Academy of PHYSICAL MEDICINE

Transcript

326 – Affirming Gender Identity with Robert Withers

Steven Bruce
Well, good afternoon again. Lovely to see so many people joining us for these lunchtime broadcasts and thank you for being one of them. I wanted to say as well how much we appreciate all the messages of support that we've received for Claire recently. I do want to emphasise that she is okay the problem is not life threatening, but it's it's been pretty stressful for her and has left her really wiped out. She is on the mend, not back to full fitness yet. But that said once she's up to it, we're going to be using her as one of our cases for our lunchtime case based discussions. And I think you'll find it pretty fascinating to be honest, turning so today, however, I've got Bob with us waiting to join me via the video link. And we are going to be talking about gender issues gender dysphoria affirming gender identity, trauma informed treatment. Now, I recognise that gender issues can be pretty divisive. And I've already had a few emails stating people's opinions one way or the other. But it's not something we can ignore in the modern world. And of course, we've got an obligation to treat impartially and so on. To such an extent that the GCC has made it the focus of CPD this year for chiropractors to look at diversity and inclusion. So if you're a chiropractor, this is a particularly relevant piece of CPD for you, Bob, welcome to the show. Thanks for Thanks for joining us here. I mean, this is something which you're a psychoanalyst yourself and you're and this is something which you've been involved in for some years. Do you want to give us a bit more background about yourself and rather set the scene for the discussion?

Robert Withers
Yes, well, I've been asked here as a member of an organisation called the clinical advisory network on sex and gender, which includes a variety of people from a number of backgrounds, psychiatrists, GPS, psychotherapists, and psychoanalysts, like myself largely. But the reason that I was volunteered to be the one to appear today is because I also have a background in complementary medicine. So before I trained to be an analyst, actually practised as an acupuncturist and as a Homoeopath. And I did some academic research into homoeopathy at the University of Sussex. And then I went on to teach for 14 years at the University of Westminster, where I was a senior lecturer in the Department of complementary therapy studies. And I was particularly interested in and devise module modules for the master's programme on the mind body relationship in particularly in complementary medicine, and also on working with the therapeutic relationship in a psychotherapeutic informed way. So you can see that I think that today's subject is kind of up my street, really, because as you as you'll hear later, I believe that we can help conceptualise some kind of rudimentary understanding of

gender dysphoria through a consideration of the Mind Body relationship. And I'll very briefly say how I got into this area of work with with transgender people. And it was it was like this, initially, my first transgender client I saw in the early 1990s. And he was actually a D, transitioning male to female back to male transsexual person, as we used to call him in those days. And he'd lived as a woman, having fully medically transitioned for nine years. And he'd found that it hadn't resolved his psychological problems. So he came to see me and I worked with him analytically for four years, seeing him three times a week, and going to a very considerable understanding of where his trans identification had had come from, really. And he wished that he had had proper psychotherapy before he'd done something permanent to his body. So that's my first introduction to transgender issues was somebody who had to pump the harm to his body. Obviously, he'd been castrated. And he was taking oestrogen. And he couldn't get his his body back. And alerted me quite early on to the importance of trying to work psychologically or non invasively if we can before reverting to more radical treatments, including surgery and hormones. So that's my kind of background. I've sometimes been accused of being transphobic because I don't just affirm people in their trans identity and just automatically support their medical transition. Because part of my work as a researcher has been also to look at the science which underlies some of the research papers and although this isn't The place for me to talk about that today I have been astounded by the incredibly poor quality of the evidence which has been put forward in support of the so called gender affirming treatment. Unfortunately, it's more driven by ideology than by scientific evidence. And

Steven Bruce
sorry, if I may interrupt here is I feel that the argument is polarised very polarised. And I imagine that there are those who are just as vigorously opposed to anybody transitioning as there are those who are vigorously in favour of people being allowed to or encouraged to make that transition. And one of the areas where I'm trying to do here is to is to enable us to have an understanding of how you decide what's appropriate for people how you can help people in that situation.

Robert Withers
Yeah, thanks. So Minda, that's really, that's really good and important. And it is incredibly polarised. You're so right, you know, there are people on both sides. There are some people who think it never should happen, nobody should ever medically transition. And there are some people who think it's an infringement of trans people's rights, if they don't get immediate access to the Oral surgical and hormonal treatments that they demand. Those two camps can roughly fall into the transformative camp and the what sometimes called the gender critical camp. And what I'm very glad about is that you've asked somebody, not just from the transformative side, to speak today. And it's very important that we consider all of these issues as you're hoping to do in a kind of a balanced way.

Steven Bruce
I think I did mention to you didn't know that. I've had a couple of discussions with a chap called Simon Croft, a trans man from the from the may have gendered Intelligence Organisation in London. And he spoke very, very well. But his his was largely making an assumption that transitioning was what was required on the basis of the people that he'd come across. And I think it's really important to hear that the other side of the story as well.

Robert Withers
Yeah, thanks very much. Yes. So, as I say, I'm not against transitioning. And I don't deny that people feel better often if they have transitioned, but as somebody who has researched homoeopathy in the past, which also had powerful effects on people. I would like to make a plea for the power of the

mind. And one of the research areas that I have tackled at the University of Westminster is the placebo effect. And although people may say that they feel better from homoeopathy, it doesn't when you do a scientific study actually outperform placebo. And it's entirely possible that the same could turn out to be true for the medical treatment of gender dysphoria. Because the evidence so far collected has not been scientifically rigorous, as I said. But before going into a bit more detail about this, I just thought I could step for a moment into some slightly less controversial territory around trying to illustrate what the power of the mind can be in my experience. And if you bear with me for a couple of minutes, what I think I'd like to do, just to set the scene, because there are some people who don't really fit think that the mind has much effect on the body. And who, perhaps, you know, I know from working with osteopaths in the past and acupuncturists and doctors as well, that there are some people who take quite a materialistic view of the human, the human condition. And they think that the only really effective treatment is going to be physical treatment. And they think that the only real suffering is physical suffering. And there are other people more from the psychotherapeutic side, perhaps, who feel more or less the opposite, which is the they think about the power of the mind, sort of trumping the power of the body. And one of the areas that we researched at Westminster was this, this is a book called Understanding the placebo effect in complementary medicine, edited by David Peters, colleague of mine, who's professor, I think he may be retired now. He's an osteopath. And the following extract is from my chapter in that book, and it's called psychoanalysis complementary medicine and the placebo so bear with me for a moment starts off Mr. X and the Nasi bow for the NA SIBO is the opposite of the placebo. I'll start with a case from my work as an acupuncturist taken from my chapter, complementary medicine, psychoanalysis and the placebo in that book some 15 years ago and actually was writing this in about 2000. So maybe the case was in 1985, before I trained to be a therapist, some 15 years ago, I was the recently qualified acupuncturist. A man walked into my consulting room suffering from acute rheumatoid arthritis. He was a small man in his late 20s with a pronounced fear of needles, and his symptoms were severe enough to keep them off work. He tried conventional treatment without any lasting success. And he turned to acupuncture and desperation. But he was too frightened because of his fear of needles in the first session, to allow me to insert any needles, and instead, we talked about the origins of his fear. In the hope that if we could understand it, he might be able to overcome it enough to let me treat him in the next session. Mr. X, as I shall call him was one of those people who have an intuitive grasp of their own psychology without ever having been in therapy. And with very little prompting from me, he went on to describe his relationship as a boy with his much love grandmother. She was a large and friendly woman, and he was in the habit of a morning of climbing into her bed and romping about before she got up, and he recorded obviously emotion, a particular incident as a six year old. On the morning in question, he climbed into her bed as usual, but noticing that she was very still, it began talking to her to wake her up. Eventually, he succeeded in rolling her over, but to his horror, she fell out of bed, pinning him to the floor underneath her trapped and panicking. His cries eventually alerted the other adults who came and removed her dead body from on top of them. She died in the night, and he stated his fear of being trapped and helpless, and hence his fear of acupuncture to this incident. Following this account, Mr. X gradually became able to tolerate my needles, and I began treating him according to the principles of TCM traditional Chinese medicine. They responded well, and within a few treatments, he was able to return to work and gradually reduce the frequency of his sessions. things progressed in a satisfactory if unspectacular manner until one day when he missed an appointment. So happened at this time that I was having trouble with people cancelling appointments in what I consider the casual manner. And having recently started psychotherapy myself where Miss sessions are charged for I decided to tackle him about it when he turned up for his next session. In order to do this, I chose the time when he was lying on the couch with the needles in as this as a fellow time not taken up with what I

considered the more important business of information gathering and diagnosis. He told me that on the day in question, it set out as usual for his appointment, only to find the British Rail had changed their timetable. He said he understood the tide lost my income for that session, but he didn't feel inclined to pay the fee himself. Since the charge changing timetable wasn't his fault. I commented that it wasn't my fault either. And in the end, we settled on a compromise where he paid half the fee, and apparently satisfied he walked out. I was horrified when he hobbled in wracked with pain for his next session, the redness and swelling had returned to his joints, and he was off work again. And as bad as state is when I first seen him, my first thought was to check my treatment notes. But there was nothing unusual about the points I'd used. Next, I asked whether he'd done anything different to himself since we last met, but he said he hadn't. puzzled and disappointed, I could see no option but to continue with the treatment as usual, which I did. When the session ended, he thankfully thanked me for my help and said they didn't want to spend any more money on a treatment that had stopped working. And it was my lunchtime at this point. And as he turned to me one last time, he asked whether I thought the mind could have an effect on the body. And I said I was sure it could, but I asked him what he meant. In time now outside the official session, he proceeded to tell me with great vehemence, how it made him feel in the previous session, I'd known about his fear of being trapped. So he found it incredible that I chosen his time on the couch to confront him about the money. He'd felt pinned down by me and my needles aren't able to express his anger, but I've been charged anything for a session that hedonists are no fault of his own. And he attributed the return of his symptoms directly to this experience went on in this vein until exactly half of sessions worth of time have passed. He turned and left, leaving me feeling crashing. So that was just something to illustrate how the dynamics of therapeutic relationship and how the mind can affect the body in quite powerful ways.

Steven Bruce
So I'm getting because we want to put this into the context of physical therapy where people are coming to my audience today, which is predominantly osteopaths and chiropractors. Someone comes in I imagine it is possible that their concerns about their own gender identity might come Up in the in the case history taking during a discussion during treatment. And I suppose what we need to get out of this is to be able to offer evidence based advice, rational, reasonable advice to anyone in that position without sort of driving them down any particular route?

Robert Withers
Well, absolutely. So one needs to remain neutral. And people often don't want to talk about that gender problems or their psychological problems. I mean, I don't want to spend all the time on this case, but I did get, sometimes you hear from a patient after, after you've seen them. And I heard from this guy, and he said, Hi, Bob, I was surfing the net to see if he was still in practice in Brighton, it appears that you're not but your name did come up. And I found the above article in which I features Mr. X, I remember you asking me about the use of the story, which is fun, it seemed very strange to read about an incident in which I feature and never thought I'd ever get to read it. So stardom for me. And he goes on to say I just thought you'd be interested to know that in the quite recent past, the wheels have come off my waggon. In health terms, I've become somewhat disabled with RA. And the side effects of the conventional treatment of cause more problems than the actual disorder, but a considerable period of work. And he talks about how he was seeing a TCM practitioner professor for Chinese medicine in a shopping mall, and he's born, but because of language problems, he didn't really have the chance to talk to her about some of the emotional issues. And he said he hated talking to me about but realised with the benefit of hindsight, had actually been very important. So I think that when you're raising the question, you just raised people about, how do we work with the

psychological side of people who present maybe with a straightforward problem, you know, bad back, or poor pain in the limbs, or you know, jaw or whatever it is. But they also have gender issues. And maybe these are related to, you know, maybe maybe their their physical symptoms might relate to No, you sometimes find that people who have been sexually abused, for instance, have inexplicable, medically inexplicable abdominal pains, which are kind of body memories of traumas which have been suffered and stored in the body. And some of these people will defensively in my opinion, identify as trans as a way of trying to escape the vulnerability in the body. So I've seen since then a couple of other D transitioners, one of them, a woman who was sexually exploited by people who were very close to her. And she considered something about her own dependency needs, and her femininity had moto vulnerable to that exploitation. And after she identified as trans that was, she thought of herself as male, had the surgery and hormones, and then ended up regretting it, and there's now a do transitioner. And the other thing that went on, of course, if she'd been able to talk to the practitioner beforehand about the trauma that she'd suffered, there's a strong chance that that would have helped relieve some of the discomfort that she felt with her female body, and she might not have actually gone through with the surgery and hormones. So I'm not trying to say, you know, never have surgery never have hormones, because some people, that may be the best way that they can manage their pain. What I am pleading is that if it is possible to resolve the gender dysphoria, psychologically or through a physical treatment like osteopathy, without having that invasive medical treatment, then that's better than becoming a long term medical patient of treatments with very poor treatment, record very poor evidence of effectiveness, and long term side effects, some of which are really quite difficult. Another common theme that that can happen, unfortunately, is sometimes if people are brought up in rather a homophobic environment, they can, they can feel very uneasy with their own bodies sexual response to that physical bodily response, and they can interpret that as being born in the wrong body or as gender dysphoria. And so one of the other D transitioners I've worked with, that was the case he realised that he was just a gay man brought up in a very macho homophobic environment and like my first patient, he very much regrets what's happened to him and is quite despairing. So although one must accommodate diversity, and that includes inclusion of people who are trans identified, I think there are other groups as well. Who need consideration And and that includes the D transitioners. We can learn a lot from the people who regret that transition about what went wrong and how we might have been able to prevent that. So that before they do something drastic and immediate, they have a chance to explore other options. I'd also like to make a distinction, which I think is important between gender identity being trans and gender dysphoria, because gender dysphoria is a discomfort that can arise for some people who are trans, but it doesn't arise for everybody. If you read the book, for instance, the book time to think if anybody's really serious about finding out what went wrong at the Tavistock, Gender Identity Development Service, Hannah Barnes his book, time to think is really excellent. And in there, she's got a case of somebody who is identified in terms of their gender identity as male, but they're biologically female, but they don't want any medical treatment for it, because they're able to live with that diversity within their own human makeup. So not everybody wants cycle psychotherapy or medical treatment.

Steven Bruce
Bob, do you have any idea of the the proportion of trans people who regret their transition, and I suppose the only measure of that is those who have the transition, but maybe you get a feel for how prevalent the problem is?

Robert Withers

Well, unfortunately, the people that I've come across who this has happened to have been so vilified, and trolled and regarded as traitors by the people who are advocating easier access to surgery and hormones that they don't, they don't, I mean, they have to be very brave to come out as D transitioners. And none of the people I've seen have gone back to the clinics where they've been transitioned in the first place. And they don't, the data has not been properly collected. And the studies again, if you do you know, because I'm former academic, I'm retired now from University of Westminster. But if you look at the studies, there are studies which claim that it's a very, very low regret, right. And what they don't mention is that 35% of people in the biggest study by somebody called week has dropped out of it, they don't count people who are dead at the time of the study. So if somebody is so upset by what the what has happened, that they commit suicide, that's not counted as transmission regret, they just not part of the figures, anybody who, so the study is again, a very poor, I mean, I, alright, I will just say, at the risk of getting a little bit too technical, the weakest study, which is largest one, only accepts people as valid D transitioners. If they go back to the clinic, where they transitioned, originally have had full GYN genital surgery, done adapters, and request the hormones to go back to their original set. So it's a pretty high bar for somebody to actually say, I regret it, and I want to go back. And they find between the blog point five and 1%. But other studies which have a wider definition of regret, there are very few that this is an area that's not been properly researched, because anybody tried to research it gets accused transphobia. But there was a recent study in Cambridge, which showed set about 7% of people actually regretting it in their study, and about another 7%, who were not sure who looks at they might end up regretting it. And the other thing that studies have shown is that regret when it occurs, tends to happen about 10 years after the initial transition. And this new wave of people, it's increased from about 50 people at the Children's gender identity clinic in 2009, to about 2700. In 2019, this huge increase has happened within the last 10 years. So we don't know is the honest answer how many of these people are going to regret it. But the danger is that if there are psychological elements, which are encouraging people to identify as trans in order to get away from trauma stored in their body, or being bullied at school for being gay, then we're not going to find out the true figures of regret until much later. So we don't know yet that that Cambridge study was a fairly small number. And the area needs researching a man called James caspin, a colleague of mine had a place to research detransitioning and his university, first of all, gave him permission to go ahead and then because of the fear of the accusation, shins of transphobia he had to abandon his research. So it's a complicated area where I mean, I as you said before the introduction, Steve and I have been accused of transphobia or being anti trans because I do advocate working in non invasive ways if if it's possible to resolve the gender dysphoria you know, without radical surgery and hormones, I'm I do think that's preferable. But there are actually but

Steven Bruce
if I can, I've got a couple of observations that are coming from the audience. Matthew says, As a practitioner, it can be hard sometimes to negotiate the division between affirmation and accusations of transphobia made often seems to be too strongly driven by the personal agendas of the people involved. And I think you'll sympathise with that, Bob, you can do a lot to mostly get it right. But you're guaranteed to get it wrong sometimes. And I hope this can be accepted as okay in practice. Now, I don't know what situations Matthews got in mind there in terms of getting it wrong. But I know what he means that for many of us, it would come as a surprise when a patient perhaps admits to acknowledges that they are in some way transitioning. And we then start to worry about what language we use and what we can ask them to do and whether we have to consider binders and all the other things that might affect their health. And therefore we might say the wrong thing.

Robert Withers
Thank you, that is such an important question. So when working with his clients, it's very important not to be put in the transphobic camp, and it's so easily easy to be put there. And then the patient clams up and doesn't feel that they want to talk to us. So in terms of managing the therapeutic relationship, trying to be neutral, and trying to be accepting, and trying not to condemn what the patient wants to do, even though we may be inwardly, quite frightened for their safety, you know, that that's really important in terms of preserving the therapeutic relationship as a safe place where the person feels they can trust the therapist. And if as a result of some osteopathic treatment, somebody, you know, flashes back to sexual abuse and starts to get upset. I think it's important that the therapist doesn't close that up, but feels able to create to say safe place for the person to talk about their mental and emotional well being as well as working physically. And if you get out of your depth with somebody like that, I would advise you should maybe try and get some supervision from somebody with some psychological knowledge or skill. But remember what I was going to say earlier, which slipped my mind, which is this, which is that I actually think it's transphobic to encourage people to have a medical treatment with evidence, which has been called either poor or very poor, by neutral agencies, such as the National Institute of clinical excellence. I think that's a kind of transphobia because we wouldn't, we wouldn't advocate poorly evidence treatment for any other disadvantaged group of people. So why aren't these people entitled to the same quality of evidence for treatment? Does everybody else. And it seems to me that there's been so much political disturbance. And, you know, the, the culture wars that we've all been part of, the feelings have got so high, and people have become so frightened to speak about, you know, what they believe what they think what they can see what they can hear that somehow the people who have got damaged by this and swept up in it, unfortunately, I think we're going to find in the long term, are the vulnerable children with other mental health problems. Autism has very high trauma, trauma stored in the body is quite common. And I think we will, we're in danger of finding that in the rush to affirm and support people. We've let these people down and I am in favour of trans rights. But I'm also in favour of the rights of autistic kids, of gay people not to be encouraged to transition of women to have safe space and safe competition in sports where they're not being out competed by biological males. So I think it's a question of balancing different rights. And although that's not really my concern, I'm not concerned so much with the social stuff in the political stuff. I am concerned with trying to work in a sensitive and effective way that honours the bio psychosocial, holistic approach. So not just the chemical or physical one, not just a psychological one either. But these are people who, if they're suffering with gender dysphoria, they're suffering in a holistic, bio psychosocial way and I think they deserve proper bio psychosocial support. And

Steven Bruce
then I imagine that many of the people watching today will be thinking, well, this is outside our remit. The problem is that ours is a fairly intimate treatment environment. Whether you're a chiropractor or osteopath, you know very often our patients are undressed to some degree is very hands on in most cases. And I suspect that maybe we might be an early opportunity for someone to disclose those psychological concerns that they have. And Ken has said, when dealing with a psychological patient, you can't take the high ground of I know it will be better for you in the long term. If in the short term, they mess up, your mind stresses you out and potentially damage your career with a complaint, signpost them to the GP is Ken solution. Now there are enough simple cases to deal with. I can see what Yep, and I absolutely understand what he's saying though. We do need to signpost people to the services which can deal with them more effectively than we as non psychotherapeutic professionals can.

Robert Withers
Excuse me, yes, I agree. And I think when I was making my transition from being a complementary therapist, to being sorry, choking on my water to being a psychotherapist, it was very useful for me to have a friendly psychotherapist or two that I could refer to with confidence. But I think you're absolutely right, that sometimes it's in the complementary therapy consulting room that people first talk about the emotional issues, maybe being trans perhaps being traumatised. And sometimes our reaction as complimentary therapist is to think no, this isn't my concern, I've got to refer the person away. And although that might be true, and although one should be able to recognise the limits of one's competence, I think if a complementary therapist is working holistically, it is important to have some psychological and emotional empathy and understanding. And I think often it is possible to create a space where people can talk about emotional issues, relationship issues, feeling uneasy body. Very often there's, there's a condition here where it's known as mind body dissociation, where the person identifies with a disembodied mind and feels that the body is alien. And that often happens when somebody has been physically or emotionally traumatised, then they can experience the body as somewhat where they don't feel at home. And, and the dissociation can be anything mild, like a sense of tingling or numbness. To some complete sense of this isn't my body, this is completely unreal. And if the person is identified with a disembodied mind, which is gendered Oppositely, to the body, then the whole notion of attempting to settle back into the body becomes very frightening, because that person might encounter a trauma or a feeling, which is at odds with diametrically at odds with the psychological identification that they've got. And actually, one of the simplest ways of getting a person to get rien bodied is to is, is through touch. So if you're touching the back of somebody who is feeling that their genitals aren't working on functioning sexually, they're numb. And in the course of the treatment, they find themselves back in touch with the feelings in their genitals, that can be very alarming for that person, and it can bring back memories of the sexual trauma that caused them to dissociate in the first place. Now, I'm not suggesting that osteopath should work in depth with people who've been sexually traumatised. But if that happens in your consulting room, and you'd say, and you just shut up shop and say, This is too too far for me, I can't handle this, you're giving that person a message that they've got to go back to the dissociation, they've just had an experience where they've opened up maybe for the first time to somebody who they're hoping can be receptive and sympathetic understanding. And I think we'd let people down if we get if we let them go too quickly. And if we refer them on too quickly to specialists, and the other question is, which specialists will refer them on to because the gender world in therapy is divided into these two camps? You've got the gender affirming camp who say, Okay, well, I'll affirm you and your trans identity, and I'll support you getting surgery and hormones, because that's gender affirming treatment, and you've got other people in the gender critical camp who will say, No, before we do that, it's really important to to work psychologically. Because you might make a mistake. So who do you refer to? And are you referring to somebody who's gender affirmative or somebody who's gender exploratory? And do you know the difference and does the patient know the difference? So it It's quite it's, you know, even that referral is a huge responsibility. And in the past, people have referred to the specialist clinics like the Gender Identity Development Service at the Tavistock Jude's, and as I said earlier, the Hannah Barnes book exposes just what went wrong there because that whole organisation, became in thrall to activist organisations like moments who were very radically in favour of transitioning and advocated easier access to surgery and hormones. So

Steven Bruce
long as one of our viewers has said that he feels at the moment that we haven't really dealt with how we handle transgender issues in our own clinics. I think that's quite a very, I think it's a very

difficult question to answer because there are so many aspects to the problem, or if it if it's a problem, what would you say?

Robert Withers
Um, well, I would say that each person is individual. And in a clinic, what we need to do is be welcoming to everybody. We need to accept everybody. Some people come into a clinic absolutely convinced that trans absolutely convinced that they need surgery and hormones. So they might be coming for an osteopathic treatment, because they've got some pain in the back or some numbness in some part of their body. And we don't, we don't need to take them on and challenge them in that but if we just give them the support and the treatment that they've come to us for, and it would be a mistake to antagonise them. But other people come genuinely curious wanting to think about whether there are other ways of managing their discomfort with their body. And they might well be open to a certain amount of exploration with the Osteopath.

Steven Bruce
Perhaps one of the perhaps one of the issues that we need to think about is well, how would we how would we discover that this is part of the problem? And you're certainly preaching to the converted when you talk about the power of the mind and the biopsychosocial? model? But it it wouldn't be a standard question anyone's a case history. Are you worried about your gender? Do you feel you ought to be what you're not at the moment?

Robert Withers
No, although some people do recommend having a as a part of a questionnaire you know what, Jack, what gender are you I'm not sure that you see, I think is just speaking as a psychotherapist now, which is, you know, what I've been doing for over the last 35 years. Very often, people with gender issues are actually struggling with ordinary psychotherapeutic problems, you know, they're depressed, they don't get on with their parents. sex lives aren't functioning very well. As I said, they may have been traumatised, there may be people bullied at school, and may be suffering from anxiety and lots of them may be autistic. And so we wouldn't necessarily have to focus on the gender issue, we wouldn't necessarily have to be a specialist area, it could just be part of the holistic treatment, where the person may talk about their gender if they wanted to. And they may not if they don't want to, as I said earlier, some people are quite happy to have a gender that's opposite to their body. Some people might feel really distressed by that. So then you can actually they were distressed, you explore the nature of the distress, when did it happen? What makes it worse? What does it feel like? What actually distresses you? You know, the typical one is people who hate their male body, they don't like the hair, they don't like getting erections. And if you ask them, like what, what's your experience of masculinity? Well, it's something that I find quite often is they've had very negative experiences of masculinity, toxic masculinity, you know, maybe they've had a father who's sexually abused them, or one of my patients, father used to get drunk throw knives at Mother and then ran away to the circus when he was four, you know, so if you get a very bad image of masculinity through your childhood experience, then you can end up filling variabilities with your own male body. And so I would work with with that, and trust that there's a good chance that if the work is effective, that and I'm talking about work as a psychotherapist here, that might result in somebody seeking a solution to their gender dysphoria that doesn't involve becoming a lifelong medical patient is sterile. And, you know, Let's call a spade a spade, castrated, you know,

Steven Bruce

yeah, there's a couple of observations I've seen in the notes here about that have come in. Kind of looking at two different sides of the psychological aspect. One person identified by the system as quest says, they're not transphobic. But her children, his or her children at secondary school, see their friends thinking that trans is a fashion. I don't know if that's something which you feel is an influencing factor. Julia, on the other hand, says I had a female patient many years ago who fully transitioned to male and I just let Him guide me through conversations over time trends. took a couple of years and was completed with no drama or problem. And Julie's point is there seems to be rather a lot of hysteria about the problem at the moment, you know, perhaps driven by the polarity of the argument.

Robert Withers
Yeah, and also the radical nature of the treatment, perhaps. There is a lot of hysteria. And it's, it's unfortunate it I mean, the whole area needs cooling down, and we need a rational look at it. We need proper discussions like this, where you can ask people from both sides of the, the so called Trans debate or the trans wars or whatever you want to call it, to, to actually, you know, expressed views and just discuss it and answer questions from people, like the last questioner who were, you know, just concerned to be decent, good practitioners, giving the best service they can for their patients, whatever those patients are, however they identify, and whatever treatment courses they want to go down. But there are, you know, there are some, there is some evidence that there's a kind of a degree of social contagion going on here, because not only have the referral numbers gone up astronomically, but also the demographic has changed. So it's much more likely now to be females to males than males to females. In the olden days, it was about three to one boys who didn't want to be boys. And that's about three to one girls who don't want to be girls. So there's something going on socially, which we need to understand more about. And it's a huge area, you know, you can get lost in it. I could spend 24 hours a day, seven days a week researching and looking at all of this, but I have to resist the temptation that most of us, we all have to go back to our work fairly soon and put a limit to that. I don't know what you think.

Steven Bruce
Matthew has come in with that I'm gonna read through these last couple of comments. Matthew says patients sometimes are unwilling to accept advice and explanations, explanations, which appears to contradict their own self image and preconceptions. He had this recently when he tried to explain to existing existing patient that his history of rugby playing might affect the results you could expect from treatment. And he wanted to leave the session before it started saying I was being negative. And Matthew says you can see that applying to the this subject area of trans issues as well.

Robert Withers
Yeah, it applies to all sorts of areas and Freud called it resistance, you know, he said that there's a part of us that wants to get well, well, but there's also a part of us, that kind of gets invested in our illness and doesn't want to give it up and then we've meet resistance. So it that's a lot of what you know, Trump, being a good therapist of any sort is partly about how to work with that resistance, how to help the person sort of feel that you're on their side, while at the same time being incisive, and confronting them, if necessary.

Steven Bruce
And that probably supports what Kerry has said that she says, coming at this from never having been in a position, would it be acceptable just to be honest, and say something along the lines of I don't

have much experience with what you're going through. I'm happy to listen and support you from an osteopathic perspective. She's an osteopath, and potentially guide, you presumably have questions unfinished here, but guide you to further support other resources where possible.

Robert Withers
Yeah, I think that's a very honest way, isn't it? Same time, you'll probably find once you do start working with these people that you will get interested in trying to understand it like I did. So trying to work with my first do transitional led me to do loads and loads of research and write papers. Actually, my latest paper, if I'm allowed to plug it just before we finish, of course, is in this book, it's called on young shadow concept. And my paper is called Gender dysphoria, individuation and the shadow and there I try and set out a little bit of a sort of psychological formulation for how we might understand this mind body dissociation. And I tried to answer some basic questions, you know, frequently answered questions about sort of frequently asked questions about how might we work with gender dysphoric people, either as a therapist or as a teacher or as a parent? So yeah,

Steven Bruce
thank you. There's one area of my own personal experience, which challenges me to some degree because I know of a young person who has transitioned to male and very young person, that young person is probably now 17, or there abouts. And it's not a patient at all. But it seems to be a very well adjusted, very happy young person. The parents are both very intelligent, very engaged parents, and I don't sense that there's any dysfunction in the family. And yet I still feel to myself my word, isn't that an early age to make a decision like this? I don't know any of the details. I don't know. I don't know whether the Tavistock clinic were involved. I don't know whether any surgical intervention or hormonal intervention has been undertaken at this stage. But, of course, I just don't know enough about it. to offer any suggestions or advice not that I'm being asked you because this isn't one of my patients?

Robert Withers
No, no, well, it is very young isn't it. And of course, the brain doesn't mature fully till we're in our mid 20s. And part of beginning to feel more at home in our bodies is through sexual pleasure and sexual experimentation. So we find something that makes makes us feel good, and also connects us with someone that we love. And very often the feelings of the body being an alien place, they disappear on their own. So what's been found in a variety of studies is that gender dysphoria, which starts in childhood, by the end of adolescence, once people pass through puberty, about 80% of cases, resolved spontaneously. So I always say to my patients, look, before you do anything drastic, just for goodness sake, get out there and, you know, see what feels nice in your body with with somebody that cares about you that you care about them. So many people spend so much time behind screens just talking to people.

Steven Bruce
Using everyone indeed, yeah, as we all know, for but I'm gonna have to cut you off because we're right up against the clock. We have, as I said, we've had 400 People watching the show. So it's clearly a topic of interest to a large number of people. And it's a topic that's not going to go away anytime soon. So thank you for your expert intervention, they will send people the links to the publications that you mentioned, so that they can have the option to leave those up if they like. But we are I'm afraid out of time for today. Thank you for joining us. I hope the discussion has proved as useful as I hoped it would and as thought provoking as I expected it would for you. From my own perspective, I think, as I've said it, I think it's vital. We've got a balanced view on what is a fairly divisive topic, and

most importantly, that we can treat all our patients fairly and equally. And if you want to see our previous shows on this, where I talked to Simon Croft from gendered intelligence, gender intelligence, those will be posted on the website very shortly.