Saturday, 21 January 2023 Section 6

Notes: Stephen B. Levine, M.D. What to Do? Physicians and Mental Health Workers

Two articles are recommended and are attached:

1) *Reflections on the Clinician's Role with Individuals Who Self-identify as Transgender* by Stephen B. Levine

2) Reconsidering Informed Consent for TransIdentified Children, Adolescents, and Young Adults

by Stephen B. Levine, E. Abbruzzese, and Julia M. Mason

*This evaluation is specifically for teenagers, not children or adults.

1) Trans people are human beings. Trans people tend to think that they're a special brand of human being, that the rules don't apply to them. But everything true of humans is true of trans people. The person/family members in front of you seeking council are human beings.

2) Maintain family bonds for ongoing mental health throughout life. Everything we know in mental health in the 100+ years that it's been a field of study is that human connection facilitates maximum adaptation. Being isolated/alone/cut off is not good for you and family's mental health. For the mental health of patient, parent, sibling, preserve the parent-child bond in entire arc of life. Do not alienate each other permanently, even if temporarily angry with each other. "I can disagree with you; I can still love you." "I can hate you today; you're still my family."

3) All human beings are ultimately ambivalent about everything that they do; they weigh the positives and negatives to their decisions. The parent is the spokesperson for the worries the teen has but isn't yet old enough to recognize. Doctors consider the advantages and disadvantages of a particular treatment; they think of the hoped-for and actual benefits and know the harms/consequences of a particular intervention. In general, a child with a trans identity usually wants hormones, social transition, and eventually surgery. Because of the strength of their desire, they minimize the dangers/risks (e.g., conceptualizing having a baby later in life, sterility, sexual dysfunction, etc.). Parents are able to intuitively say what their concerns are going forward; they have read about or understand the harms, the changes in social life, and human interaction that will occur (e.g., the difficulty forming a lasting love bond as an adult). The child has some awareness of the risk, and denies those risks. The parents have stronger emotionally-laden awareness of the risks. It's not "child/teen vs. parent". The parents are the spokesperson for a larger picture of all the benefits/risks. (Parent usually talks about risks, child usually talks about benefits.) Child has the worries but won't admit to them or can't fully appreciate them. Ambivalence about taking hormones or removing one's anatomy is to be expected, because trans people are people, and people are ambivalent about most major things they do.

4) There is an important difference between "trans-phobic" and "trans-wary." The teen is the captain of their ship. Some people encourage the child to think of their parents as "trans-phobic" or "anti-trans". In general when people are accused of things, in order to avoid an argument, plead guilty but change the

language: "I'm not trans-phobic, I'm trans-wary / trans-concerned / trans-skeptical." I'm not anti, I'm worried. Sometimes in talking to a teenager (with or without the parent), doctor says this: It's your life. Ultimately you get to make the decision about how to express your gender. Doctors can give you advice, parents can give you their worries and advice, but ultimately it is your choice. (And it becomes more entirely your choice at a certain age / developmental level.) So if you are in charge of your life, it's important to use reason and lots of opinions and put together what to do and how to live your life. Metaphor to teens: you are the captain of the ship. Your parents think you are steering your ship into the rocks. You think you are steering your ship into deep water to go on a wonderful, fulfilling journey. Doctors don't know the answer of what you'll be like in ten years, whether swimmingly happy or miserable. Ultimately, you are in charge.

5) When doctors don't know what's best, our obligation is to tell the patient/family what we know and what we don't know. This is evidence-based medicine, the whole concept of informed consent. Doctors have an ethical and legal obligation to represent what is the state of knowledge. Doctors don't have data about what's best, otherwise they'd recommend that. (There is more known about how to treat pneumonia; there is less known about how to treat gender dysphoria.) As parents bring their young teen to the doctor (pediatrician, pediatric endocrinologist, psychiatrist, social worker, etc.) and seem to be looking for a recommendation "What should we do, doctor?" Re-think the concept of the doctor giving a recommendation! Doctor may say "I know that some people have reported that they go to a Dr and the Dr says "you're trans" or they make a diagnosis of gender dysphoria, and then they make a treatment recommendation." The people who put together the DSM-5 make it clear that it's a catalog, an encyclopedia of how human beings suffer psychiatrically. It's a diagnosis manual, not a treatment manual. It's putting people in categories in order to think about that category in more detail. In some people's minds there is an automatic link between F64.0 (gender dysphoria) and affirmative care. Similarly to how a doctor may help a patient distinguish between a feeling and having a reaction to a feeling, there is a difference between a diagnosis and having a treatment for that diagnosis.

6) Final Thoughts:

The initial evaluation of child's development derives from several sources: parents' recollections; child's own memories, formal psychological evaluations, talking repeatedly with family members because over time more relevant information is shared. Often co-morbitities, e.g., autism spectrum. Most of medicine considers the patient is most important focus. If under age, however, it is the family that is most important. In final evaluation session, tell parents what the findings are, not simply what the next step should be. The usual recommendation is to rebuild connection between parent and child, address the underlying problems, and set up an ongoing relationship with the child and family. Generally doctor doesn't say and should not say, "your child needs to be put on hormones." Decision by underage child about their dysphoria is made in consultation, over time, by the parents knowledge of the field and profound knowledge of their offspring. This adult process takes into account with child's history, capacities, limitations, desires, and previously defined physical and mental problems . Parents have moral and legal obligation for health and welfare of child. All of us - doctors, parents, child - must cooperate in order to make this decision. We are united in trying to help the captain be an effective captain of the ship. Over time, with thoughtfulness, then a decision decision made. The decision to delay is quite reasonable particularly if it includes ongoing work with the child and family. We want the doctors to be deeply trusted for their caring, knowledge of children's psychologies, and knowledge of the field so that our agreed upon goal—to enable the child to grow up to be an excellent captain—is most likely to be attained.