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## Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria

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### **Abstract**

The increasing incidence of request for medical services to support gender transition for children, adolescents and adults has consequences for society, governmental institutions, schools, families, health care professionals, and, of course, patients. The sociological momentum to recognize and accommodate to trans phenomena has posed ethical dilemmas for endocrinologists, mental health professionals and sexual specialists as they experience within themselves the clash between Respect for Patient Autonomy, Beneficence, Nonmalficience, and Informed Consent. The larger ethical clashes are cultural and therefore political. There is a distinct difference between pronouncements that represent human rights ideals and the reality of clinical observations. Some interpret this clash as a moral issue. This article delves into these tensions and reminds apologists from both passionate camps that clinical science has a rich tradition of resolving controversy through careful follow-up, which is not yet well developed in this arena.

## **Introduction to Gender Therapy Politics**

Two generations ago when adolescent or adult patients stated a desire to transition to a new gender, some clinicians perceived them to have a rare, relatively new form of psychopathology. Many wondered whether recurrent intense longings for transition were attempts to solve some underlying, undefined, childhood psychological problematic circumstance. This idea was consistent with a psychodynamic developmental understanding of mental life---every behavior has antecedents. While patients believed that they could live happier, more fulfilling lives in the other gender, clinicians often worried that their patients' judgments were naïve and unrealistic, and that their lives would not be objectively enhanced (Meyer, 1982). Today these clinical ideas are to many anachronistic, irrelevant, and heretical. At the time, however, no one really knew what to make of these individuals. Interested mental health professionals, endocrinologists, and surgeons formed a society to share their clinical experiences and to evolve standards for how to respond to patients' requests of the medical profession. Over decades the society evolved into the World Professional Association for Transgender Health (WPATH), which now has lay members and provides guidelines for clinicians and advocacy for trans persons.

In 2011 WPATH published its 7<sup>th</sup> edition of its Standards of Care, a 121-page text that asserted that transgendered people have no inherent psychopathology(Coleman et al, 2011). Every gender configuration is viewed as an indicator of the diversity of the human family. This declaration was the culmination of a cultural shift manifested by increasing numbers of individuals repudiating their assigned gender. Estimates suggested at least a ten-fold increased

global incidence of gender nonconformity(Deutsch, 2016; Dhenje, Oberg, Arver & Langden, 2014). Such identities among American youth have been assessed to range between 0.17% and 1.3%(Connelly, Zervos, Barone & Joseph, 2016). These estimates cannot be viewed as accurate or stable because junior and senior high school students each year recognize more gender nonconforming peers. Requests for transgender services are increasing and new clinics for the gender nonconforming are appearing in many cities and in many established institutions. Many privately trans individuals are afraid to reveal their identities on questionnaires.

Major medical institutions have issued policy statements supportive of gender diversity and advocating equal protection under the law. One emblematic policy states: “being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capability.” These statements emphasize that discrimination profoundly limits the lives of the transgendered(Drescher & Haller, 2012). The task forces that create policy statements and diagnoses are the result of discussions that weigh the evidence of opposing viewpoints. Their final decisions have great social, educational, and legal weight. The above pronouncement speaks to the deepest of American political values: the march to create a more perfect union that is inclusive of diversity and provides equal social opportunities and equal application of the law. These statements are heavily based on work in the humanities and on humanistic values intended to improve the lives of almost all sexually nonconventional groups (Van Anders, 2016). They promise the possibility of a psychologically healthy life in any gender configuration. This paradigm shift represents an impressive political accomplishment in a relatively short period of time. American society, supported by the Obama administration, has changed its attitudes at a vital policy level. The world is now recognized to consist of males,

females, transgender individuals, transsexual individuals, and a broad range of other gender nonconforming individuals. Many universities now reflect this as they have become committed to creating and maintaining a safe environment for all sexual minority students, staff, and faculty.

## **The Bathroom Controversy**

These dramatic sociological changes have provoked political opposition. In 2016, the United States became embroiled in a culture war over whether public bathroom use should be organized by biological sex or by individuals' current preferred gender identity. Supporters of the genital anatomy argument expressed concern that changing the pattern of public bathroom access represented a further moral deterioration of society that followed on the heels of the 2015 Supreme Court decision allowing gays and lesbians to marry. The bathroom controversy became inextricably mixed with attitudes about homosexuality. Thus, many American political conservatives and liberals lined up on opposite sides of the question, leaving legislators or jurists to decide what defines a man and a woman for this purpose(Liptak, 2017).

The movement to improve social and legal opportunities for homosexual persons that began after the Stonewall rebellion on June 28, 1969 has become a struggle for all sexual minorities. Gender issues in the body politic, which began with women's suffrage, continue today with the bathroom controversy. Gender politics, whatever the form, impact everyone, including health professionals, although many of us prefer to think of our work as scientifically based and beyond politics.

## **Trans Phenomena and the Medical Profession**

Trans individuals fall into five groups where medicine is concerned:

1. Patients who endorse the gender binary by wanting to transition to living as a member of the opposite sex with the assistance of various medical specialists;
2. Those who want to live outside the culture's stereotypic binary roles without having to biologically transform themselves;
3. Transgendered individuals who seek medical care for health concerns other than gender;
4. Transgendered individuals with sexually transmitted diseases. This group because of their higher prevalence of HIV, depression, anxiety, substance abuse, suicidality, and eating disorders are of interest to public health institutions as well as individual service providers
5. Apparently cis-gendered persons who seek psychiatric help for a mental disorder and reveal their struggles with gender.

The vast majority of the medical literature has focused on the first group, usually without emphasizing that the second group exists. Transgendered individuals are described as hesitant to interact with the medical profession fearing insensitive or hostile comments from assistants, nurses, or physicians(Lombardi, 2001). The World Health Organization has been active in the global aspects of HIV in the group of underserved marginalized trans individuals. Many mental health professionals are generally at a loss when their patients reveal struggles with gender. They may consider referral to a specialist or focus only on the presenting problem (i.e., substance

abuse, depression, relational difficulties, etc.). Ironically, gender problems are not perceived to lie within the competencies of child, adolescent, or adult psychologists and psychiatrists.

WPATH has credentialed its professional members as specialists for these problems, assuming that the average mental health professional could not possibly deal wisely with this special variety of human being.

The standard for professional work with the first group is identity affirmation, support, and advocacy. This means that professionals should commit themselves to facilitating the identity choices made by patients. This guidance is based on the assumption that transition is life saving, both in terms of quality and suicide prevention, and provides a pathway to emotional growth and happiness. Many surgeons, hormone prescribers, and mental health gender specialists promulgate these assumptions. Their convictions are reinforced by the fact that they usually work with individuals at the beginning phases of their transitions. These are hope-dominated times followed by the giddy delight of having transitioned socially, hormonally or surgically. It is a forward-looking process supported by cross-sectional studies showing improvements in patients' lives (Dhejne, Van Vlerken, Heylens & Arcelus). The duration of these improvements, however, remains an unanswered question. In the United States it is extremely difficult to longitudinally follow cohorts of patients to determine what becomes of these initially pleased and grateful people. Among the unanswered questions are what percentage of them: remains satisfied with their transition for the duration of their lives; return to their natal gender; have lasting employment; sustain stabilizing intimate relationships?

## **The Ethical Dilemmas of Working with the Transgendered**

Pediatricians, primary care physicians, and other medical first responders may consider their trans patient to be an example of a well-known homogeneous entity in nature. Various media, as well as celebrities, have given positive attention to trans individuals as a discrete entity. Mental health specialists, however, are witness to four other views: the heterogeneity of transgender experience and manifestations; the alarm of parents, spouses, or children of the transgendered; chronic ambivalence of some trans patients; psychological costs of transition (Cohen-Kettenis, 2016). First medical responders, knowing that the future may hold the removal of these patients' healthy tissues, may feel uneasy ethically. They look to mental health professionals for resolution of ethical concerns. Endocrinologists and surgeons aspire to do their important work far removed from any political and ethical controversies. Their ethical unease appears to be alleviated by a detailed letter of recommendation from a mental health professional endorsing hormones or breast and/or genital surgery. Ideally, the mental health professional grapples with six tasks. These vary with the patients' age and socioeconomic circumstances.

1. Characterize the three dimensions of the patients' current sexual identity (gender identity, orientation, and paraphilic interests) to ascertain if criteria for Gender Dysphoria (DSM-5) are met;
2. Diagnose any psychiatric comorbidities;
3. Assess the family situation and remain respectful to their feelings, attitudes, and behaviors toward the patient's desires;

4. Specify the benefits the patient believes will accrue from transition.
5. Ascertain what the patient comprehends about the short term and long term negative consequences of gender change (Table 1);
6. Decide with the patient on the next step:
  - a. To continue to explore this and other dimensions of the individual's life
  - b. To attempt to ameliorate the psychiatric and medical co-morbidities
  - c. To provide emotional and endocrine support for transition now, assuming the psychiatric co-morbidities will dissipate over time
  - d. Involve family members in a treatment process
  - e. Recommend a wait and see attitude to allow for further development with a follow-up appointment in six to twelve months.

These are not simple tasks. We have to balance four ethical principles: Respect For Patient Autonomy, Beneficence, Above All, Do No Harm (nonmalficience), and Informed Consent(Levine, 2009). Our hesitation to support immediate transition in any particular case is not a reflection of our insufficient knowledge of the WPATH Standards of Care(Levine & Solomon, 2009). Having worked within a team of mental health professionals on these matters since 1974, I can attest to the fact that our assistance to gender patients is often accompanied by professional distress. We see that the patient meets the DSM-5 diagnostic or WPATH criteria for hormones or surgery, but the individual may seem too young, impaired, gravely disadvantaged,

desperate, or optimistic and certain for us to feel confident about any decision. Based on our clinical work with patients and their families, informed by published data about psychiatric comorbidities (Connelly et al, 2016; Dhejne, Van Vlerken, Heylens & Arcelus), I cannot view policy statements such as, “transgender implies no impairment in judgment, stability, reliability, or general social or vocational capability” to be based on clinical experience (Drescher & Haller, 2012).

Therein lies a dilemma for the mental health professional. Do we deny our clinical perceptions by assuming that either we must be seeing a highly selective group of limited or impaired individuals or we must be unconsciously trans-phobic? Or, do we assume that when it comes to aspirational policy statements, it is more important to protect trans people’s civil rights than to accurately reflect their developmental struggles?<sup>1</sup>

Others have noted that ethical problems are encountered in clinical decisions about these patients. A survey of 17 international groups dealing with children and adolescents recognized that ethical dilemmas stemmed from seven unanswered questions (Vrouenraets et al, 2015).

## 1. What explains Gender Dysphoria?

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<sup>1</sup> This dilemma is dramatically magnified when trans inmates facing long or indefinite incarceration seek endocrine or surgical treatment under their Eighth Amendment rights to avoid cruel and unusual punishment. Their trans identities, often crystallized during confinement, seem to emerge from early life family chaos, adolescent substance abuse, school and vocational skill failures (Osborne & Lawrence, 2016). Their lives prior to sentencing were antisocial and their diagnoses typically include character disorders. Ignoring past and current functioning and diagnoses, their attorneys argue that they have a serious medical disorder for which they have a right to treatment. Psychiatric experts duel over whether the diagnosis per se is sufficient to provide desired treatment or whether the treatments might actually harm these desperate individuals.

2. Is Gender Dysphoria a normal variation, social construct, or mental illness?
3. What role does physiological puberty play in gender identity development?
4. What is the significance of the frequent psychiatric comorbidities?
5. What are possible physical or psychological effects of early medical interventions or refraining from early medical interventions?
6. How competent are children to make decisions about their future bodies?
7. How do differing social contexts affect patients' Gender Dysphoria?

Ten additional key unanswered questions related to gender variance in children have also been articulated. These overlap somewhat with the above, but also point out the lack of accurate prevalence data, lack of agreement about how to assess interventions, uncertainty of whether distress is inherent in gender variance, and what treatment interventions are associated with long-term positive outcomes(Drescher, Cohen-Kettenis, & Reed, 2016). It seems that even with the reassurance and recommendation from a mental health professional, ethical unease cannot be entirely erased because treatment guidelines have preceded the answers to vital relevant questions.

## **Models Used to Think about the Transgendered**

The quantity of medical literature on Gender Dysphoria in adolescents has increased greatly in the last few years, but much of it does not mention the political influences of WPATH's declarations and recommendations for the treatment of these adolescents. The momentum of

emerging literature is now in the direction of rapid endocrine treatment of adolescents. Papers often have titles or sections labeled with “advances in treatment” or “advances in understanding”(Connelly et al, 2016; de Vries, Klink & Cohen-Kettenis, 2016).The significance of the comorbidities is explained as the consequences of minority stress, which assumes that these would dissipate if only family, bullying peers, educators, employers, and medical personnel would cease their derogation of the person’s gender identity(Richards et al, 2016)

In contrast to this single explanation of the source of psychiatric co-morbidities, the Institute of Medicine suggested that four models should be employed when thinking about these patterns(Multiple authors, 2011).

1. A minority stress model;
2. A life course perspective that considers how events at each stage of life influence subsequent stages;
3. An intersectionality perspective that considers the multiple identities of the person and how they interact (see Table 2);
4. A social ecology perspective that acknowledges the influence of families, communities, and society.

For mental health clinicians the question is how much time should be devoted to exploring these four ways of clinical thinking about any patient’s Gender Dysphoria.

## **Is the Transgendered State a Mental Disorder?**

A number of organizations are trying to have these problems removed as a mental or behavioral illness or at least placed in a different section within the ICD(Reed et al, 2016). The decision might be easier if there were an agreed upon definition of a mental illness or if there existed a sharp demarcation between mental illness and health. The American Psychiatric Association has for decades struggled to articulate an overarching definition. The DSM-5's version follows(American Psychiatric Association, 2013).

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (political, religious, or sexual) and conflicts that are primarily between individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above. (p.20)

Gender Incongruence or Gender Dysphoria could be viewed as something closer to mental illness than mental health. From a life course perspective, there is a vast array of cis-gender adaptive possibilities that become increasingly apparent over time to males and females. Transgender narratives about their true identity are based on stereotypes. Equally important, if not more so, is that perceptions of the retreated-from gender are also based on stereotypes.

Stereotypes further falter with each increasing year as individual differences become more apparent in every person. To cis adults these stereotypes are often offensively oversimplified notions that signify aberration if not mental illness.

The repudiation of one's assigned gender is a decision that immediately creates a serious, repeatedly demonstrated, social disadvantage among children and worsens among adolescents(Steensma et al, 2013). Various patterns of psychopathology may derive from the decision to transition(Rotandi, 2013; Rotandi (b), 2013). The decision may create intrapsychic distress that is only apparent when the person is old enough to function outside the home. Can the choice of a difficult pathway be considered a subtle form of dysfunction?

When clinicians actually attempt to understand patients' motives for the repudiation of their natal gender, the developmental sophistication underlying their reasons can become apparent. What must a 12-year-old, for example, understand about masculinity and femininity that enables the conviction that "I can never be happy in my body?" A life course perspective asserts an interest in the determinants of the repudiation. This, however, is a subject that seems to be too politically contentious to undertake. WPATH asserts it is unethical not to accept a person's current gender identity; it should be accepted and supported rather than interrogated(Coleman et al, 2011).

A life course perspective also suggests that these gender variant identity decisions represent new cultural solutions to long familiar intrapsychic distress about sexual identity development. There are many unanswered questions about adolescent gender identity development based on cross-sectional studies(Steensma, Kreukels, de Vries & Cohen-Kettenis)

Clinicians who take careful developmental histories may develop hypotheses that are unique to each person. At best, these hypotheses could be tested in carefully designed studies. The trouble is that looking intensely at the motivations seems unsupportive. The one acceptable means of studying motives is research into the basis of gender variance (Guillamon, Junque & Gomez-Gil, 2016). A biological factor is politically welcome. If a replicated robust neural abnormality were to be consistently found, it would not necessarily mean that psychosocial developmental processes are irrelevant. Science would still have to explain the dramatic increase in incidence of late.

Few sexual phenomena are simply biologically based (Levine, 2007). The fact that the rates of psychopathology among gender variant adolescents are much higher in Canada than in the Netherlands suggests cultural influences (de Vries, Doreleijers, Steensma & Cohen-Kettenis, 2011). The changing sex ratios of those presenting for care in these two countries also point to cultural influences (Aitken et al, 2015). Within a given culture, differences in familial, peer, and virtual interpersonal relationships play a pivotal role. Trans web sites provide a virtual community of support for those seeking to clarify what they are feeling and thinking. These sites, along with other media exposure, allow many to discover a category that gives them clarity as to their identity. This understanding, however, does not clarify whether or not gender variance should be considered a manifestation of an underlying mental illness.

## **Politics of a Life Course Perspective**

The trouble with any hypothesis that suggests an inherent disadvantage of the trans identity is that it is not politically acceptable to a human and civil rights perspective. This

overarching paradigm is interested in making these identities safe and hopeful, a laudatory goal. When all trans identities are declared to be a matter of developmental diversity, however, it leaves no room to acknowledge that:

1. Repudiation of one's assigned sex may be a manifestation of an undefined difficulty.
2. The process of rejecting one's natal sex may inherently generate anxiety based on knowledge of reality.
3. Cross-gender behaviors create familial conflicts and dilemmas before they lead to social marginalization that further impairs social functioning. These processes create emotional illness.

The rights paradigm is an attempt to counteract the social marginalization, which has subtle manifestations at every stage in life. But despite its humanism and its ability to passionately energize trans communities, it may actually be misleading trans people and the larger culture into thinking that both the forces of self-marginalization and ostracism can be eliminated. One can be in favor of human rights and still consider that something might have been amiss to induce individuals to repudiate their assigned gender. In order to reject the "amiss" hypothesis one has to overlook the elevated incidence of gender variance among the autistic, sexually abused, those with chaotic early life attachments, and vehemently anti-gay relatives. Stigma may not be the sole explanation for the repeated observations of adaptive disadvantages, adverse outcomes, and shortened life spans of trans individuals.

The human rights perspective has a strong fundamental historical basis in bringing about changes in social attitudes and laws to enhance the lives of women and other previously discriminated against religious, racial, and sexual minority groups. Something is wrong, however, when this perspective is being used to change clinical perceptions in a way that is antithetical to fundamental psychological notions of personal responsibility, agency, and healthy coping. Of course, there is discrimination, internal to and external to the trans person, but there is a powerful argument to be made that some trans identities are based on an unrealistic view of life possibilities. These identities often create a set of social circumstances that many will not be able to master without severe limitations. Declaring trans identity as a healthy choice does not make it so.

Political concepts have the power to organize clinical perceptions and decisions. A recent report described prevalent distress and impaired scholastic and vocational functioning among a young Mexican trans sample. Their explanation: minority stress. Their conclusion: their data support removal of Gender Dysphoria from Mental Disorder section of the ICD-11 (Robles et al, 2016). Despite the consistency of their findings with previous work (Connelly, Zervos, Barone & Joseph, 2016; Lombardi, 2001; Bechard, Vanderlaan, Wood, Wasserman & Zucker, 2016; Guzmán-Parra et al, 2016), the authors fail to entertain the possibility that these identities might be a symptom of a mental or behavioral illness or might have led to the serious functional consequences that they observed.

## **From Scientific Work with Children to Hormones for Adolescents**

A proof of concept experiment was begun in Holland in 1998 to assess whether psychiatric morbidity of adolescence and adulthood could be avoided by treating transgendered children with puberty blocking agents, transition (age 12), hormones (age 16) and surgery (age 18) (de Vries et al, 2014). This work involved elaborate psychiatric screening, continued individual and family involvement, and multiple follow-ups using objective measures (Cohen-Kettenis & Klink, 2015). Beginning in 2000, of 196 consecutively seen children, 140 were deemed initially eligible, 111 eventually went into the protocol, and 55 were reported on, having completed at least one year post surgical follow-up. The carefully measured results were impressive for the absence of psychopathology and the well being of the cohort. The authors stress, mindful of the complexities involved, that the results are preliminary (Cohen-Kettenis, 2016). They have documented as well that the majority of cross gender-identified children desisted from their interest in living in another gender during adolescence and developed a homosexual orientation (Steensma, McGuire, Kreukels, Beekman & Cohen-Kettenis, 2013). It is not yet clear how to distinguish those who will desist from those whose trans identity will persist. Complicating the matter further, it is apparent that a small number of adolescent desisters return to wanting to transition in their twenties after trying homosexual identities (Steensma & Cohen-Kettenis, 2015). This leaves the profession in an ethical dilemma in deciding which pathway represents “Above All Do No Harm.”

In North America, the one site Dutch model has become a justification for easy access to hormones for adolescents already well into puberty. Easier access to hormones has become a

new community standard (Coleman et al, 2011). The Dutch group's care in case selection for family support and absence of psychopathology, as well as the researchers' close relationship to the families are not being replicated elsewhere. Although leaders in the field recognize the uncertainties within this arena of care (Olson-Kennedy et al, 2016), their cautions do not seem to influence what is happening elsewhere---e.g., in the past year, four sets of parents have brought me their adolescent children after another gender specialist started them on hormones after one visit.

## **Five Warning Signs From the Adult Literature**

1. Researchers from Sweden and Denmark have reported on almost all individuals who underwent sex reassignment surgery over thirty-year periods (Dhejne et al, 2011; Simonsen Giraldi, Kristensen & Hald, 2016). These studies relied on information collected on all citizens and did not involve directly asking the operated upon transsexuals about their happiness. The more recent Danish study, which had health data on 98 patients, confirmed what the earlier Swedish cohort of 324 patients had demonstrated: excess mortality (three-fold in Sweden; 10 dead less than age 60 in Denmark). In the Swedish group the suicide rate was 19.1 times greater than controls; many of these deaths occurred within 12 years of surgery. Two of the 10 Danish deaths were suicides. In both national groups, psychiatric hospitalization after surgery was far more common than in controls. Both studies concluded that there are considerable psychiatric problems after gender affirmation surgery.
2. Fifty-three percent of 796 diverse Swedish trans individuals are on disability (Zeluf et al, 2016). Gender nonbinary respondents had increased the odds ratio of disability, exceeding

the trans women by 2.18. They also rated their health as poorer than trans women. Illicit drug use in the previous six months increased the odds ratio of disability by 3.29. Negative health care experiences and limited social supports were associated with lower quality of life scores.

3. Swiss trans people, 15 years after sex reassignment surgery, reported significantly lower quality of life for the domains of general health, role limitation, physical limitation and personal limitation compared to female controls(Kuhn et al, 2009).
4. A surgical group reported on a series of seven MtF patients requesting surgery to transform their surgically constructed female genitalia back to their original male form(Djordjevic, Bizic, Duisin & Bouman, 2016).
5. The death rates of trans veterans in the United States are comparable to those with schizophrenia and bipolar diagnoses---twenty years earlier than expected. These crude death rates included significantly elevated suicide rates(Blosnich, Brown, Wojcio, Jones & Bossarte 2014).

Based on numerous positive post surgical studies, despite the high lost to follow-up rate of some of them, we can presume that some trans individuals remain content and lead fulfilling lives after genital confirming therapy(Lawrence, 2003). We have occasional contact with happy and healthy post-operative individuals in our clinic. The unanswered question is what proportion has such lives. The public health concern is based on the many who do not have good long-term outcomes. Knowing that all research has limitations, it is important to note that the Swedish and Danish gender affirmation surgery follow-up studies did not, as a comparison, provide the information on those who did not have surgery. The work that established the prevalence of

disability was self-reported via the Internet. Here are the recurring discussion points made in the papers drawing attention to the post-operative psychiatric difficulties.

1. The world is changing its attitudes towards the transgendered; it will now be easier to live as gender nonconforming or in a new gender because political enlightenment is reflected in governmental and institutional policies and in the general population. More social support will translate into less psychiatric impairment. The future is brighter than the past.
2. Earlier intervention facilitating gender transition may prevent the observed psychiatric comorbidities, including suicide.
3. Poor genital surgical outcomes lead to poor psychological adaptations. (Approximately 30% of gender conforming surgeries require additional surgical procedures.)
4. Inadequate psychiatric screening leads to poor psychological outcomes;
5. Trans incompetent health care systems keep patients from the services they need;
6. Absence of legitimized legal status demoralizes individuals(Richards et al, 2016).

## **Passion and Clinical Science**

Transgendered individuals feel strongly about their rights to self-expression free of discrimination and seek out only those professionals who are sympathetic to their desires. They often feel an urgent need for hormonal or surgical treatment. Lawyers for trans-declared prisoners stress the urgency when suing for hormones, surgery, or simply accommodations to their identities(Osborn & Lawrence, 2016). Specialists often have passionate beliefs about

minority rights and consider what they provide to be absolutely medically necessary.<sup>2</sup> Many view their work as suicide prevention. They are certain that nothing can change the initially declared trans identity structure, ignoring anecdotal information to the contrary (Faludi, 2016). They believe that transition, hormones, and surgery are the essence of competent health care for this discrete medical entity (Berlin, 2016). Specialists and their patients form an intense bond based on these shared beliefs.

The word psychopathology has acquired a stigmatizing connotation in this arena (Levine & Solomon, 2009). It no longer conveys a disadvantageous emotional state such as do the diagnoses of Generalized Anxiety Disorder, Restrictive Eating Disorder, or Major Depressive Disorder. Employing the term as in the context of a trans identity seems to mark a professional as an enemy. Individuals who are outraged by this common term have deliberately damaged professional lives as have those who are certain what should be done with other parents' trans children (Dreger, 2015; Wente, 2016).

Some of the passion seems to come from a moral imperative to create safety for all individuals in democratic societies. Similar to other great moral issues---war, slavery, women's rights, segregation, etc.--what matters most is the principle. The assumption is that establishing the principle will greatly improve the lives of future generations. Today's casualties matter less. Political ideals are felt as moral ideals.

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<sup>2</sup> For an indepth discussion of medical necessity, its history and the criteria that are theoretically based on, see the reference Levine, 2016.

Professional passions in the opposite direction exist, although their expression is muted by the fact that many health care professionals assiduously avoid these patients. These views share the belief that the cultural gender shift is actually endangering the future health of the transgendered(Nicholson & Levine, 2017). Some consider transgender phenomena as a complex symptom that should only be treated with psychotherapy and the goal of living in the biological sex (Corradi, 2016; Mayer & McHugh, 2016). They have noted the distinctly diminished role of psychotherapy in the latest version of the Standards of Care and the current movement to declassify Gender Dysphoria as a psychiatric disorder (Reed et al, 2016). They view institutional policy statements that support transitioning adolescents and adults as a triumph of sexual minority politics over reason, clinical knowledge, and the responsibility of basing clinical decisions on science. They consider the quality of science in this arena to be low.

These arguments are weakened by the observation that no form of psychotherapy has demonstrated a frequent ability to eradicate the subjective appeal of cross gender living. It is misleading to invoke the concept of delusion, when trans phenomena are closer aligned to passionate religious, political, or love decisions than schizophrenia. Magical thinking about identity and delusion are different phenomena. Some of the arguments seem to have an anti-homosexual bias(Corradi, 2016). General condemnations are blind to the fact that many gender specialists perform their ethical obligation to educate the patient and, in the case of younger patients, the parents about all the treatment options, despite the limitations of knowledge about the long-term outcome of each approach(Bryne et al, 2012).

## Denying Patients' Obligation to Others May Harm Them

Even though there are a myriad ways to suffer in life, the pain of gender incongruence has enabled patients and their specialists to view this form as a special case(Freud, 1916).

Transgender individuals are exceptions---physicians can break their thousands-year tradition of nonmalfeasance and remove healthy tissues and impair normal physiology with hormones. In the zeal to help this fascinating group, however, clinicians may inadvertently assist patients to jeopardize their connections to others and to inadvertently maintain isolation throughout their lives. Ironically, transition which may have been motivated by the wish to escape isolation due to the sense of inauthenticity as a natal male or female, may lead to isolation. Here are a few examples that alienate.

1. It is difficult for a teacher, sibling, or physician to shift from he/she/him/her pronouns to *them* or *ze*. Many also do not know how to respond to individuals who are outraged when they are not referred to as *them* or *ze*. (Additional terms some prefer include e, hir, and hirs; ey, em, eirs;, zir, and zirs, or singular they.)
2. When a mental health professional wants to speak over time with a patient about the consequential decision to transition, the patient may threateningly respond a letter can be obtained from someone else or by reminding the doctor that hormones can be ordered over the Internet.
3. When individuals transition, their lives become preoccupied with learning how to express themselves as a convincing member of the other gender. They often reassess the worth of

others to them. Nonsupport or questioning may instantly rupture their familial and friendship bonds.

4. Spouses often agree that the MtF and FtM partners become narcissistic and develop rage or depression when their spouse cannot acquiesce to a particular request.
5. When a teenager suddenly expresses the wish to become a girl or a boy and is able to quickly obtain hormones, depression, grief, anger, and anxiety often envelop family relationships.
6. Many physicians and psychologists discover that the typical trans narrative that they were presented when desiring a diagnosis, hormones or surgery was a fabrication that was carefully tutored by other trans people who knew how to game the system.
7. When a trans person who passes well reveals his or her background, many would-be mates lose interest. When a trans person who does not pass well seeks an intimate partner for a long-term relationship, the person discovers the available pool of prospects is quite small and often includes those who are looking for an exotic erotic experience.

What should our professional response be to these circumstances? Are the needs of others unimportant to us? Do we think these aspects of trans persons' lives are not legitimate professional concerns? Do the intense reactions of the teacher, physician, psychologist, parents, friends, siblings, spouses, and strangers in a bathroom not matter much? Are we telling others to "Just get over it."? The literature laments that some families reject their children, but it does not

mention the patients' rejection of their families. What is the doctor to do when the patient's story cannot be believed?

## **Ethical Conundrum**

In diminishing our patients' gender distress we are enacting the ethical principle of Beneficence. But we are ignoring our empathic concern for those deeply connected to our patients. Perhaps the protocol for these patients ought to include counseling on how not to lose connection to others. By not doing so, it is likely that we are failing to help our patients to understand and preserve their familial and peer bonds.

This is an ethical conundrum: in helping one, we often harm the other, which may, in the long run harm our patient. In helping the patients now, we may be setting them up for future despair. In asserting our patients' rights to express their gender in the way that they currently see fit, but not patiently helping them to weigh the likely costs, we are ignoring much about transgender life problems. In explaining problems primarily as the consequence of discrimination (which is real), we miss the opportunity to help the patients see that they have agency and are not just victims.

Medicine has long ago risen above ad hominem attacks on those who disagree. This is not so in the political realm of transgendered life. Health professionals must be vigilant about our passions. Our tradition is that careful follow up is a scientific way to answer clinical controversies (Michaels, 2016). Can we let data speak for themselves in this arena?

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**Table 1. Potential Negative Consequences to Consider Prior Social, Hormonal, or Surgical Transition**

1.	Loss of reproductive capacity--infertility
2.	Impairment in sexual physiological capacity for arousal and orgasm (MtF)
3.	Emotional distancing and isolation from family with eventual persona non grata status with married siblings with children
4.	Exchange of friends for friends from the trans community
5.	Greatly diminished pool of individuals who are willing to sustain an intimate physical and loving relationship with you
6.	Become of sexual interest to a special group of men who are interested in your trans status
7.	Eventual being neither male nor female, feeling inauthentic in new gender, and still being in the category of trans rather than simply a man or a woman
8.	High risk of subsequent serious depression, suicidal ideation, and functional disability
9.	Retain genetic vulnerability to disease related to natal sex
10.	Higher death rates
11.	The larger world will always regard you with suspicion

Table 2 **The complex intersectionality of identity**

1.	Biological sex
2.	Racial
3.	Religious
4.	Ethnic
5.	Economic status
6.	Vocational
7.	Political
8.	Familial
9.	Gender
10.	Orientation
11.	Intention: kink vs. ordinary
12.	Spousal
13.	Cultural
14.	Dietary
15.	National
16.	Regional
17.	Illness bearer
18.	Recreational
19.	Sports fan