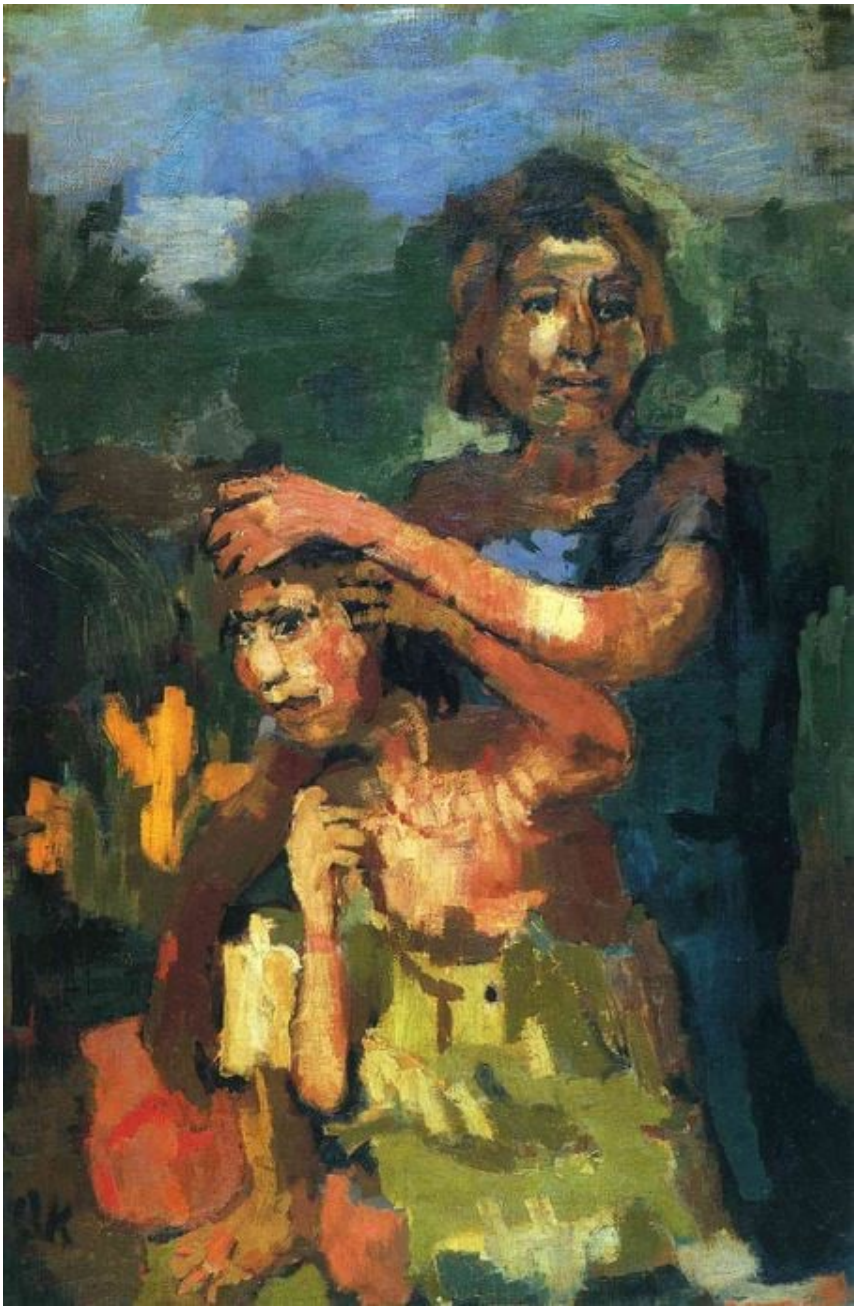
Traversing the Landscape of Transgender Politics, Part I

Read Part II

by Sarah Dillingham (November 2019)



Two Children, Oskar Kokoschka, 1922

Last Monday, a Texas jury granted sole custody of 7-year-old twins to their mother, a pediatrician (a decision later overturned by a judge). The following day, a college athlete who placed second in a cross-country event was named Big Sky Conference Female Athlete of the Week. These headlines would be unremarkable but for the fact that not the parents, jurors, or judge in the custody case, nor the 204 competitors or countless spectators of the qualifying cross-country race, are able to reach epistemological consensus about the biological and moral context in which these events took place.

One of the biologically male twins tragically embroiled in the custody battle has been diagnosed with gender dysphoria by therapists after their mother, Dr. Anne Georgulis, insisted that her child—formerly called James, now Luna—identifies as a girl, while their father, Jeff Younger, maintains that both twins happily identify as boys and Luna's gender-dysphoric presentation is a product of Georgulis' influence and prompting. Younger has desperately tried to impede his ex-wife's plan to pursue potentially irreversible medical transition therapy for his child, which could include hormone blocking drugs started immediately, followed by cross-sex hormone treatment and surgery.

June Eastwood, who won the Big Sky title, is also the first transgender athlete to compete on an NCAA Division I women's running team. Eastwood competed on the men's team for three years before competing on the women's team, after undergoing hormone therapy for a year, per NCAA rules. Eastwood joined the women's team as the fastest distance runner ever to compete in an NCAA Division I women's race, with personal best times which beat the women's collegiate records by significant margins. However, these times never earned Eastwood a national title on the men's team.

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Is it fair for Eastwood to compete against biological females? Is it ethical for the judicial system to favor one parent's reported observation of a child's gender identity over the other parent's? Is it ethical to administer potentially risky, off-label medical treatments to a 7-year-old child against a parent's express wishes, when those treatments have never been safety tested or approved by the FDA and the outcomes are unclear at best? How are June Eastwood, Luna Younger, readers of this article, and others ultimately impacted by the use of "she" versus "he" versus some other descriptors to report the material facts of these cases? Is it inherently bigoted or an act of psychic violence against Eastwood, Younger, or others to pose such questions? How did we get here?

Throughout our history as a biologically dimorphic species, humans living in organized societies have established gender roles based on and differentiated by male and female sexes; and there has been a well-documented history of people whose anatomy and lived experience have deviated from dimorphic gender norms. But it wasn't until the mid-20th century that surgical and pharmaceutical sex reassignment therapy became available, which arguably thrust us into an entirely uncharted biological and philosophical landscape. In 1952, Christine Jorgenson, formerly George Jorgenson, captured the world's imagination when she underwent one of the first successful sex change operations. It was around that time that use of the

word "gender" began to expand beyond a descriptor of biological sex. "Queer Theory" emerged in the latter 20th century and popularized definitions of "gender roles," or behavioral characteristics and expectations based on biological sex. Meanwhile, coalitions of lesbian, gay, and bisexual activists worked to force psychiatric institutions to eliminate the diagnosis of homosexuality as a mental disorder from the psychiatric Diagnostic Statistical Manual of Mental Disorders (DSM) in 1973, after which the "LGB" umbrella expanded into the current "LGBTQ+" to include transgender, queer-identified, and other activists working to ensure the physical safety and equal opportunity of gender non-conformists.

However, with the recent and ever-broadening expansion of this umbrella, competing interests conflict with common goals among these subgroups. Transgender politics in particular seems to have eclipsed the long-standing shared goals of the LGBT community to live and love as they see fit, with equal access to protections and pursuit of happiness under the law. Organizations such as PFLAG, which formed to protect LGTBQ+ people from harassment and discrimination, have expanded their missions to promote laws which mandate universal societal norms of expression, interpretations of physical reality, and most importantly, radically new and untested courses of irreversible medical treatments for children.

How and when did this sea change occur? Who or what was the catalyst?

Throughout the latter half of the 20th century, transgender people were medically defined by the DSM as suffering from "gender identity disorder" (GID), a mental illness. Criteria

for diagnosis were largely based on the patient's stated perceptions and desire to conform to gender norms of their opposite biological sex. Early treatment protocols favored non-surgical therapies which guided patients toward acceptance of their biological sex. Dr. Paul McHugh, the now-controversial chief of psychiatry at Johns Hopkins from 1975 to 2001, pioneered this treatment protocol, shuttering one of the nation's first gender reassignment clinics after only a few years at the helm. McHugh's legacy continues to embody the 20th-century paradigm that a patient's intense discomfort with their genitalia and secondary physiological sex characteristics, and assertion that their biological sex is fundamentally mismatched with their experiential existence in the larger world, indicates a kind of psychiatric delusion best treated with therapy which guides the patient reconcile their feelings with their physical body, rather than adapting the physical body to reflect the patient's inner experience and described preference.

Defining this state of dysphoria as a mental disorder has unquestionably been stigmatizing for transgender people diagnosed as mentally ill, who have historically been ostracized, physically abused, and worse. Vigorous pushback against this stigma certainly seems warranted and may explain both the scope and popular acceptance of trends among LGTBQ+ activists, who have sought to redefine themselves and their environment. Trans activists in recent years have successfully popularized the concepts of gender identity as an infinitely fluid, self-determined continuum, and biological sex as non-binary, socially constructed, and largely irrelevant to material reality. In the postmodern tradition, these concepts have been deployed largely through popular use of language, specifically introduction of various gender-neutral pronouns and popular redefinition of "he" and "she" to mean the subject's preferred gender identity rather than their

biological sex. This deployment was successful enough by 2016 to inspire New York City legislation enforcing use of preferred pronouns, followed in 2017 by passage of the similar Canadian law which sparked Professor Jordan Peterson's meteoric celebrity when he publicly opposed it. The same year, AP announced its adoption of "they" for gender-neutral use. Enthusiastic popular endorsement of treatment protocols which adapt trans people's physical bodies to their experiential reality, rather than the other way round, has firmly taken hold.

Meanwhile release of the DSM-5 in 2013 officially replaced the GID diagnostic definition with "gender dysphoria"—deliberately shelving the term "disorder." There was considerable controversy about whether to retain any diagnosis categorizing transgender people, but the classification was included because transgender people seek medical remedies to treat their gender dysphoria, for which a diagnosis is required in order to get insurance coverage and access to care. Herein lies a conundrum: if transgenderism is simply part of the natural variation in an infinitely diverse physical world and there is no medical condition associated with transgenderism, why do transgender people seek medical care which can't be provided with existing diagnoses applied to the general population? Must we choose between labeling transgender people, currently estimated at approximately 3% of the population, as inexplicably delusional from very early childhood, or conversely declaring sex and gender to be social constructs which exist on their relative continuums, in a world in which babies are routinely born into "wrong" bodies which require radical surgery and lifelong chemical therapy to correct? If our species has always been gender-fluid and non-binary and has evolved to be so, with 3% of us landing in wrong bodies from birth, how have we survived the last several hundred millennia without these interventions at the ready?

Contemporary paradigms of transgenderism present another conundrum: distinct and fixed gender roles must exist in order for children to recognize one set of roles and identify into the other. If children are encouraged from birth to dress, play, behave, and inhabit the world in ways which feel comfortable and natural to them, as LGB activists and feminists have advocated for decades, then there are no rigidly defined sets of gender roles for children to toggle between. Almost all contemporary children are tracked into activities they love, while biological males and females are welcome to wear all styles of formerly gender-specific clothes. The diagnostic criteria for gender dysphoria include "strong preference for wearing clothes typical of the other gender," "rejection of toys, games, and activities typical of the other gender" and "strong preference for toys, games and activities of the assigned gender." What's the "other" gender if gender is fluid? And since, according to contemporary gender theory, children and adults of infinite genders with no material biological sex toggle between two discrete but gender-non-specific classes of clothing, games, activities, and behaviors at a constant rate, there's no way to accurately determine any gender at all after a single generation puts these theories into practice. So even if children experience dysphoria inside their bodies, they have no means within contemporary gender theory to classify or categorize what gender they are or what they might become to alleviate it—nor do clinicians have the ideological or clinical framework with which to treat gender dysphoria. From which gender is the patient transitioning, and to where? The common denominator of this infinitely muddled and circular theoretical message to children becomes: if you feel uncomfortable in your own skin at any time, hormone therapy and surgery are medically necessary.

If we concede that gender dysphoria is neither a psychiatric delusion, nor can it be a standard point along an infinite non-binary spectrum of experiential diversity if the human species is sexually dimorphic, there may be a third possibility: does it make sense to classify gender dysphoria within the broader category of intersex conditions, which includes the condition formerly defined as "hermaphroditism?" The term "intersex" describes the class of medical conditions involving variations in the system of dimorphic sex characteristics which enable our species to reproduce, including gonads, hormones, chromosomes, and genitalia. These conditions vary in complexity and the comprehensive understanding of what constitutes an intersex condition is not strictly consistent across medical and popular disciplines; at least philosophically, gender dysphoria seems to fit within this category. While the diagnostic criteria for GID outlined in DSM-IV specified that "the disturbance is not concurrent with *physical* intersex condition" [emphasis mine], it seems possible that there may be some sex-specific element of cognition which could possibly be impacted by anomalies or disruptions of endocrine function. Studies examining sex-specific distinctions of the human brain have yet to yield firmly conclusive results, but there is ample evidence that hormones can bear upon cognitive function. Transgender people are at disproportionately high risk for other psychiatric issues, including depression, anxiety, attempted suicide rates as high as 42%, and notably autism spectrum disorder (ASD). While the American Academy of Pediatrics (AAP) speculates that trans youth are at greater risk for depression, anxiety, and suicide primarily due to inadequate social acceptance, this can't be the case for ASD. Furthermore, there's compelling evidence that chemical and surgical transition don't significantly reduce suicide risk.

The 2012 documentary "Intersexion" features accounts of

various people with intersex conditions, many of whom grew up to realize the sex assigned to them by their endocrinologists and surgeons, often for convenience or ease of treatment, was fundamentally mismatched with their innate experiential sense of sex and gender. These compelling stories tragically illustrate the immense pain and suffering caused by surgical procedures which were often medically unnecessary, offered with the promise to confer a reasonable facsimile of the desired sex traits in both appearance and function, but rarely did. These patients truly had their gender assigned to them, not by recognition of their genitalia at birth, but by medical interventions administered without adequate informed consent. Certainly the majority of intersexual people have loving parents who want the best for them, and compassionate healthcare providers following what they understand to be the most beneficial, rigorously vetted standard of care. And yet, many intersexual people denied the opportunity to grow up in their healthy, functional yet atypical intersex bodies until they came of age, now find themselves traversing an uncanny valley. They must accept and live in their post-operative bodies, as they attempt to reconcile their current selves and what happened to them without their consent. Their plight offers a chilling harbinger of possible outcomes for the pediatric transgender population currently undergoing irreversible social, chemical, and surgical transition at increasingly younger ages, based on expressed childhood desires which carry implications they couldn't possibly understand.

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Estimates of people who identify as transgender increased 9-fold between 2011 and 2016. While much of this increase is attributed to greater social acceptance and early identification, there are indications that social contagion over media platforms may contribute. Accurately tracking and understanding trends among transgender youth is difficult when definitions, diagnostic criteria, and recommended treatment protocols change so rapidly. In 2007, the generally accepted treatment protocol for transgender children was "watchful waiting" along with psychiatric counseling, implemented by Dr. Kenneth Zucker—another leading psychiatrist in the field who was once renowned and now controversial. He ran the highly sought-after and successful Child Youth and Family Gender Identity Clinic (GIC) for decades, through the Center for Mental Health Addiction (CAMH) in Toronto; but his careful, traditional approach ultimately got him forced out of practice by trans activists in 2015. Under Zucker's watchful waiting approach, the desistance rate among transgender patients, or rate of those who went on to happily identify as the gender consistent with their biological sex, hovers around 80%. This figure is consistent across studies conducted prior to the shift in recommended best practice toward a potentially irreversible multi-stage course of social, chemical, and surgical interventions, initiated well before the onset of puberty.

The watchful waiting approach and 80% desistance rates have disappeared in the last decade. The first pediatric gender transition clinic in the U.S. opened its doors in Boston in 2007; there are now at least 50 such clinics across the country. There was a 20% year-over-year increase in gender reassignment surgeries from 2015-2016. More significantly, the Obama administration issued guidance to all public institutions in 2016, urging a fundamental change in Title IX interpretation to include transgender students. Although the

Trump administration revoked those guidelines, in 2016 the AAP partnered with the Human Rights Campaign, a non-profit organization advocating for LGBTQ* communities, to issue a report overhauling the recommended treatment protocols for transgender youth. In their joint updated report issued in 2018, the AAP replaced the watchful waiting approach with a new protocol termed "gender affirmation." This approach encourages "social affirmation" as soon as young children can express their preferences, followed by puberty-blocking drugs as early as age 8 or 9, subsequent cross-sex hormone treatment, and surgery during teen years. Use of the puberty-blocking drug Lupron, listed as "reversible" in the AAP report, is entirely off-label and without FDA testing or approval for gender affirmation treatment. An overwhelming body of evidence suggests it may confer profound, lasting, or fully irreversible side effects. There is relatively little long-term data reflecting what happens to kids who grow up on Lupron followed by cross-sex hormones, which increase cardiovascular risk, and surgeries which carry myriad risks difficult to quantify. Although there is no comprehensive data on desistance rates among children treated with the integrated "gender affirmation" protocol, the path is a much more difficult one to reverse. Anecdotally, hundreds of detransitioning accounts are beginning to emerge—remorseful youths and young adults which are harrowingly similar to those of intersex patients. How did transgenderism and the accompanying radical medical interventions explode so quickly with such ubiquity in every facet of our culture? With treatment centers and pharmaceutical companies banking record profits—Lupron treatment cost $10,000-20,000 per year in 2015—we must ask ourselves, *who really stands to gain?*

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Sarah Dillingham is a freelance writer on matters of health and wellness, and mom to a rambunctious boy in the D.C. suburbs.

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