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Ethical Issues of Hormonal and Surgical Treatment of Transgender Youth: An Update

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Transgender individuals are the subject of much debate in society, and specifically within the medical community. This population has a much higher incidence of depression, suicidal thoughts and attempts, and death by suicide. This fact has prompted a movement to affirm transgender persons in their perception and experience, assuming that many of the mental health issues experienced by transgender people are sourced in society's reaction to the fact that one is transgender. The expectation is that once society completely accepts transgender individuals and assists them in transitioning socially and biologically into their experienced gender, the mental health issues will desist. This essay will explore whether or not there is evidence to support that premise, and if evidence exists, whether that fact alone is enough justification for treating minors with

medications and surgeries that can have life-long implications. This discussion is further complicated by the well-established fact, which will be discussed below, that most youth who show some form of gender nonconformity will not persist in this nonconformity through adulthood.

Terminology

In order to properly discuss this topic, one must understand the terminology. Currently there is disagreement within the lesbian, gay, bisexual, and transgender (LGBT) community as to what language should be used to name the disorder as well as the language to delineate the criteria for this disorder.¹ The American Psychiatric Association (APA) currently uses the term gender dysphoria,² while the World Health Organization (WHO) has reportedly chosen the term gender incongruence;³ however, this could not be

confirmed on the WHO website.⁴ Several of the papers cited use the term gender identity disorder (GID). For simplicity, throughout this article, unless quoting from cited works, the abbreviation GID will be used. The APA's Diagnostic and Statistical Manual, fifth edition (DSM-V) defines GID in children as: "A marked incongruence between one's experienced/expressed gender and assigned gender . . . associated with clinically significant distress or impairment."⁵ Marked incongruence in children is defined by desire for behaviors associated with the non-natal gender, rejection of stereotypical behaviors of natal gender, rejection of natal primary and secondary sexual characteristics, and desire for those of the opposite (or other) gender. Adolescents and adults have similar criteria, based mostly on primary and secondary sex characteristics or conviction that one's feeling and reactions are typical of the opposite gender. Currently the APA and DSM-V focus on the uncomfortable feeling (dysphoria) brought about by the experience

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of being transgender and the reactions of those around the transgender person. Therefore, treatment of the condition is to affirm the experienced gender to resolve the dysphoric feeling and experiences.⁶

There are also conflicting claims about the association between homosexuality and GID. One source asserts that part of the problem with terminology is that, historically, theories of sexuality conflated transgenderism with homosexuality.⁷ Another source states quite clearly, “Children with GID can be classified into at least two subgroups: the pre-homosexual children and the pre-transsexual children.”⁸ Other studies show an association between GID and bisexuality or homosexuality.⁹ One study showed that all persistently GID participants were attracted to natal sex partners, but did not consider themselves homosexual.¹⁰ This source did not explore whether the same (natal) sex attraction came before and perhaps was the source of the transgender ideation, or came subsequently. Some of the youth whose GID did not persist also later identified as homosexual.¹¹ Another problem with terminology

is the idea that this is a disorder, which prompted the WHO’s movement to change the terminology in the 11th version of the International Classification of Diseases (ICD-11).¹² Another author claims that some of the diagnostic criteria confuse discomfort with one’s biological sex and discomfort with gender roles, which the author argues are very different phenomena.¹³

Gender Identity Formation

With this milieu of confusion about terminology yet unresolved, one turns to the question of how gender identity forms, how long is it moldable, and what factors contribute to the development of a gender identity incongruent with one’s natal gender. According to Hembree et al., the “normative psychological literature” does not address these issues.¹⁴ Other authors assert that sexual preferences evolve throughout an individual’s lifetime, but are solid enough by age 15 to engage in treatment which may have life-long implications.¹⁵ Hembree et al. argue that if GID is severe, “an early complete social transition may result in a more favorable outcome,”¹⁶ though currently no criteria exist to identify the individuals to whom this expedited treatment would apply.

Incidence

With terminological and developmental questions left unsettled, one hopes to find a more solid answer, using empirical research, regarding the incidence of GID. For example, Zucker and Lawrence point out that 5% of boys and 10% of girls are rated by parents to behave like the opposite sex, but only 1% of boys and 3.5% of girls report a desire to be the other sex.¹⁷ By the time of adulthood, the prevalence rate is quite varied depending on which study one reads. Zucker and Lawrence compiled data from several studies resulting in an estimated rate of GID in adults to be 1:10,000–1:20,000 in birth-assigned men and 1:30,000–1:50,000 in birth-assigned women.¹⁸ The

highest documented incidence was 1:2,900 for natal males, 1:8,300 for natal females,¹⁹ much lower than the 0.6% touted in the media.²⁰ Because the incidence rate appears to change throughout childhood and adolescence, there has been much discussion about the age at which it would be appropriate to start any treatment.

The Question of Persistence

To answer this question, some seek to understand the development of gender identity, and what factors might be involved in the persistence or desistence of GID. Unfortunately, little is known about cognitive gender development.²¹ In an attempt to better understand this concept, several studies have been done to determine what percentage of children who have “cross gender” thoughts will continue to have those thoughts and persist in the transsexuality. The results vary from 2–27% persistence, with an average of 15%. This means that the majority (85%) of prepubertal children who seek initial evaluation for GID did not remain gender dysphoric in adolescence.²² Responses to this data about persistence vary. Hembree claims that GID rarely desists after the onset of pubertal development.²³ However, one of the sources he cites states, “Many boys with pervasive . . . gender dysphoria do not show persistent gender dysphoria by late adolescence or young adulthood.”²⁴ The APA task force on gender issues also states that 20% showed persistent GID in mid-adolescence.²⁵ Similarly, Steensma et al. found minimal differences in childhood gender variant expression between “persisters” and “desisters.”²⁶ Members of both groups reported feeling indifferent about their gender identity in early childhood. By the age of 6–7 years, the youth started to identify with the other sex: persisters stated they felt they were the other sex, while desisters only wished they were the other sex.²⁷ With regard to sexual attraction, all persisters reported feeling exclusively attracted to persons of the same natal sex, which they saw as confirmation of their perceived gender.²⁸ Those individuals who did not persist gradually experienced less



gender discomfort from the age of 10 and 13 years, attributed to changes in their interests, friendships, physical changes during puberty, experiencing sexual attraction, and falling in love. Desisters noted a complete resolution of gender discomfort by the time puberty was completed.²⁹ All girl desisters felt exclusively attracted to boys, which was integral in weakening their identification with or as the opposite sex.³⁰ Because this was a retrospective study, recall bias might account for the difference noted that persisters stated they *were* the opposite sex, while desisters said they *wished they were* the opposite sex.³¹

Goals of Treatment

Unfortunately, the literature leaves many questions unanswered. It is in this confusing state that one now turns to examine the goals and timing of treatment. Puberty suppression treatment is the first step in medical treatment of GID youth, accomplished using gonadotropin-releasing hormone analogs (GnRHa) administration. Most authors recommend against hormone blocking medications until the first signs of pubertal changes, defined as Tanner stage 2, to avoid the worsening dysphoria associated with pubertal changes.³² After suppressing puberty, cross sex hormone treatment (CSHT) is typically started at age 16, based on a statement by the Endocrine Society that most adolescents have sufficient mental

capacity to give informed consent by this age.³³ The final stage of treatment consists of sex reassignment surgery (SRS), which is divided into top surgery (mastectomy or breast augmentation) and bottom surgery (vaginoplasty or metoidioplasty).³⁴

As previously stated, one concern about initiating treatment too soon is that going through puberty may help the individual to become congruent with their biological sex.³⁵ The emphasis to start treatment rather than allow GID youth to proceed through natural puberty comes from guidelines that “place a high value on avoiding an unsatisfactory physical outcome” (secondary sexual characteristics) over “potential harm from early pubertal suppression.”³⁶ This philosophical approach to gender dysphoria places a higher value on the perceived psychological harm which would be caused by one’s own bodily changes which occur as a result of natural puberty than the physical and physiologic harm caused by the hormones used to block the natural progression of puberty. Hembree asserts that the current guidelines select adolescents whose GID persists (or will persist?), implying that these are the individuals who would benefit from puberty suppression;³⁷ however, he does not describe *how* the process selects persisters, and his own study demonstrates that going through puberty is part of what made the desisters *desist*. Early treatment also limits the growth of the penis and

scrotum, making SRS more difficult.³⁸ To further complicate treatment decisions, the Endocrine Society states, based on “very low-quality evidence,”³⁹ that there may be “compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents . . . though there are minimal published studies.”⁴⁰

There are also medical concerns about treatment unrelated to the gender issue. One known issue is that puberty suppression using GnRHa stops the normal accumulation of bone density that occurs with the onset of puberty, and treatment with CSHT does not bring bone density back to the level expected if puberty suppression had not occurred.⁴¹ In fact, the *z* score (comparison to age matched controls) at age 22 years was lower than at start of treatment.⁴² GnRHa treatment “is relatively new and controversial,”⁴³ therefore additional research is needed. Bizic et al. once again bring a heavy dose of reality when they assert that the strongest argument against CSHT is the absence of any studies documenting its long-term effects.⁴⁴ One area they especially want to see more data on is for cross-sex hormonal therapy in individuals below 16 years of age.⁴⁵ Indeed, CSHT has many long-term effects, including potential impairment of future reproductive functioning.⁴⁶ If an adolescent elects to proceed immediately from pubertal suppression to CSHT, they will never undergo the physiologic puberty of their natal sex, and never



develop mature gametes to cryopreserve, resulting in permanent sterility.⁴⁷

Consent

With the exception of women's health issues, no one under the age of 18 is legally able to consent for any medical care. From consenting to a visit for a sore throat requiring an exam and possible swab of the throat, to consenting to an emergency appendectomy where time is of the essence, all medical treatment requires the consent of a legally responsible guardian, usually the parent. There is concern about the adolescent's true ability to give informed consent for gender identity issues. Individuals 16 years and younger have better comprehension of near-term consequences, such as worsening gender dysphoria as they enter puberty, compared to long-term consequences, such as their potential future fertility.⁴⁸ Pain may also cloud their judgment, impairing their ability to make a truly informed and rational decision. We know that physical pain isolates people from society and from one's self, causing people to seek surgery "in the hope that if it is just cut off or out they will not be burdened."⁴⁹ This statement is made about a gangrenous extremity, but would this same argument be true of mental anguish causing obscured informed consent for removal or reversal of undesired secondary sexual characteristics?

Comorbidities

Because individuals with GID often have psychological comorbidities, it is recommended that mental health care be available through the entire transitioning process.⁵⁰ One author asserts that for this reason, the only health professionals who should make the diagnosis are mental health professionals trained in pediatric psychiatry and transgender issues.⁵¹ Several studies have documented a disproportionately high rate of suicidal thoughts, attempts, and actual suicide amongst young people in the LGBT community.⁵² This issue is large enough that it warrants a special task force of the APA.⁵³ Some writers point to victimization as a cause for the psychological issues;⁵⁴

however their data shows a strong baseline of attempted self-destructive behavior which only increases (approximately 50% from baseline) when bullying occurred.⁵⁵ It is only natural to want to find a treatment that will lessen the suffering of individuals with this high rate of self-harm. Unfortunately, while there are studies that show people rate their quality of life as being better after SRS,⁵⁶ studies demonstrate persistent self-harm behavior. One particular study showed a 19-fold risk of death from suicide, as well as increased mortality from cancer (presumably from ongoing CSHT) and overall mortality in transgender individuals. Increased risk for suicide attempts, inpatient psychiatric care, and criminal convictions were also demonstrated.⁵⁷ This was one of the few longer-term studies, and these findings did not become evident until at least 10 years after completing SRS.⁵⁸

Ethical Considerations

With a more robust understanding of the manifold issues involved, we may turn to consider the ethical questions of treating minors with GID. The field of bioethics has transformed over the years as technology has progressed, but one approach has become a standard for evaluating ethical issues: a four-legged approach known as the Georgetown Mantra of principlism. Using this approach, one evaluates the ethical considerations of an issue through the lenses of beneficence, non-maleficence, autonomy, and justice.

Evaluating treatment through the principle of beneficence, one article claims that beneficence obliges clinicians to help the person by prescribing hormonal treatment because "there are no better options at this moment."⁵⁹ However, a counter argument is made that SRS is equivalent

to the surgical alteration of healthy organs; therefore, they argue SRS would not align with doing "only what is in the patient's best interest."⁶⁰ Because one is considering treatment of an adolescent who likely has several decades more to live, one must look not only at the short-term benefits and harms but also long-term considerations. If treatment truly minimized self-destructive behavior⁶¹ and improved self-rated quality of life over subsequent decades, not just months or years,⁶² then this treatment might meet the requirements of beneficence. However, long-term studies show an increase in suicide attempts and death from suicide, as well as increased overall mortality, which did not become evident until

at least 10 years after completing SRS.⁶³ The small size of the studies and limited participation in follow up also make it difficult to assess the beneficent results of treatment.⁶⁴ Even the Centers for Medicare and Medicaid (CMS) wrote a proposal stating that "there is not enough evidence to determine" beneficial outcomes, and also states: "The quality and strength of evidence were low."⁶⁵

Turning to the principle of non-maleficence, treatment must not harm the individual "in an emotional, social, or physical sense."⁶⁶ GnRHa treatment might meet this requirement because the potential harm is low—lower peak bone mass. One has more difficulty with CSHT, which runs the risk of permanent sterility. Some take the view that doing nothing causes harm because of the bullying and increased risk of suicide. Therefore, they would conclude that the least harmful treatment plan involves the least invasive surgery.⁶⁷ Another way to view harms is to consider whether something as complicated as SRS is truly without harm, considering the fact that individuals may change their mind and want to transition back. One woman who has detransitioned states, "telling my old providers about how transitioning hurt

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me is intimidating, overwhelming. . . . Why would it be easy to tell those who prescribed me testosterone that doing so helped me hurt myself?⁶⁸ There are many who feel they have been hurt by transitioning to the opposite sex and seek detransitioning as part of their restoration.⁶⁹

When one examines this topic through the lens of autonomy, it seems at first glance to sway the clinician in favor of any treatment the patient desires; however, GID does not persist through adolescence in the vast majority of children, so a primary concern regarding performing SRS from this lens would be the possibility of regret.⁷⁰ How does a clinician help someone walk through the decision of whether it is better to suffer the consequences of GID or SRS? Are children or teenagers mature enough to make these kinds of decisions?⁷¹ One might even argue that parents might be shortsighted in their decision making, seeking relief from pain now over potential for regret in what seems like the distant future. Puberty suppression only delays the inevitable decision that one day needs to be made and is not a neutral stance as it prevents what appears to be curative for the vast majority of afflicted individuals: puberty. One reason we may never know the answer to that question is that it has become unsafe to even ask. One leading expert, Dr. Kenneth Zucker, was fired in 2015 for holding the stance that it may not be in the long-term interest of the child's well-being to automatically be encouraged to transition.⁷²

Completely missing from this discussion of the ethics is the concept of justice.

Perhaps this is because the transgender agenda runs counter to the claim that justice “sets limits on the absolutization of autonomy.”⁷³ The goals of medicine must be determined by what medicine is in its internal essence. Current terminology makes the physician into a “provider,” no different from an insurance provider, internet service provider, or cell phone provider, and if the patient is not receiving the “service” the patient desires, the patient merely changes providers. Medicine as a profession implies that the physician has knowledge that the patient does not have, and must use that knowledge to the patient's benefit, over and above the physician's benefit. If physicians are merely providers, then physicians are guided—or driven—by goals that are socially constructed, goals which “could stretch the limits of medicine to include provision of whatever treatment a society might want.”⁷⁴ Paul McHugh of John's Hopkins University states that psychologists typically challenge patients' thinking, and so he suggests that the best way to treat GID may be the same way psychologists treat other dysphorias: by recognizing that feelings are not the same thing as reality.⁷⁵

Conclusion

As this essay displays, there are many issues to consider when discussing the treatment of transgender individuals, especially youth and adolescents. Some individuals experience increased dysphoria with the onset of puberty. Proponents of treatment use this fact as a reason to urge treatment at younger ages. Several studies show that most gender incongruent youth become gender congruent

by adulthood. Studies examining treatment are small and follow subjects only 1–2 years. These studies show improved quality of life defined by less dysphoric feelings. Only one study followed a reasonable population over decades, and documented a much higher mortality and morbidity from psychiatric illness. This calls into question whether treatment actually is helping those who suffer from GID. After examining the research, the implications of GID, and the ethical issues involved, one can reasonably conclude that there is no adequate justification for CSHT or SRS, especially in the child and adolescent age group. Some of the studies mentioned show lack of benefit more than 10 years out, so it would be reasonable to omit the “especially in the child and adolescent age group” from the previous sentence. This article has argued from a Hippocratic “first do no harm” perspective, which supports the Christian perspective that each and every individual is created in the image of God, not a random collocation of atoms. This belief not only states that treatments discussed in this article are not beneficial, but are wrong in the sight of our holy God, and these individuals as they were born, without any need for ‘improvement’ are “fearfully and wonderfully made.” ●●●

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