A Proposed Approach Treating Gender Dysphoria Through Body Image Therapy

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Abstract

Gender dysphoria (GD) is a mental illness documented on Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) and is widely experienced by people within the transgender population. Current treatment approaches include hormone replacement therapy (HRT), sex reassignment surgery (SRS), and psychotherapy. Due to the hardship to get medical attention, many transgender individuals face severe psychological distress from their body. However, current psychotherapy is inadequate in addressing the body dissatisfaction among the transgender population. Meanwhile, body image therapy is used for eating disorder treatments. Given the parallel between the symptoms of eating disorder and GD, this article draws from an existing Cognitive-Behavioral Therapy (CBT) group treatment for eating disorder and applies it to GD. The proposed advantage of using body image therapy for GD treatment is that it will help to directly alleviate body dissatisfactions, thus leading to an alleviation of GD.

Key word: transgender, CBT, body image, gender dysphoria

Body Image Therapy for Gender Dysphoria Drawn from Eating Disorder Treatment

Introduction to Gender Dysphoria

Transgender refers to the broad spectrum of individuals who identify themselves as a gender different from the one they were assigned at birth. Gender Dysphoria (GD) is used to describe “an individual’s affective/cognitive discontent with the assigned gender” (American Psychiatric Association, 2013, p. 451). This discontent can be manifested in the individuals’ dissatisfaction with their body, social identity, and other aspects of their lives. It is important to note that self-identifying as a transgender individual does not mean that one has GD. The term applies only to transgender individuals whose condition is associated with clinically significant distress or impairment in social, occupational/school, or other important areas of functioning as indicated in the DSM-V. According to the DSM-V, those individuals with GD experience “a strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)” (American Psychiatric Association, 2013, p. 452).

Typically, GD is clinically reported by adolescents and adults, and it is usually accompanied by a persistent feeling of distress and dissatisfaction towards their bodies. Therefore, some of the transgender population will have the desire to use medical treatments to help them achieve physical appearance that is in alignment with their chosen gender. Transition-related medical treatments, including puberty blockers, hormones, or surgeries may help to

alleviate the body dissatisfaction, and therefore, may help to alleviate GD (Becker, Auer, Barkmann, Fuss, Möller, Nieder et al, 2018).

However, many transgender individuals experience trouble getting the medical care they need. Common barriers include financial issues, insurance issues, and employment issues. A lack of availability of care, a lack of education about medication, and biases from medical providers also prevent the transgender population from seeking the medical care they need. (Puckett, Cleary, Rossman, Mustanski, & Newcomb, 2018). Given these limitations in getting medical care for the general transgender population, mental health care becomes another important means to help this population to address GD and other related mental health issues. However, to date, mental health approaches to specifically treat clients with GD have been quite limited (Sloan & Berke, 2018).

There do exist psychological treatments that target the comorbid conditions of GD. Because of the minority stress from a societal level (i.e., negative stigma and discrimination) and GD itself from an individual level (dissatisfaction towards their assigned-gender), transgender populations are at higher risks of related mental health problems such as depression, substance abuse, suicidality, etc. (Blosnich, 2018). For example, the reported rate for having the thoughts of killing themselves in a statewide survey was 79% among FtMs (female to male transgender) and 58% among MtFs (male to female transgender) (Xavier, Honnold, & Bradford, 2007), while the current rate estimated among general U.S. adult population is 3.9% (Substance Abuse and Mental Health Services Administration, 2014).

Although it is important to treat these comorbid conditions, treating GD directly is more critical, as it addresses the problem rather than the related symptoms alone. Psychotherapy is needed to directly target the antecedents of GD, including the primary issue of dissatisfaction towards one's body. Therefore, this paper will be focusing on the direct treatment for body dissatisfaction among transgender population. It is important to note that the psychotherapy is not intended to change people's gender identity but, rather, to help them achieve long-term comfort with their gender identity and expression (Coleman, Bockting, Botzer, Cohen-Kettenis, DeCuypere, Feldman et al, 2012).

Existing Treatments for Gender Dysphoria

As stated previously, research or evidence-based treatment for Gender Dysphoria has been very rare. Additionally, there is no treatment that targets directly the body dissatisfaction aspect of GD. Existing transgender-affirming psychotherapy addresses the topics including: (a) clarifying and exploring gender identity and making plans for gender role change and social gender role transition, (b) addressing the impact of stigma and minority stress on one's mental health, and (c) facilitating a coming-out process (Coleman, Bockting, Botzer, Cohen-Kettenis, DeCuypere, Feldman, et al, 2012; Bockting & Coleman, 2007; Devor, 2004; Lev, 2004). Psychotherapy has also provided support and helped transgender individuals with GD to build interpersonal skills and resilience. Coexisting mental health concerns such as depression and anxiety have also been addressed through counseling treatment.

Validating clients' identities and supporting their transition processes are important things to address in counseling; however, evidence has shown that while counseling treatments enhance transgender clients' well-being, none appear to be directly alleviating GD itself. Currently, the only psychotherapeutic approach that has been aimed at treating GD directly is Dialectical Behavior Therapy (DBT). DBT has primarily been used for treating suicidal behavior and emotion dysregulation among general population (Sloan & Berke, 2018). The transgender population is subject to chronic invalidation from the dominant culture that often assumes gender identity and birth sex to be synonymous. Research has shown that under long-term invalidation, people may experience difficulties in regulating their emotions (Koerner, 2012). Consequently, in DBT with transgender clients, the therapist provides "direct feedback about the potential impact of invalidation on their ability to regulate emotions, behavior, and a stable sense of self" (Sloan & Berke, 2018, p. 126). DBT is both a change-focused and an acceptance-focused therapy that allows the counselor to take a non-judgmental stance with clients while also to helping them redirect their anger or other emotions from GD towards problem solving (Sloan & Berke, 2018). DBT has been proven to be an effective approach to treat clients living under constant social oppression and invalidation, but the approach falls short in addressing the body dissatisfaction experienced by transgender population.

Therefore, as there is no other existing treatment for GD, yet the constant body dissatisfaction is one of the main symptoms of GD (Becker, Auer, Barkmann, Fuss, Möller, Nieder et al, 2018), we are making an assumption that a body-image related therapy can be

helpful for individuals who are experiencing GD. Currently, existing body image therapy are used for eating disorder treatment, so the rest of the text will discuss how to utilize this approach for transgender populations.

The Parallel Between Gender Dysphoria and Eating Disorder

There exist important parallels between the physical and mental conditions associated with GD and eating disorder; for most clients, both disorders require medical assessment and monitoring, as well as psychological treatments (Cook-Cottone, 2015; Becker, Auer, Barkmann, Fuss, Möller, Nieder et al, 2018). Additionally, clients diagnosed with eating disorders and GD both require a change in their current physical status. For individuals with GD, many need medical treatments to help them achieve the physical appearance that is aligned with their chosen gender. For individuals with eating disorders such as anorexia nervosa or Binge Eating Disorder (BED), many need to gain/lose weight to maintain a healthy physical status. Members of both disorders also experience a significant amount of distress from body image.

Body image has been found to be associated with eating disorder. Research shows that obese participants with BED showed significantly greater impairments in the cognitive–affective component of body image compared to obese women without BED in a control group (Lewer, Nasrawi, Schroeder, & Vocks, 2016). In a later study, researchers found that body image flexibility, the ability to accept and experience both positive and negative thoughts, beliefs, and feelings about one's body, is the strongest predictor and moderator of global eating disorder, followed by body image avoidance, the avoidance of mirrors, excessive weighing, and avoidance

of tight clothing. Negative affect, personality beliefs, and self-efficacy were all significant predictors for eating disorders, but not as strong as body image flexibility or body image avoidance (Pellizzer, Waller, & Wade, 2018).

Body Image Therapy and Eating Disorder

Body image has been a primary consideration in treatments for eating disorder (Morgan, Lazarova, Schelhase, & Saeidi, 2014). Some treatments have incorporated positive body image into the treatment for mental disorders related with eating behavior. For example, it has been suggested that attunement (having healthy, embodied awareness of the internal and external aspects of self) and mindfulness are useful in cultivating positive body image (Cook-Cottone, 2015). Attunement allows the client to navigate the relationship between the body, the demands of the external environment, and the self. Experiencing a more positive body image is seen as a route for the eating disorder patients to achieve greater mental and physical health.

Other research suggests that people with eating disorders can also benefit from a manualized Cognitive Behavioral Therapy (CBT). German researchers designed a ten-session CBT-based body image therapy for the BED population. The study shows that body image therapy is a worthy complement to the current approaches for BED treatments, as it significantly lowers the dysfunctional cognition related to body and self-esteem (Legenbauer, Schütt-Strömel, Hiller, & Vocks, 2011). The same manualized treatment was used in another research study where 15 overweight female participants with BED showed significant improvement in the cognitive-affective component of body image disturbance (one's mental picture of oneself)

compared to the obese women in the control group who did not receive the treatment (Lewer, Kosfelder, Michalak, Schroeder, Nasrawi, & Vocks, 2017).

Another manualized ten-session, CBT-based body image group therapy for anorexia nervosa has been developed and tested by British researchers (Morgan, Lazarova, Schelhase, & Saeidi, 2014). The results of testing show that after ten sessions, group members show a significant decrease in body checking and body avoidance and anxiety, indicating that CBT may be an effective short-term treatment for anorexia nervosa.

Addressing Gender Dysphoria Through Body Image Therapy

The remainder of this paper shall propose that the ten-session CBT treatment model for BED developed by German researchers Legenbauer, Schütt-Strömel, Hiller, and Vocks (2011) could be effectively adjusted to address the negative body image issues of the transgender population experiencing GD. In the original model, the sequence of the structured CBT group sessions includes: (a) identifying the etiology for BED behavior, (b) identifying and modifying the dysfunctional cognitions for body image, (c) mirror exposure/video feedback, (d) reducing the body avoidance and checking, (e) identifying positive body-related behaviors, and (f) preventing relapse. This model uses the first two procedures to identify and modify the dysfunctional cognitions, attitudes and beliefs related to body image. The later procedures are used to cultivate positive body-related behavior and reduce body-related avoidance and body-checking behavior. The last procedure is used to stabilize the result from previous sessions and prevent relapse.

The proposed model revised for the treatment of GD, adheres to the original model's main theme, techniques, and the sequence of sessions. In the proposed model, theme (a) is changed to "identifying the etiology for GD" (i.e., the social expectation for the appearance of men/women and the social pressure for a transgender to be seen as a cis-gendered person). The general procedures from BED treatment remain the same. The major change is that, in the proposed model, the discussion questions are revised to be gender specific (see Table 1). For example, by challenging potential dysfunctional cognitions group members have towards their body, such as chest and body curves discussion for transmen and height and facial features discussion for transwomen, they can realize that a cis-gender's appearance may also not fit into the stereotypical social norm for men or women. By introducing the mirror, group members can objectively learn about their positive and negative body parts to increase the awareness towards their body. By developing a hierarchy of exposure plan, group members can gradually expose themselves to situations that are more affirming to their gender. In the last session, the group will discuss how to prevent members from relapse and develop coping strategies for triggers.

Analysis and Discussion

The advantage of the proposed model for treating negative body image in GD is that by directly addressing the distress of transgender individuals towards their bodies, we can alleviate a major antecedent of GD. Through addressing identity change and exploring the minority stress in previous GD treatment models, the counselor can help transgender clients to feel more comfortable with their identity, but not necessarily their bodies. By exploring the cognitive-

behavioral association between body image and GD, gradually exposing the transgender population to negative thoughts and affects related to their body and redirecting them to focus on the positive sides of their body, clients can learn to accept their bodies that are not masculine/feminine enough.

In implementing the proposed model, it will be important to note that not every transgender individual shares the same ideal body image and the same goal to work towards. It is recommended that when organizing a therapeutic group for transgender individuals, a trans-masculine group and trans-feminine group should be conducted separately to avoid conflicts resulting from different ideal body image, i.e., a body part that might be hated by a transman might be admired by a transwoman. Additionally, transgender individuals are likely to present in different stages of transition (e.g., pre-hormone, on-hormone, pre-operation, post-operation). It will therefore be important for group facilitators to be cognizant the difference in body types present and to validate everyone's identity regardless the body they are in.

It is important to note that this treatment model should be strictly applied with the acknowledgement of one's self-identification and the understanding of one's wish to transition. It is not intended to persuade clients out of the transition process or talking them into getting medical procedures.

Without further research, there is no way to found out the effect and validity of this treatment for population with GD. Therefore, experiential groups are needed to prove our hypothesis of whether the CBT group drawn from BED treatment can be used to reduce body

dissatisfaction that is typically experienced by transgender individuals with GD. Future research should focus on the self-assessment of GD before and after the group therapy. A significant decrease in these areas may indicate that this group can be an effective tool for GD treatment.

In their report Legenbauer, Schütt-Strömel, Hiller, and Vocks (2011) cite several weaknesses in their research: (a) a lack of control group, (b) participants concurrently receiving additional treatments for their comorbid conditions, and (c) self-report methodology. Therefore, future researches that are intended to study the relation between this CBT framework and its effect on treating GD shall be mindful of the critiques mentioned above. As mentioned in weakness (a), psychotherapy groups are proven to be an effective intervention for a number of mental disorders (Montgomery, 2002). Therefore, without a control group, it is hard to attribute the behavioral and self-assessing improvements to the specific CBT group treatment. The introduction of a controlled group can narrow down the potential effects that participants may get from purely sitting in a therapeutic group. At the same time, a screening for comorbidity should be included when recruiting participants to avoid potential confusion in the result caused by comorbidity.

Future research might also point to the direction of examining the relationships between body image flexibility and GD or body image avoidance with GD. A supportive literature in these fields can further enhance the assumption that individuals with GD can benefit from body image therapy.

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Table 1. Comparison between BED treatment plan and GD treatment plan.

Session	Session theme	Method (BED)	Method (GD)
1 and 2	Identification of etiologic and maintenance factors	Development of a cognitive-behavioral model of body image and eating disturbance. Identification of individual factors contributing to the development and maintenance of body image disturbance.	Development of cognitive-behavioral model associating body image and GD. Identification of contributing factors (i.e., the social expectation for the appearance of men/women and the social pressure for a transgender to be seen as a cis-gendered person, minority stress, etc).
3 and 4	Identification and modification of dysfunctional cognitions and core beliefs	Analysis of dysfunctional cognitions by behavioral analysis; discussion of content of dysfunctional cognitions within the group; analysis of body-related core beliefs; Socratic Dialogue (i.e., “the women think I am fat when she looks at me”. Development of an alternative interpretation of the situation; role play with other group members to challenge the dysfunctional thoughts).	Analysis of dysfunctional cognitions related to body image; discussion of content of dysfunctional cognitions within the group; analysis of body-related core beliefs; Socratic Dialogue (i.e., for transmen – “they must have seen my chest when I was walking and think I am a girl”; for transwomen – “people think I am too tall to be a girl”). Development of an alternative interpretation of the situation (“some men have enlarged breast”; “some girls are tall as well”); role play with other group members to challenge the dysfunctional thoughts).
5 – 7	Mirror exposure/video feedback	Repeated exposure to the whole body using mirror and video feedback; continued exercise as homework assignment. Focus on negative body parts in order to habituate to negative body-related emotions; focus	Repeated exposure to the whole body using mirror and video feedback; continued exercise as homework assignment. Focus on negative body parts in order to habituate to negative body-related emotions (i.e., for transwomen, the broad shoulder); focus on positive

		on positive body parts in order to overcome the attentional bias towards assumingly negative body parts.	body parts in order to overcome the attentional bias towards assumingly negative body parts (i.e., for transmen “I have a heard”).
8	Reduction of body avoidance and checking behavior	Identification of individual body-related avoidance and checking behaviors; repeated exposure to these dysfunctional behavioral patterns; exposure exercises as homework assignments. Develop a hierarchy of avoided situations and checking behaviors; plan exposure exercises (e.g. going to the swimming pool).	Identification of individual body-related avoidance and checking behaviors; repeated exposure to these dysfunctional behavioral patterns; exposure exercises as homework assignments. Develop a hierarchy of avoided situations and checking behaviors; plan exposure exercises (i.e., for transwomen, gradually wearing feminine clothing out in public, under the premise of undergone the coming out process).
9	Assemblance of positive body-related behaviors	Identify positive body-related behaviors (grooming; moderate physical activity); plan positive activities as homework assignment (i.e., taking a yoga-session, buying a new tight fitting skirt).	Identify positive body-related behaviors (i.e., for transwomen, trying make up and feminine clothing); plan positive activities as homework assignment (i.e., for transmen, going to the gym and working on upper body muscle building; for transwomen, learning to wear makeups).
10	Relapse prevention	Discussion of individual risk factors for relapse and development of individual coping strategies (i.e., what are situations that might trigger negative body-related thoughts or avoidance and checking behaviors in the future).	Discussion of individual risk factors for relapse and development of individual coping strategies (i.e., what are other body image related triggers for your GD and how to cope with them).