S. L., Austin, S. B., & Katz-Wise, S. L. (2017). Disordered weight management behaviors, nonprescription steroid use, and weight perception in transgender youth. *Journal of Adolescent Health*, *60*(1), 17–22. https://doi.org/10.1016/j.jadohealth.2016.08.027

Harrison, K. J. (2015). As a trans woman this is the unity I want to see. *Opinion*, Counterfire. Retrieved from https://www.counterfire.org/articles/opinion/19538-as-a-trans-woman-this-is-the-unity-i-want-to-see

Henry, R. S., Perrin, P. B., Coston, B. M., & Calton, J. M. (2018). Intimate partner violence and mental health among transgender/gender nonconforming adults. *Journal of Interpersonal Violence*. Advance online publication. https://doi.org/10.1177/0886260518775148

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., Crepaz, N., & HIV/AIDS Prevention Research Synthesis Team (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS and Behavior*, *12*(1), 1–17. https://doi.org/10.1007/s10461-007-9299-3

Heylens, G., Verroken, C., De Cock, S., T'Sjoen, G., & De Cuypere, G. (2014). Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *The Journal of Sexual Medicine*, *11*(1), 119–126. https://doi.org/10.1111/jsm.12363

Hunt, J. (2014). An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling and Psychotherapy Research*, *14*(4), 288–296. https://doi.org/10.1080/14733145.2013.838597

Kibirige, H. (2018). *Creating a trans-inclusive school environment: Response to Transgender Trend*. Stonewall. Retrieved from https://www.stonewall.org.uk/our-work/blog/education-youth/creating-trans-inclusive-school-environment-response-transgender-trend

Kiesling, M. (2011) *Remembering our dead* [Blog]. National Center for Transgender Equality, Retrieved from https://transequality.org/blog/remembering-our-dead

Kosenko, K. A. (2011). Contextual influences on sexual risk-taking in the transgender community. *Journal of Sex Research*, *48*(2–3), 285–296. https://doi.org/10.1080/00224491003721686

Kuiper, B., & Cohen-Kettenis, P. (1988). Sex reassignment surgery: A study of 141 Dutch transsexuals. *Archives of Sexual Behavior*, *17*(5), 439–457. https://doi.org/10.1007/BF01542484

Lancashire Children and Young People's Trust. (2014). *Transgender guidance*. Retrieved from http://www.lancashirechildrenstrust.org.uk/news/?articles=79289

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2002). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, *42*(1), 89–101. https://doi.org/10.1300/J082v42n01_05

McKay, T., Lindquist, C. H., & Misra, S. (2017). Understanding (and acting on) 20 years of research on violence and LGBTQ+ communities. *Trauma, Violence & Abuse*. Advance online publication. https://doi.org/10.1177/1524838017728708

McLemore, K. A. (2018). A minority stress perspective on transgender individuals' experiences with misgendering. *Stigma and Health*, *3*(1), 53–64. https://doi.org/10.1037/sah0000070

McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans mental health and emotional wellbeing study 2012*. Sheffield: Sheffield Hallam University.

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, *72*(2), 214–231. https://doi.org/10.1111/j.1365-2265.2009.03625

Narang, P., Sarai, S. K., Aldrin, S., & Lippmann, S. (2018). Suicide among transgender and gender-nonconforming people. *Primary Care Companion for CNS Disorders.*, *20*(3). Advance online publication). https://doi.org/10.4088/PCC.18nr02273

Nemoto, T., Bodeker, B., & Iwamoto, M. (2011). Social support, exposure to violence, and transphobia: Correlates of depression among male-to-female transgender women with a history of sex work. *American Journal of Public Health*, *101*, 1980–1988. https://doi.org/10.2105/AJPH.2010.197285

Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2014a). Gender abuse and major depression among transgender women: A prospective study of vulnerability and resilience. *American Journal of Public Health*, *104*(11), 2191–2198. https://doi.org/10.2105/AJPH.2013.301545

Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2014b). Gender abuse, depressive symptoms, and substance use among transgender women: A 3-year prospective study. *American Journal of Public Health*, *104*(11), 199–206. https://doi.org/10.2105/AJPH.2014.302106

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research*, *47*(1), 12–23. https://doi.org/10.1080/00224490903062258

Nuttbrock, L., Rosenblum, A., & Blumenstein, R. (2002). Transgender identity affirmation and mental health. *International Journal of Transgenderism*, *6*(4). Retrieved from. https://cdn.atria.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no04_03.htm

Operario, D., Nemoto, T., Moore, T., & Iwamoto, M. (2011). Unprotected sexual behavior and HIV risk in the context of primary relationships for transgender women. *AIDS and Behavior*, *15*(3), 674–682. https://doi.org/10.1007/s10461-010-9795-8

Peterson, C. M., Matthews, A., Copps-Smith, E., & Conard, L. A. (2017). Suicidality, self-harm, and body dissatisfaction in transgender adolescents and emerging adults with gender dysphoria. *Suicide and Life-threatening Behavior*, *47*(4), 475–482. https://doi.org/10.1111/sltb.12289

Pfäfflin, F. (1993). Regrets after sex reassignment surgery. *Journal of Psychology and Human Sexuality*, *5*(4), 69–85. https://doi.org/10.1300/J056v05n04_05

Pfäfflin, F., & Junge, A. (1992). Nachuntersuchungen nach Geschlechtsumwandlung: Eine kommentierte Literaturübersicht 1961–1991. In F. Pfäfflin, & A. Junge (Eds.), *Geschlechtsumwandlung* (pp. 149–459). Stuttgart: Schattauer.

Pfäfflin, F., & Junge, A. (1992). *Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961-1991*. Düsseldorf, Germany: Symposion.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine*, *84*, 22–29. https://doi.org/10.1016/j.socscimed.2013.02.019

Rajkumar, R. P. (2014). Gender identity disorder and schizophrenia: Neurodevelopmental disorders with common causal mechanisms? *Schizophrenia Research and Treatment*, *2014*, 1–8. https://doi.org/10.1155/2014/463757

Robinow, O. (2009). Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy*, *24*(2), 143–151. https://doi.org/10.1080/14681990902951358

Robles, R., Fresán, A., Vega-Ramírez, H., Cruz-Islas, J., Rodríguez-Pérez, V., Domínguez-Martínez, T., & Reed, G. M. (2016). Removing transgender identity from the classification of mental disorders: A Mexican field study for ICD-11. *The Lancet Psychiatry*, *3*(9), 850–859. https://doi.org/10.1016/S2215-0366(16)30165-1

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health*, *14*(2), 94–108. https://doi.org/10.1080/19359701003622875

Simons, L., Schrager, S. M., Clark, L. F., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *Journal of Adolescent Health*, *53*(6), 791–793. https://doi.org/10.1016/j.jadohealth.2013.07.019

Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine*, *35*(1), 89–99. https://doi.org/10.1017/S0033291704002776

Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(6), 582–590. https://doi.org/10.1016/j.jaac.2013.03.016

Steiner, B. W. (1990). Intake assessment of gender-dysphoric patients. In R. Blanchard, & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 95–117). Washington, DC: American Psychiatric Publications Inc.

Stömbäck, J., & Shehata, A. (2010). Media malaise or a virtuous circle? Exploring the causal relationships between news media exposure, political news attention and political interest. *European Journal of Political Research*, *49*, 575–597. https://doi.org/10.1111/j.1475-6765.2009.01913.x

Totton, N. (2003). *Body psychotherapy: An introduction*. Maidenhead, UK: Open University Press.

Wiepjes, C. M., Nota, N. M., de Blok, C. J. M., Klaver, M., de Vries, A. L. C., Wensing-Kruger, S. A., … den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, *15*(4), 582–590. https://doi.org/10.1016/j.jsxm.2018.01.016

Willging, C. E., Salvador, M., & Kano, M. (2006). Pragmatic help-seeking: How sexual and gender minority groups access mental health care in a rural state. *Psychiatric Services*, *57*(6), 871–874. https://doi.org/10.1176/ps.2006.57.6.871

Williamson, C. (2010). Providing care to transgender persons: A clinical approach to primary care, hormones and HIV management. *Journal of the Association of Nurses in Aids Care*, *21*(3), 221–229. https://doi.org/10.1016/j.jana.2010.02.004

WPATH (The World Professional Association for Transgender Health). (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people*. 7th Version. http://www.wpath.org.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Singh, D., Blanchard, R., & Bain, J. (2011). Puberty-blocking hormonal therapy for adolescents with gender identity disorder: A descriptive clinical study. *Journal of Gay and Lesbian Mental Health*, *15*, 58–82. https://doi.org/10.1080/19359705.2011.530574

## AUTHOR BIOGRAPHY

**Danielle Tanner** is relational body psychotherapist, and supervisor. She trained with Silke Ziehl, of the Entelia institute at The Open Centre, in neo-Reichian body psychotherapy and Postural Integration. She furthered her training with Dr. Asaf Rolef Ben-Shahar in Integrative Mindbody Therapy (IMT) and relational hypnotherapy. She has the deepest gratitude for her teachers, and her supervisor, Nick Totton.

**How to cite this article:** Tanner D. The body politic: The changing face of psychotherapy and transgender. *Psychother Politics Int*. 2019;17:e1507. https://doi.org/10.1002/ppi.1507