Gender Dysphoria: A Psychological Model

ANNA LAWS

Abstract

Background: Gender dysphoria is usually defined as the experience of distress or discomfort caused by a sense of the mismatch between a person's gender identity and their sex assigned at birth. This goes some way to explaining the experience of gender dysphoria but misses important aspects. Nor does it explain why medical interventions to change bodily characteristics, to bring them into line with a person's gender identity, do not remove gender dysphoria completely.

Proposal: This article proposes a new model of gender dysphoria which suggests how it might develop, and be maintained, across three different domains of relating. Namely, Self to Self, Self to Other and Community to Culture. The author proposes that this model will bring a clearer understanding of the experience of gender dysphoria and provide a framework from which explorations and dialogue can take place in therapy and other healthcare settings.

Gender is a Cultural Construct

Traditionally, mainstream western cultures have viewed gender identity and biological sex as unified concepts, indistinguishable from one another. An idea, that genitals are the same as gender identity, has become embedded in our culture over many generations and underpinned many societal views on the topic. It has led to a binary cultural construct of gender identity as existing as two categorical possibilities, to match the two perceived types of genitals: male and female. However, there are very few things in nature which are categorical and almost all things lie

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on a spectrum of some kind. (Even genitals and internal sex organs vary to a greater degree than is allowed for in the traditional cultural view, see, for example, Praveen, Desai, Khurana, et al, 2008).

The linking of gender identity to a categorical model of biological sex has allowed the dialogue about gender identity to become one of 'nature vs nurture' to such a degree that variation from the orthodoxy of categorical genitals and their associated gender identity has been pathologized and seen by some as unnatural and somehow an indication of dysfunction or disease (Meyer-Bahlburg, 2019).

It is extremely difficult to estimate the prevalence of diversity of gender identity because gender is defined differently in each culture. Estimates of prevalence have struggled with incomplete data because of a lack of consistent data collection at a national level, and some understandable reticence to share sensitive information (for a summary see ONS, 2009). With this caveat in mind, an estimate of the prevalence of a gender identity that does not match with biological sex has been given as 1:11900–1:4500 in birth assigned males and 1:30400–1:20000 in birth assigned females (WPATH, 2012).

Gender identity is highly subjective and can be defined as an individual's sense of the degree to which they experience gender to include masculinity, femininity, both or neither. It can be stable in a single gender identity or fluid across two or more. This is a definition which recognises the diversity of gender identity as a natural part of human experience, which has universal application, (see for example Halberstam, 2018, Bouman, de Vries, and T'Sjoen 2016, Beek, Cohen-Kettenis and Kreukels, 2016).

Identity is a multifaceted concept, with some parts originating internally, and being core parts of selfhood, (such as gender identity and sexuality), and other parts originating externally, in relation to other people, culture and to society, (such as being a parent, astronaut, or gin drinker).

Identity develops over childhood and adolescence and is usually crystallised during the exploration and disruption of self in puberty and early adulthood (Erikson, 1968).

Like sexuality, awareness of gender identity can be clear from early on. Children can make sense of it for themselves, or it can take many years to crystallise. For some youth, who are gender non-conforming, puberty is a key time when their gender identity, and the direction in

which their biological body is moving into adulthood, are at odds. Often this is when gender dysphoria really comes into focus and exploration can begin in earnest (Ashley, 2019).

Gender Dysphoria

Gender dysphoria is the distress caused to a person when there is a conflict between their gender identity and the way that they, or others, perceive, or relate to, them directly or indirectly (Galupo, Pulice-Farrow and Lindley, (2019), Lobato, Soll, Brandelli, Costa, Saadeh, Gagliotti, FrÈsan, Reed and Robles, (2019)).

Many people find that parts of their body are a source of their gender dysphoria, because they experience them as wrong, not theirs, or that something is missing, or is there when it shouldn't be. This can be the case of any gendering aspect of the body being present or absent (body or facial hair, breasts, hips, body fat distribution, skeletal frame (particularly height and size of hands, feet and shoulders), genitals, voice and facial bone structure) and is usually not as obvious earlier in childhood because children's bodies are more androgynous before pubertal hormones begin to take effect.

Gender dysphoria has a range of impacts on daily life. For example, people may avoid sport or entering sexual encounters because they may find attending to their own body a source of disgust or distress, because they experience it as the 'wrong' gender. Or they feel another's attention to their gendered body is unbearable. Equally they may face a multitude of social restrictions based on real or feared resistance from others (Dowers, White, Kinsley and Swenson, (2019)).

Gender dysphoria can be extremely debilitating for some people and can lead to mental health problems such as anxiety, depression, substance misuse, sexual risk behaviours, self-neglect and self-harm (Morris and Galupo, (2019), Schulman and Erikson-Schroth, (2019), Johns, Lowry, Andrzejewski, Barrios, Demissie, McManus, Raspberry, Robin and Underwood (2019), Testa, Michaels, Bliss et al, (2017), Dhejne, Van Vlerken, Heylens, and Arcelus, 2016, Millet, Longworth, Arcelus, 2016, McNeil, Bailey et al, (2012)). For some people this mental illness may be resolved by social or medical transition to live in ways which are gender affirming (Bouman, Claes, Marshall, Pinner, Longworth et al, 2016). There is increasingly strong evidence that being affirmed and supported, by those people closest to the individual, protects against mental illness in

the presence of gender dysphoria (Pariseau, Chevalier, Long, Clapham, Edwards-Leeper and Tishelman (2019), Puckett, Matsuno, Dyar, Mustanski and Newcomb (2019), Medico and Zufferey, (2018)).

Transition can have unwanted consequences, but regret, which is usually related to loss of family, friends, employment and experiences of transphobia, is reported by only around 2% of people (McNeil, Bailey et al, 2012).

Responses to visible gender variance are diverse and can often come from a position of not understanding the experience of the other, low personal self-esteem, or struggling to accept the difference that the presence of the other brings to mind (Callahan, and Zukowski, (2019), Harrison, and Michelson, (2019), Molofsky, (2019), Anderson, (2018)). When this conflict arises, in society, between individuals, or in the individual, it can create, in gender non-conforming people, a desire to be acceptable to the other, either by appearing to be more cis-heteronormative (i.e. conforming to essentialist views of biological sex matching gender identity and the typically associated gender roles and / or the assumption that most people are, or should be, heterosexual) or to suppress their own needs to appear to be less threatening to society or the individual (Arayasirikul, and Wilson, (2019), Butler, Horenstein, Gitlin, Testa, Kaplan, Swee and Heimberg, (2019), Pham, Inwards-Breland, Crouch, Albertson, Ahrens and Kerman, (2019).

Whilst there is no place, in any therapy, to seek to change a person's gender identity (UKCP, 2014), Cognitive Analytic Therapy (CAT) is well placed amongst other therapies to provide a framework in which people affected by gender dysphoria can explore the impact that it has on their lives and seek to reduce it through therapy alongside medical or social transition. CAT offers a dialogue that is open to individual perspective, rather than a diagnostic framework. Uniquely, it offers a space in which a client can conceptualise their gender dysphoria as a dialogue which happens 'in the space between' parts of themselves, and between themselves and others. The author proposes that gender dysphoria is well suited to being conceptualised in a CAT framework.

CAT Theory of Development of the Self

CAT is a therapy which is grounded in the interpersonal and internal processes of personal development. As infants we experience the world not just through our own senses, but those sensory inputs are mediated

through interactions with our caregivers. The interactions, when repeated with more, or less, consistency over time, become internalised patterns by which we organise our sense of the world, our self and others. These patterns then become the ways in which we mediate our own interactions with the world, self and others throughout life (Ryle, 1975).

The influence of Vygotsky on CAT has been considerable, (see for instance, Leiman, 1994a and b). Integral to Ryle's description of personal development is the inter-related nature of that development. The child does not develop in a vacuum, but rather, in reference to another, and both the child and their 'others' are embedded in social and cultural contexts. Together the child and the caregiver co-construct a meaning out of that context and, with this mediated meaning making, the child comes to know about themselves, the world and the other. It is this repeating relational enactment, which is the means by which the child makes sense of the state of the world and knows about themselves. However, it is largely the *process* by which the repeating relational enactment occurs with the caregiver which forms the basis of their internalised set of self-management and interpersonal resources, or in CAT terms, reciprocal roles (Ryle and Kerr, 2002, Vygotsky, 1978).

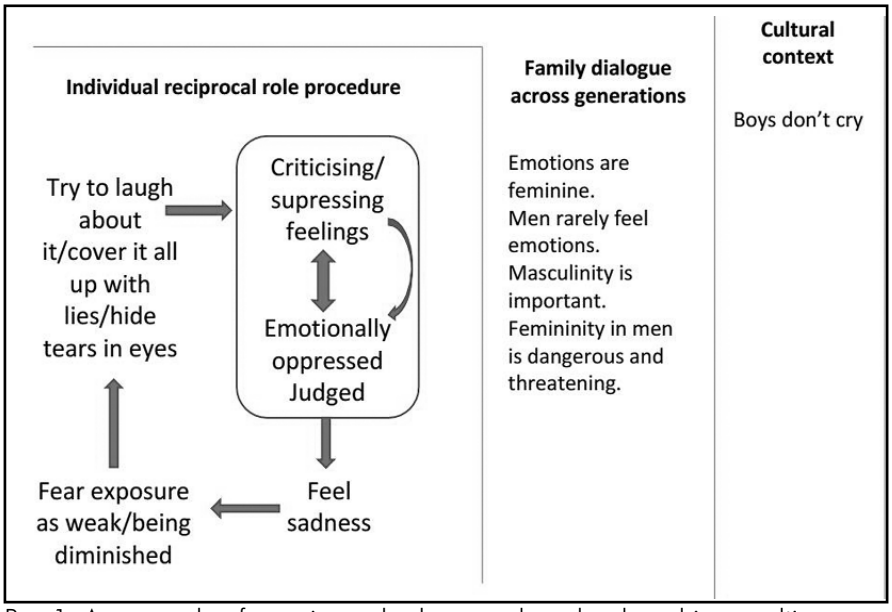
Ryle drew on the work of Bakhtin to develop the notion of the dialogic in CAT. For Bakhtin, the nature of human interactions lies in dialogue. He saw humans as being in constant dialogue with those around them, concretely as well as those who exist in the abstract; our culture, our ancestors, a god or imagined other. Bakhtin described all experience, thought and action as expression, of ourselves in relation to a real, or imagined, other and in dialogue with them (Bakhtin, 1986, 1992).

As a child develops, they are in direct dialogue with their caregiver in verbal, interpersonal and behavioural terms. The caregiver embodies, not only their part of the dialogue, but also that of the dominant current and ancestral cultural voices who give the caregiver legitimacy and transmit that cultural dialogue to the child. All interactions then contain that cultural dialogue and refer back into history as well as forward into an imagined future. Bakhtin proposes, and Ryle expands, that we never act in isolation but always in reference to another and in expectation that the other will respond (Ryle and Kerr, 2002).

As we develop in this context, we learn the whole dialogue, that of culture and caregiver alongside our own voice, and internalise all three. This underpins the development of the two poles of reciprocal roles, acted out between the caregiver and child and then internalised to

become self-to-self relating, offering us two positions from which to respond within that role in seeking or eliciting relationship with others (Ryle, 1991).

Over time we develop a repertoire of reciprocal roles and learn to move between them by way of reciprocal role procedures (RRPs). Ryle described problematic movements between these reciprocal roles as dilemmas, traps and snags in which unconscious processes limit options for positive change and reinforce negative assumptions or beliefs (Ryle, 1979). Leiman, (1997) developed this further to include the concept that these patterns themselves represent a chain of dialogue in progress.



Box 1. An example of a reciprocal role procedure developed in a multi-generation family and cultural contexts

As in the example of box 1 (reading right to left) the cultural context contains ideas, distilled through historical and current dialogues, that men and boys do not display emotions. Family dialogues process and perform these ideas, through history to the present day, in parenting and other enactments, and in embodied responses. These can be seen in what men and boys do when they feel sad or emotional and how family members respond to those emotions (or lack of them). The developing child has repeated relational enactments with their caregiver and the family (in a cultural context which is borne out of dialogues about men and emotions) and internalises them into a reciprocal role

procedure. This then becomes their primary way of managing emotional states as they arise.

Moving from a minority stress model to a CAT approach

Previous attempts to understand the experience of gender dysphoria have centred on a minority stress model, in which an individual faces exposure to distal stressors such as discrimination, lack of representation, rejection and violence by virtue of their gender identity. These may then prompt proximal stressors such as concealing aspects of one's identity, anxiety, and rejection of their identity. Over time these combined stressors become a pattern of chronic stress that makes individuals susceptible to poor health including poor mental health (Meyer, 2003, Hendricks and Testa, 2012).

This model recognises the importance of the attributions made to trauma experienced by people in their cultural and societal contexts, as a result of their gender identity, in forming internalised transphobia and in prompting the proximal stressors such as repressing, or hiding, their gender identity. However, the author suggests that it lacks complexity and detail. It is limited in being able to describe the development of gender dysphoria, or how, and when, it is maintained, or resolved. Whilst the minority stress model does recommend that people with gender dysphoria compare themselves to those within the group with which they identify (rather than those who do not share the same gender identity), it does not offer more specific assistance in resolving gender dysphoria than to make social connections and 'receive skills and support'. For many people this is not a sufficient level of detail to afford understanding or make changes in their life.

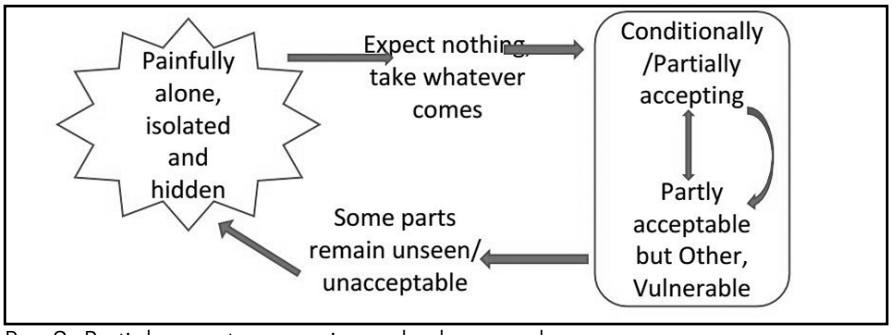
A Psychological Model of Gender Dysphoria

The author proposes a new, CAT informed, psychological understanding of gender dysphoria as an experience that arises out of the culture in which the person is embedded. It uses Bakhtin's description of inherited cultural dialogue which offers a perspective that encompasses the views of the individual and the history of all the views of gender which have come before them, as well as those of the future. This CAT model describes the development and maintenance of gender dysphoria by proposing an overarching model with space for each individual to respond with their unique set of strengths and resiliencies.

The model is described in three parts and considered from the perspective of the individual relating to themselves (self to self), to those who populate their world now, and in the past, (self to other) and from that of the gender diverse community to the wider culture in which it exists (community to culture). Each section is illustrated with the words of Amy, Ben, Claire and David, who generously offered their personal experiences of gender dysphoria and the model. Their names have been changed to protect their anonymity.

The following are three layers of patterns of interaction using the concepts of CAT reciprocal role procedures and dialogical sequence to explore the multiple interactions of self-management, interpersonal and culture coping procedures. They are from the point of view of the person dealing with gender dysphoria. Detailed below are three reciprocal role procedures, each broken down into perspectives which represent the different dialogues and the ways in which they build up a context in which Gender dysphoria is created and maintained.

Part 1. Partial acceptance reciprocal role procedure (RRP)



Box 2. Partial acceptance reciprocal role procedure

The following are three layers.

Self to other: Whether or not they grow up in a family which is wholly accepting of their gender identity, the response – to a person expressing their gender identity when it does not fit the cultural norms for their birth assigned sex and gender – is most often rejection. It is the indication that their gender expression is not acceptable to the other. Over childhood and adolescence and into adulthood, this is reinforced, whilst other aspects of the person's identity are given a different reception. This leads to a

sense that the person is only partly, or conditionally acceptable (subject to them not expressing gender identity outside of the cultural norm).

Self to self: As individuals we learn to reject those parts of ourselves that others view as less acceptable and, be less accepting of them ourselves. We develop an 'if only I' identity, that wishes away aspects of a gender identity which we see as unwanted or difficult. We learn to hide our 'Otherness' from ourselves and others, for fear of judgement, aggression and comparison. This results in avoiding relationships and not thriving. When we do make connections, we fear being discovered as 'other' and this leaves us vulnerable to making relationships on the basis that 'something is better than nothing'. This gives permission to those to whom we relate, to only accept those parts of us that feel valid to them. This makes us vulnerable to suffering abuses at the hands of others.

Community to culture: We live in a society that is in the early stages of equality and acceptance of diversity in gender identities, but still fears, erroneously, that gender diversity is, at its heart, a psychopathology and a matter more superficially of a sexual preference. Western society tolerates expressions of gender diversity as entertainment but struggles to allow conversations about mundane personal experience, except though a media lens of 'otherness'. Fearing a backlash against individuals, or against the gender diverse community as-a-whole, much of those in the community stay hidden and quiet about the reality of living in this society. It is a reality of accepting representation and the beginning of national 'conversations' whilst continuing to face systematic and institutional discrimination.

Lived experience of the partial acceptance reciprocal role procedure

Amy, 27 years old
At 16-18 years old I tried to suppress it. I became depressed and tried to be normal. I didn't want to be, seen as, a freak. I was worried about losing friends and family, of being bullied and disowned. I felt down, and there was a dissociation between myself and the person in the mirror. I was in lots of pain, but I put on a smiling face to everyone else. I felt trapped in who I was. I met my ex-girlfriend aged 18. I suppressed things more and tried

to live up to the boyfriend ideal. I tried to just really focus on the needs of others. I hated myself but if she could love me, then it was worthwhile, if someone saw some good in me. I saw no good in myself. I broke up with my ex because she was abusive but someone who loved me, and I couldn't love myself. I try and hide my being trans so that people don't find it unacceptable. I still lean towards trying to isolate myself.

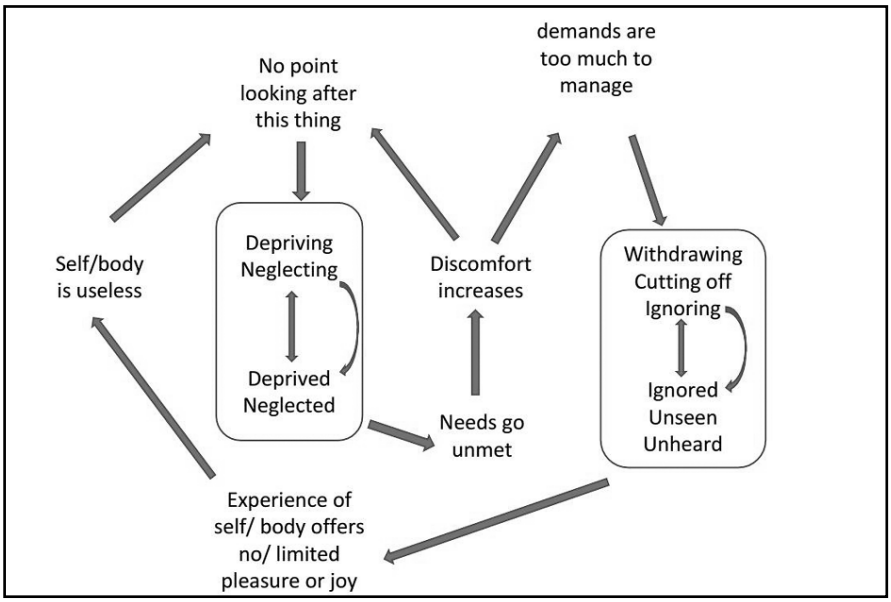
Ben, 36 years old
It's how my family was when I came out. It was a case of I was ok when I was a lesbian but not when I was a male. I was still hiding parts of who I was. I used to have to hide all of me and that led to self-harm and suicide(attempts).

In my late teens and early twenties, I was depressed and suicidal but deep inside I wanted to be a man. I brought it up with my family when I was younger, but I was disregarded. They told me to think about the effect on the family and brushed it under the carpet. It was always there in the back of my mind though, and I still don't speak to my family now. I have a little brother who is 15 years younger than me and he was small in school. They told me to think of the effect on my brother at school, he could be bullied because of me. It felt like they were ashamed and didn't think about the impact that all of this was having on me. It was all about how it was for them.

Claire, 47 years old
Growing up in the 70s and having a female aspect that I kept hidden, like it was 'just fun' and didn't mean anything. My father accepts me now, but it's far from comfortable. He and his wife still misgender me regularly. It's difficult for us to have a relationship because I refuse to hide myself anymore. I'm the only openly trans person in [my workplace]. This [partial acceptance RRP] hit home. I still worry about parts of myself that remain unseen. It took a long time to work out that I'm not really a cross dresser.

David, 45 years old
The meeting didn't go down well with the family. They told me that I had always been different and pleaded with me not to have the surgery. We lost contact for almost 18 months. For 30 years, all I had thought about was them and they couldn't see what life was like for me. For a while I lived a double life [in a large town]. I got my first flat and changed my name and moved in as David. I still had to go to the bank with my birth name and my girlfriend and I had to hide from people we saw from back home on the streets. After 8 years, I wasn't prepared to live in secret anymore, but my girlfriend got cold feet and couldn't go forward with the plan to tell people and be together. We split up and I moved back in with my parents.

Part 2. Withdrawing and depriving reciprocal role procedure



Box 3. Withdrawing and depriving reciprocal role procedure

Self to self: Holding parts of our self away from sight and awareness, means that we are limited in how we go through life. Our body feels wrong and useless and can be unavailable for use, or enjoyment. We see others having a different experience and come to feel that our body, and even our whole self, is useless to us. We neglect and deprive our body, and our self, struggling to seek medical care, or see the point in working hard to achieve. Our physical and social needs go unmet and we are further dismayed with ourselves. At times the demands on us become overwhelming and we withdraw and cut off from our bodies, wholly or in part, leaving parts of our physical and emotional selves ignored and avoided.

Self to other: Fearing rejection and an upsurge of distress, people hide their bodies from sight. Diverse bodies/identities go unseen and when they do come into view they are often labelled as 'not real'. When people approach medical or other services for help, they are often seen as somehow dysfunctional and denied the help because attention is erroneously diverted to their gender identity. They experience chronic neglect as a result. If they continue to raise issues of unmet need, they are seen as

demanding, and support is withdrawn. People learn that their needs and their bodies are unacceptable and not valued.

Community to culture: Our society places a high value on specific versions of masculinity and femininity and less value on diversity from those norms. Communities who are not perceived as complying with these norms are marginalised and devalued and go unrepresented. Expressing gender diversity openly in this society becomes increasingly difficult and unsafe until it is too unmanageable, and communities move underground again for their own protection and relief.

Lived experience of the withdrawing and neglecting reciprocal role procedure

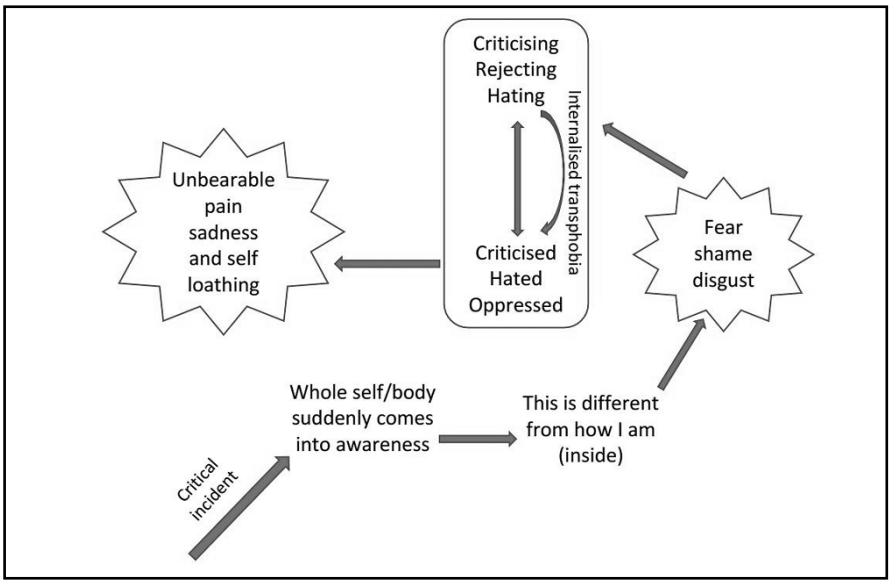
Amy
I had periods of not eating or not washing but when I got into a relationship I looked after myself. I found work and got into a routine. I forgot about it and survived that way. In the past I struggled daily and only working helped. I accepted my dysphoria, but I couldn't have worn a suit. I kept my hair long and wore black and didn't think about what I was wearing or doing.

Ben
I blocked puberty out. I knew it was happening, but I blocked it out. Periods were the worst part. I wasn't coping, I was self-harming and suicidal. I went to the GP and they were good. They didn't know what to do but they wanted to help and said they would find out and get back to me.

I cut off from myself and from society and it happens over and again, so you don't expect different outcomes. You end up just ignoring it and not doing anything about it. It's hard sometimes with professionals who don't understand and refuse care, or have to be educated. In my old GP surgery, I saw a locum who didn't understand what gender dysphoria was and just refused to give me treatment. I kept on seeing locums there and eventually I just left.

Claire
I often thought that if my marriage broke down, I would live full time as a woman, but I didn't think about a medical transition, [gender dysphoria] was just [at] a very low level [of distress] for a long time. Once I told my wife the floodgates opened. I had permission to feel it. The unhappiness and dissatisfaction and disconnect with my body started coming in.

Part 3. Rejecting and Criticising reciprocal role procedure



Box 4. Rejecting and criticising reciprocal role procedure

Self to self: An incident occurs in which we suddenly see our whole self (physically in the mirror/shower or emotionally). Parts of us, that we have been ignoring, are seen and we are abruptly met with the incongruence between our gender identity and our whole self – which contains congruent and incongruent parts. We are distressed and respond negatively, criticising and rejecting our whole self for having parts which are difficult to bear, and feeling that our experience of ourselves makes us somehow lesser (internalised transphobia). In terrible pain we push away parts of us that are unbearable and cut off from them again (see box 5 for clarification).

Self to other: As we move through the world, others label our sex and gender unreflectively and act on these labels. When the labelling is incongruent with our identity (misgendering) we suddenly see ourselves through the other person's lens, bringing parts of our experience that were held at arm's length into our awareness. Both we and others may suddenly become aware of our perceived 'otherness' and react negatively. The otherness is pushed away forcefully with rejection, criticism and hatred leaving a feeling of being criticised, hated and oppressed.

Community to Culture: When gender diversity is only represented as sensationalised, oppressed or in crisis, the ordinariness of real people's lives is lost from the narrative. Stereotypes are formed because ordinary people feel too frightened to disclose their gender identity and so go unseen.

When the community profile is raised within the society it is in the context of unrepresentative incidents or issues and the society does not easily connect with the humanity of individuals. Fearing that the community is somehow different, society pathologizes, rejects or sensationalises them, oppressing the community and reinforcing the negative stereotypes of gender diversity.

The whole model is shown in box 5 with the interconnecting reciprocal role procedures.

Lived experience of the rejecting and criticising reciprocal role procedure

Amy

The anxiety is still there that people will think that I am a trans freak. I don't hate those people; they're not educated or accepting about others. I only hate myself more when I hate them. I blame myself for being visible as trans and not being cis.

When I look in the mirror it's triggering, it's my face. I don't like getting my hair cut, I see myself as I was, when they wash my hair and pull it back from my face, it's my hair line. I hate it and feel angry. My biggest fear is being judged as how I was, not how I am.

Ben

In the past misgendering was a massive problem for me. It's the looks you get when people are trying to work out what gender you are. I was anxious using the male toilet in case someone said something. My voice gave me away, so I avoided speaking.

I see my self-harm as a coping mechanism. I could wake up and be having a great day and all it takes is to walk past a mirror and see parts that match and don't match and that sets you off. I don't get changed in front of my partner. I know I'm male, but I've still got these female parts and it can ruin your day.

Claire

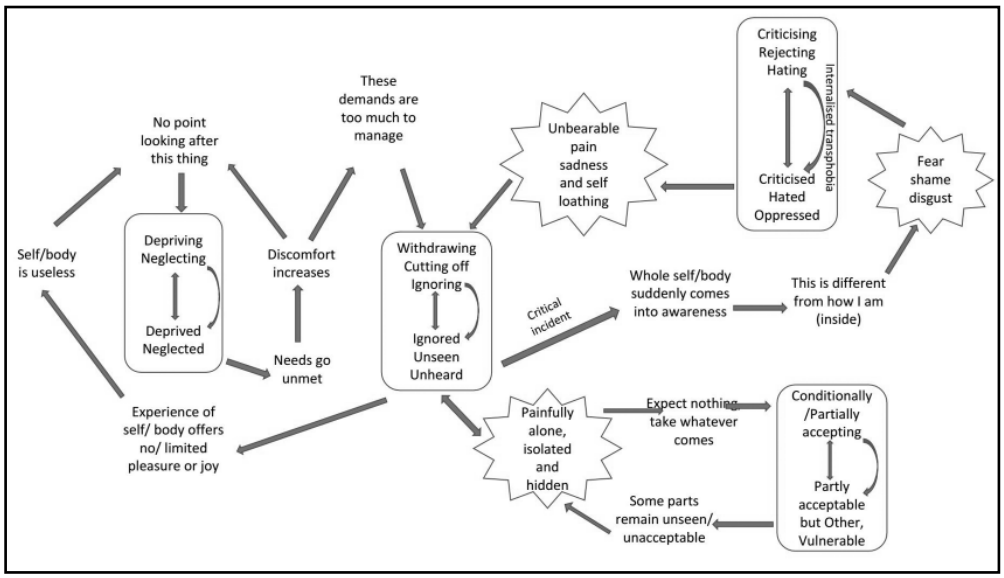
There's a societal aspect to it as well. The knowledge that people would see me as a man in a dress. It's less so now but the worry and anxiety that it causes with how other people see you is part of

it. Thinking 'is today the day that someone will say or do something'. It adds to it all; factors that amplify your feelings and imagination. It's a feeling of failure. I'm doing this wrong and there's nothing I can do to fix it. Discomfort and distress are at the core but there's more, it's a negative loop and everything makes you feel more and more 'I'm wrong'.

David
I told my GP in [isolated rural area] and he was just a rural GP and he looked at me like I was an alien. It was 2004! I needed time off work so the GP wrote a sick note that said that I was 'mentally disordered' because that was what he thought I was after hearing about my gender identity. I wasn't going to hand that in at work!

I didn't use to talk about it. You can't ever trust anyone. My partner told people at the beginning and some weren't supportive, they called me a freak. I hated the label of being trans and was angry when I visited the GIC.

The bit about internalised transphobia, I am still critical about myself that I've not achieved [something more]. I'm critical of myself a lot, a huge amount, internally and privately. I'm angry. I'm waiting to start my life and I feel like it's so late and I'm having to play catch up. I can't go forward because I'm still waiting for things to be sorted out with my dysphoria.



Box 5. The psychological model of gender dysphoria

Application of the psychological model of gender dysphoria

This is the first comprehensive model of gender dysphoria (GD) and, as such, seeks to create a description of the development and maintenance of GD in Western culture. In proposing this model the author seeks to offer a framework in which people who experience GD may be able to understand their experiences more fully and seek to remedy those parts of their distress which have been brought about by parts of our culture which are pathologising of gender diversity. The intention is not that psychotherapy based on this model should replace necessary and life-saving medical transition for those who need that intervention. However, it may be that finding greater self-acceptance and being able to see one's bodily characteristics and gender identity as being of equal value, regardless of their adherence to the norms of cis-heteronormativity, may mean that some people feel that they can live with less GD and as a result need fewer medical interventions to be content and affirmed.

In addition, it provokes the question of what cultural, societal and systemic changes we should seek as a health service, as practitioners and as members of society to shift our attitudes and practices to understand and accept that all gender identities are normal and natural parts of human experience. This would in turn, reduce the prevalence of the idea that some expressions of gender identity, or differences of bodily characteristics and gender identity were somehow less acceptable or valuable.

In practice the model can be used to educate health professionals to allow a greater understanding and increase confidence in working with people presenting with GD. It offers a means by which to develop a non-judgemental dialogue with clients about their experiences that does not focus solely on their experience of their body in isolation, which is a narrowing of dialogue which can understandably occur if a professional has no lived experience of GD themselves.

As a CAT model it allows for the formation of changed patterns or exits; new procedures and reciprocal roles that can bring about changes to the ways that we relate to ourselves, to others and to the wider society. It is evident from speaking with people who experience GD that these exits have been found by some and that many could benefit from being supported in finding similar patterns. Future work should identify these and seek to operationalise them, so that the widest possible group of people can benefit from the relief that this could bring. □

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