Bringing Transparency to the Treatment of Transgender Persons

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Transgender is a term that was coined by Dr. Kenneth Zucker to describe the condition of a biologic male or female person who believes they are born into the body of the wrong sex. This term replaced the term transsexual which was regularly used by sexologists in the 1950's to refer to the same population. Dr. John Money, a psychologist at Johns Hopkins applied the word gender to describe "the identity of the inner sexed self" of human beings. The word gender had previously been only a linguistic term used in languages to describe nouns as either masculine or feminine. Money theorized that human toddlers generally figured out their gender as early as 18 months.[1] Johns Hopkins was a major referral center for evaluation of infants and toddlers with disorders of sexual development (DSD), then referred to as hermaphrodites or pseudo-hermaphrodites, depending on whether they had germ cell lines of both sexes, and just one sex, respectively. The incidence of transsexual patients was difficult to determine because of rejection of such persons by society. Dr. Harry Benjamin, a family practitioner from New York City, medically treated a transsexual biologic male who assumed the identity of Christine Jorgenson. Christine traveled to Europe to have his surgical "conversion" which was eventually accomplished in Denmark.[2] Benjamin, Money and Alfred Kinsey, an insect biologist-turned-sex researcher from Indiana, were instrumental in creating the Sexual Revolution of the 1970's which sought to normalize a broad spectrum of previously deviant sexual behaviors. After Benjamin died, his colleagues established the Harry Benjamin Society to promote the normalcy of transsexualism. Today that organization is named The World Professional Association of Transgender Health (WPATH).

Establishing normalcy of a spectrum of sexual behaviors was the aim of the Kinsey Institute, which was founded in the 1940's.[3] Money arrived at Johns Hopkins in the 1950's and established the Psycho-hormonal Division of the Psychiatry

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Department where he applied his theories to the treatment of children with DSD and to children with precocious puberty. He also established a treatment protocol for transsexual adults which included medical, and then surgical interventions. The application of Money's theories to the treatment of the children and adults resulted in adverse outcomes often enough that his program was closed by the incoming Department Chairman, Dr. Paul McHugh in the 1980's.[4] The established academic medical community in the United States did not accept the concept of medical or surgical treatment to convert the sexual appearance of males to females and vice versa. Such treatment could be readily had in the Netherlands, Belgium and Scandinavian countries, but in the U.S. such interventions were accomplished by an "underground" network of doctors outside the purview of mainstream medical practice and with no endorsement by the major medical professional societies.

Dr. Zucker established a clinic in Toronto in the 1980's to evaluate and treat children with gender identities which were incongruent with their biologic sex. He coined the term Gender Identity Disorder (GID) to describe this clinical entity. His success rate in resolving the incongruence was substantial in both boys and girls by the time they had passed through natural puberty. He used in-depth psychological evaluation of the patient and their families to unearth the undercurrent psychopathology which led to the feelings of being born into the wrong body and did not affirm their delusional thought. He published his experience with 560 children, thus establishing a standard of care that was eminently successful, and above all, ethical.[5] Elsewhere, patients who were treated instead with hormonal manipulation and surgery sought continued emotional and social support by joining the Harry Benjamin Society and subsequently WPATH. Instead of being a scientifically-based organization, WPATH acts as a politically active entity pushing aggressively for worldwide acceptance of gender incongruence as a biologically-based variation of normal behavior. WPATH pushed the American Psychiatric Association to eliminate GID as a disorder. Dr. Zucker, who chaired the committee to create the DSM-5, fought to retain an entity, which he termed Gender Dysphoria, to describe the emotional suffering of those persons with gender incongruence. This would allow patients to receive insurance coverage for treatments related to resolving the dysphoria. He succeeded in his efforts and the term GID was thus replaced.[6]

There are two clearly different approaches to the person with gender incongruence. The first approach is to view the condition as a psychological one that is not determined by biologic factors. The second approach is to view gender incongruence as having an innate biological foundation. These opposing viewpoints dictate what kind of therapy is offered. For the sake of side-by-side comparison, the scientific validation of either theory will be addressed later.

Approach #1 is often referred to as the counseling, watch-and wait approach. The prototype of this therapy is based on the work and clinical experience of Kenneth Zucker. It is outlined in detail in the treatise by Lawrence Mayer and Paul McHugh.[7] Often referred to as "conversion" therapy by trans- activists, it is actually *affirmation* of

the patient's biologic sex. Counseling is core treatment modality. Discovery of Childhood Adverse Events (CAE's) is common.[8] The techniques used are not different than for other behavioral morbidities, so this therapy can be done by any competent behavioral therapist. The only medical intervention is to treat undercurrent depression, anxiety or dissociative thought. The watchful waiting part is not an abandonment of therapy, but is a continuation of counseling support while the patient moves into and through natural puberty. The patient's family plays a pivotal role for a number of reasons. Often, there is much family dysfunction. This dysfunction needs to be recognized and treated in hope that the patient can live with the family successfully and receive positive feedback in resolving the gender incongruence. The goal, above all, is to relieve gender dysphoria by resolving gender incongruence. Throughout this approach, it is mandatory that the patient is cared for compassionately and non-judgmentally by the therapist and the family.

Approach #2 is now referred to as "Gender Affirming Therapy" (GAT). It ideally involves a baseline psychological evaluation of the patient, followed by counseling of the family to "affirm" the incongruent gender. It promotes total acceptance of the patient's wishes to be the opposite sex by the home and school environment, and by society at large. Once puberty starts, treatment with gonadotropin releasing hormone (GnRH) super-agonist therapy (puberty blockers) to halt gonad-driven hormone production so the physical body can remain in a neutral state. The usual changes brought about by biologically driven male or female puberty are kept from happening, although the adrenal sex steroid production remains intact, causing primarily adult body odor, some sexual hair growth, oily skin and acne. During this pause in true puberty, patients have an opportunity to ponder further their incongruence and subsequently decide about the institution of cross-sex hormone therapy to change some of their body habitus. The next step is to have surgical removal of the gonads and the external genital structures in the male, and removal of the breasts and all internal female anatomic organs including the ovaries in the female. The most challenging final surgery involves creation of a perineal orifice for males and a phallus for females. There is little emphasis on counseling for the short term or long term since this approach purports to alleviate all emotional suffering.

At this point, there is ample scientifically valid medical literature to support Approach #1. Likewise, there is valid published data to show that adults who chose Approach #2 have a period of satisfaction with their converted selves for about 10 years, followed by diminished satisfaction and a significant increased risk of suicide completion.[9] A *Hayes Directory* review of published studies revealed that publications finding long-term satisfaction from Approach # 2 were seriously flawed and without scientific merit.[10]

The Endocrine Society is a U.S.-based professional organization whose membership consists of board-certified adult and pediatric endocrinologists from around the world. This organization is highly revered for its academically-based publications. Since 2009, with the publication of the first version of *Clinical Guidelines for the Treatment of Trans-*

gender Persons by the Endocrine Society[11] there has been a geometric, if not logarithmic increase in the number of persons claiming to be transgender.[12] What had been a stable worldwide incidence of 6/100,000 males and 3/100,000 females for three decades has changed to 27/100 according to a survey of high school students in California.[13] There has also been a reversal of incidence to twice as many females compared to males. The expansion of use of social media on the internet by teenagers has clearly facilitated these changes over time.[14]

Close examination of the influence of WPATH on this scenario is warranted. The Endocrine Society special interest working group that wrote the 2009 Guidelines and the revised 2017 *Guidelines* were packed with WPATH advocates, if not members. WPATH actually created these guidelines for their own use[15] and then let the Endocrine Society mirror them. Missing from the list of authors of the guidelines were Kenneth Zucker and Paul McHugh. Forty percent of committee members were from Europe and most members were aligned with adult health care. The 2009 guidelines numbered 22 and all but three recommendations had little or no scientific validity. Those three guidelines based on a moderate degree of scientific evidence had to do the known risks of using puberty blockers and cross sex hormones. The same concerns were voiced in the 2017 revised guidelines,[16] with the added proviso that permanent sterilization risk should be explained to the patient as a result of the recommended treatment. Interestingly, both published guidelines recommended initial psychological evaluation of the patient and family but suggested that the evaluation be done only by someone who was an expert in the field of transgender counseling. The reality is that the so-called "experts" are proponents of the affirmation pathway, easily found on internet searches. This conveniently bypasses the in-depth psychological analysis of the patient and family.

Following the Endocrine Society recommendations, only Approach # 2 was endorsed by the American Academy of Pediatrics, the American Association of Family Practice, and the American Medical Association. The Pediatric Endocrine Society (a US based professional organization) made their own guidelines which mirrored those of the Endocrine Society and additionally focused on the need for governmental intervention to assure insurance coverage for all recommended treatment modalities.[17] The most recent set of guidelines, from the American Academy of Pediatrics,[18] eliminates the recommendation for any psychological evaluation or treatment. Approach #1 is described as cruel and ineffective by the author of those guidelines. With each new iteration of guidelines, the recommended age for medical and surgical intervention is lowered further below the age of 18 years, which is generally used as the age of legal consent. The illusion of expertise by the creators of these guidelines and the concept that only those who agree with them should be trusted has created a cocoon of protection that is nearly impenetrable. Proponents of Approach #1 are marginalized and their communications are squelched. You will not be published or invited to speak at the educational symposia supported by major medical professional organizations. Your faculty position is in jeopardy if you speak out against Approach #2. Medical schools

are now creating curricula for medical students, residents and fellows to promote only Approach #2.[19] *U.S. News and World Report* encourages hospitals and clinic systems to have a transgender treatment center in order to add points to their tally which determines a ranking of excellence in their Annual "report card."[20]

The reality of this is that if the Endocrine Society *Guidelines* were followed in the first place, but mental health evaluation was performed by unbiased professional who included evaluation for ACE's, the majority of patients would travel down the path of Approach #1. Lifelong morbidities from puberty blockers, cross-sex hormone therapies and surgical manipulations would be eliminated, as would the mental health problems found in the patients who pass through the transient satisfaction achieved by choosing Approach #2.[9,21]

It is apparent that we need to develop entirely new guidelines by bringing all opinions to the table after an unbiased review of all published literature. All clinical research on the subject should adhere to the existing principles for protection of human subjects. No treatment protocols should be developed or implemented until there is clear evidence of safety and efficacy in a population of patients treated from young childhood through middle-age adult life. Currently, only Approach #1 can claim such validity. Identification of the various environmental factors and pathways that trigger gender incongruence in biologically vulnerable children should be one focus of research. Particular attention should be given to the impact of childhood adverse events and social contagion. Another area of much needed research is within psychotherapy. Large long term longitudinal studies in which children with GD and their families are randomized to treatment with various therapeutic modalities and assessed across multiple measures of physical and social emotional health are desperately needed. In addition, long term follow-up studies that assess objective measures of physical and mental health of post-surgical transsexual adults must include a matched control group consisting of transgender individuals who do not undergo "affirmation." This is the only way to test the hypothesis that the "affirmation" pathway itself may cause more harm to individuals than they otherwise would experience with psychotherapy alone.

As we clinical scientists move forward to solve this dilemma, there must be first and foremost a dialogue established between proponents of Approach #1 and Approach #2 which is devoid of political activism.

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