

12 MORE MINUTES ON
**TRANSGENDER MENTAL
HEALTH**

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NOTHING COMMERCIAL TO DECLARE

- I co-direct a psychiatric service for transgendered folks
 - I am the senior editor of Handbook of Clinical Sexuality for Mental Health Professionals
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WHAT I HAVE LOVED ABOUT THE STUDY OF
SEXUALITY-- INCLUDING TRANS PHENOMENA--
IS HOW IT CAN ILLUMINATE THE OVERLOOKED
COMPLEXITY OF THE ORDINARY

ELEMENTS OF HUMAN IDENTITY

1. Sex: Male or female
2. Race
3. Religious
4. Ethnic
5. Vocational
6. Political
7. Gender
8. Orientation
9. Intention: kink vs. ordinary
10. Spousal
11. Cultural
12. Familial
13. Dietary
14. National
15. Regional
16. Illness bearer
17. Recreational
18. Sports fan

IDENTITY: WHO AM I? = SENSE OF ONESELF

- Each aspect of identity
 1. Can be passionately held
 2. Can be the source of one's values/energy/preoccupations/developmental differentiation
 3. Can be life:
 - Enhancing
 - Limiting
 - Destroying
- Most aspects of identity evolve from youth to old age, predictably and unpredictably
- Some aspects are more stable than others
- Psychiatry has ignored most aspects of identity

THE TRANS IDENTITY

- Its declaration to the self is the beginning of a life-long evolution;
- Its natural history is not known
- There is no reason to assume a trans identity is more stable than others over a lifetime

SEXUAL IDENTITY IS A MOSAIC

- Everyone's sexual identity is subtly subjectively composed of bits masculine and feminine, homoerotic and heteroerotic, paraphilic and conventional desires

ASSUMPTIONS AND LIMITATIONS OF THE HIDDEN DETERMINANTS OF CLINICAL THINKING

- 1 Medical Disease Paradigm
- 2 Minority Rights Paradigm
- 3 Developmental Paradigm

MEDICAL ILLNESS PARADIGM ASSUMPTIONS

1. *The diagnosis, Gender Dysphoria, should determine the treatment*
2. The physician employs what is best for the patient after considering the danger of untreated condition, the effectiveness of the treatment, its short-term and long-term side effects and economic cost.
3. All treatments are medically necessary—from electrolysis to cricoid cartilage shave to neophallus construction
4. SRS "cures" Gender Dysphoria.

MEDICAL ILLNESS PARADIGM: 6

LIMITATIONS

1. Patient preference is the primary determinant of SRS and cosmetic procedures. MHPs only cooperate with the patient's request for hormones or surgery.
2. There is no credible evidence of the genetic dictation of GD
3. The broad range of prevalence estimates suggest multifactorial influences.

MEDICAL ILLNESS PARADIGM: 6

LIMITATIONS

4. Gender Dysphoria is known to resolve spontaneously in response to life processes.
5. The majority of children with Gender Dysphoria become homosexual adolescents.
6. Treatments do not target any biological abnormality

MINORITY RIGHTS PARADIGM

1. **The** treatment of Gender Dysphoria should be determined by the patient's wishes because individuals have the right to express their gender as they see fit
2. Psychiatry viewed homosexual persons as mentally ill until 1976. Homosexuality is now viewed as a developmental variation. This paradigm perceives trans people as similarly misunderstood, marginalized, diagnosed, stigmatized and cruelly ignored or inappropriately delayed in their medically necessary endocrine and surgical therapies.
3. Anyone who hesitates supporting transition and SRS is a dinosaur committed to an outgrown inherently discriminatory understanding of trans persons and needs to be defeated in court or in the public arena.

PARADOXES OF THE MINORITY RIGHTS PARADIGM

1. This political perspective borrows the medical paradigm to get patients their desired treatment but then denies that Gender Dysphoria is a form of illness.
2. WPATH claims to be a scientific **and** a minority rights document and ignores the inherent conflicts between science and advocacy.

PARADOXES OF THE MINORITY RIGHTS PARADIGM

3. WPATH asserts that gender identity and orientation are two ever-distinct aspects of sexual identity denying the obvious overlap and two-way traffic between
4. WPATH aims to decrease stigmatization by declaring all trans individuals as normal and views trans individuals' sufferings as s consequences of social rejection.

THE DEVELOPMENTAL PARADIGM: 4 ASSUMPTIONS

1. Gender Dysphoria is an adaptation to an evolving problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood.
 - a. The source and the evolution of this uncomfortable and behaviorally problematic sense of self are explained by the interaction of changing biological, social, psychological and cultural forces.
 - b. The declaration of the self as transgendered is an attempted solution
 - c. After these declarations, trans individuals view their life histories as containing elements that provide conviction that they have always been that way. They now see that they have had a feminine or masculine self, struggling for expression over their false but culturally approved of gender roles

THE DEVELOPMENTAL PARADIGM

2. During adolescence these forces create other unstable identities involving gender, orientation, paraphilia and dysfunction in partner sexual intimacies.
3. Fluidity of the person's gender identity, as well as other aspects of identity, is noted before and after SRS—trans individuals may change their ethnicity, religion, religiosity, diet, or first and last name
4. The diagnosis of Gender Dysphoria, per se, does not mean that hormones and surgery are medically necessary

THE DEVELOPMENTAL PARADIGM: CLINICAL RESPONSES

1. Compassionate treatment is based on history, co-morbidities and motivations for the transition. What can be done to help the patient in the cultural setting of the patient's life?
2. Clinicians urge hope, patience, and continued clarification of the forces that shape the individual's distress, current needs and behavior through ongoing psychotherapy
3. Clinicians work with the environment to make life easier by addressing the person by her preferred name, meetings with family, environmental education and support groups.
4. Asserts that this intrapsychic problem dictates a thoughtful relationship-based process intervene between diagnosis and medical/surgical treatment

THE DEVELOPMENTAL PARADIGM: CLINICAL RESPONSES

5. Ongoing psychotherapeutic investigation can in some circumstances help the person to face past dilemmas and recognize the underlying conflicts that are being avoided through transitioning.
6. Clinicians raise the question with the patient to what extent and in what ways anyone can start their life over?
7. Psychotherapy also allows a clinician to recognize the **reasonableness** of hormones and SRS for some individuals

4 LIMITATIONS OF THE DEVELOPMENTAL PARADIGM

1. It often conflicts with the patients' wishes. Many patients do not want to consider the impact of their past adversities, their convictions about the sources of their suffering and that they might not be correct about what is necessary to relieve their distress.

4 LIMITATIONS OF THE DEVELOPMENTAL PARADIGM

2. Understanding a developmental process does not mean that the patient's ambitions can be changed.
3. Change depends in part on patient capacity to use a therapeutic relationship to grow; many do not seem to have this capacity.
4. Many MHPs no longer conduct depth psychotherapies with anyone, let alone the transgendered!

WHAT MOTIVATES THE WISH FOR SRS?

- Far more individuals have cross gender identifications—gender nonconforming, gender queer, gender questioning, transgender, you and I-- than who are interested in SRS

ONE POSSIBLE IMPORTANT SEQUENCE

1. A failure to understand and integrate one's sexual identity mosaic—an inability to accommodate to, sublimate and express cross-gender identification
 2. Feeling like a freakish outcast based on having “abnormal” desires
 3. The culturally acquired belief in the power of transition to cure
 4. The support of the trans community and its professional advocates on Internet and locally
 5. Happiness in the new gender presentation, gender role and gendered body while rationalizing and denying the losses
 6. Growth of feeling inauthentic and sensing one's isolation and marginalization. Increasingly feeling like a freak who cannot find a sustainable love relationship.
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11-YEAR FOLLOW-UP OF ALL SWEDES WITH SRS OVER THIRTY YEARS HAZARD RATIOS SRS VS. CONTROLS

- All mortality, 2.9 x
- Death by Suicide, 19.1x
- CV disease, 2.6x
- Cancer, 2.1x
- Any psychiatric admission, 4.2x
- Suicide attempts, 7.6x
- Substance abuse, 3.0x
- Auto accidents, 1.6x
- Crime, 1.9x
- Violent crime, 2.7x

Simonsen, Giraldi, Kristensen & Hald (2016) Long-term Follow-up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity and Mortality, Nordic Journal Of Psychiatry, 70:4, 241-247,

- Danish Psychiatric Central Research Register and the Cause of Death Register through a retrospective study of 104 sex reassigned individuals (98% of all individuals with SRS) from 1978 to 2010.
- 28% diagnosed with psychiatric morbidity pre-SRS and 22% post-SRS. 7% had a dx pre and post SRS
 - Anxiety, depression and neurotic personality most common dx
- 10% of the patients died, all less than 60. Life expectancy in Denmark is 82 and 78 years. Two suicides
- Need for continual social and psychological support after SRS