

Moving Beyond Mismatch

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Trans adolescents who are denied puberty-blocking treatment (PBT) by unsupportive parents can -- and often do -- suffer devastating psychological and physical harms. In their insightful article, Maura Priest outlines these harms, drawing on substantial empirical evidence to show that trans adolescents' experience of undergoing puberty of the "wrong" gender frequently results in serious, long-lasting, and potentially irreversible harms (Priest 2018, 16).¹ Among these, Priest notes the vastly increased risk of suicide, future need for complex and costly surgeries, and self-medication with counterfeit and sometimes toxic puberty-blockers. Given all this, Priest argues that the state should reduce harms to trans youth by ensuring their access to PBT independently of parental approval (Priest 2018, 4).

I support Priest's proposal. Like Priest, I think the evidence regarding the effects of denying medical care to trans youth -- or, indeed, any trans person -- leaves little room to doubt that providing this care is crucial. And, like Priest, I believe that the state should intervene when parents deny crucial medical care to their children.

That said, I have reservations about how Priest frames their argument. In what follows, I first briefly argue that this framing ignores additional social explanations for the psychological costs of denying PBT to trans youth. I then argue Priest relies on a cisnormative framework -- i.e., a framework that assumes certain bodily features 'match' certain gender identities -- that not only is philosophically treacherous, but also renders invisible nonbinary and gender non-conforming (GNC) youth. In closing, I suggest Priest's conclusion would be strengthened by including arguments based on informed consent, in addition to harm reduction.

¹ Here and throughout the paper, I will use 'they' as a singular, gender-neutral pronoun. For philosophical reasoning behind this decision, see Dembroff and Wodak (2018).

1. Psychological harms aren't just from the head

Priest argues that denying trans youth PBT causes harms that are accounted for by an internal mechanism: gender dysphoria. Priest defines this dysphoria as “the feeling of disconnect and unease at the difference between one’s biological gender and one’s sense of gender identity” (Priest 2019, 47). According to Priest, this “difference” is often “insufferable”, and is exacerbated for trans youth who undergo puberty of their assigned sex (47). Such insufferable dysphoria, Priest claims, explains subsequent psychological and physical harms.

I don’t deny that gender dysphoria is an important explanation of these harms. But Priest’s argument suggests, by omission, that anti-trans stigma and discrimination is not an additional central explanation. This suggestion unnecessarily medicalizes trans identities, and also ignores nefarious social realities. While Priest does discuss negative health outcomes for trans youth with unsupportive parents, parents are but one piece of a larger system that demands and enforces gender conformity. This is not to downplay youths’ psychological discomfort or dysphoria. But even if such dysphoria were explained entirely apart from social factors -- which is dubious -- we must still ask why this dysphoria often is psychologically devastating. What is it about this ‘mismatch’ that leads trans youth to attempt suicide ten times more often than their peers? Placing the blame solely on gender dysphoria ignores the place of daily bullying and harassment in trans youths’ lives. PBT is needed not only to assuage an internal dysphoria, but also to help youth (who so choose) to navigate hostile social environments that give them vanishingly few options for socially legible and acceptable bodies.²

2. Beyond the ‘mismatch’ model

My second concern with Priest’s argument concerns its reliance on a version of the ‘wrong body’ or ‘mismatch’ model of trans identity -- a model that prevails within discussions of trans medical care.³ Talia Bettcher (2014, 383) describes this model as one where “transsexuality involves a misalignment between gender identity and the

² For another example of a case where, it is argued, doctors should provide medical procedures to help patients cope with unjust social norms (while also working to change those norms), see Earp (2013).

³ E.g., “For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her” (American Psychiatric Association (2013): gender dysphoria).

sexed body,” such that trans persons are “trapped in the wrong body.” While Priest does not use the ‘wrong body’ language explicitly, Priest does explicitly attribute to trans youth a “mismatch” between their bodies and gender identities. This model of trans identity has been sharply criticized by Bettcher (2014), Engdahl (2014), and Halberstam (1998), among others, who argue that it pathologizes trans persons, essentializes gender, reinforces the gender binary, and marginalizes trans men and women even when granted status as men and women. I set these arguments aside to focus on two criticisms of the ‘mismatch’ model as it is deployed in Priest’s argument.

My first criticism concerns the argument’s failure to address nonbinary and GNC youth’s right to PBT. In particular, the argument’s framing suggests not only that certain sets of bodily features ‘match’ particular gender identities, but also that PBT is only needed by youth whose biological features ‘mismatch’ with their gender identities.

To see why this is, we must begin with Priest’s claim that PBT is necessary for youth who suffer from gender dysphoria. Priest describes this dysphoria as affecting youth who “insist that they are the gender opposite the one on their birth certificate,” and then proceeds to describe these youth as struggling with “mismatch between their physical body and their gender identity” (Priest 2018, 48). From this framing, and through a variety of examples, Priest’s argument strongly suggests that certain bodily features ‘match’ certain gender identities: namely, masculinity and male-coded bodily features (facial hair, broad shoulders, etc.) ‘match’ male gender identity; femininity and female-coded bodily feature (breasts, low waist-hip ratio, etc.) ‘match’ female gender identity.⁴ From this, it seems that Priest assumes that adolescents’ right to PBT is predicated on their having an internal gender identification deemed a “mismatch” with their bodily features, such that PBT is needed to minimize the psychological harms of this mismatch.

Consider an example. Suppose an adolescent was assigned male at birth and considers themselves male, but nevertheless wants to begin PBT and eventually move on to hormone therapy. This adolescent does not, by Priest’s definition, experience gender dysphoria. They do not identify with a gender other than the one they were assigned at birth, nor do their bodily features ‘mismatch’ with their gender

⁴ Priest (2018, 8): “PBT freeze the child in time physiologically. Hence, a transgender boy need not go through the horrors of developing breasts nor a transgender girl look in the mirror and see facial hair.”

identification. Yet, on my view, the adolescent in question is equally entitled to PBT as their trans peers. The fact that they identify as male does not render their desire to control their gender expression any less legitimate or important. To assume otherwise is to assume that there is a natural ‘match’ between male (or female) gender identification and a certain set of physical features, and furthermore, that only ‘trans’ and never ‘cis’ youth experience gender dysphoria, or desire gender nonconforming features.

The example illustrates a larger, serious problem with Priest’s reliance upon the ‘mismatch’ model: it renders invisible nonbinary and “cis” GNC youth (i.e., youth who identify with their assigned gender, but resist norms associated with this gender). Indeed, Priest’s paper fails to mention genderqueer or nonbinary youth even once. This is, to my mind, a shocking oversight. It is particularly shocking given that an estimated 30 to 40% of trans-identifying youth identify outside of the binary (Clark et al. 2018; Frohard-Dourlent et al. 2017; White et al. 2018).

And yet, given the argument’s framing, this omission is easily diagnosable: there is no gender expression or set of bodily features that ‘match’ with nonbinary gender identification (Dembroff 2018; manuscript).⁵ While some nonbinary youth seek out PBT and other medical interventions, this is not due to identifying as nonbinary *per se*, because there are multitudes of ways to embody nonbinary identification. By basing adolescents’ right to PBT on a ‘mismatch’ between gender identification and bodily features, then, Priest’s argument undermines nonbinary and GNC adolescents’ right to this medical care.

Granted, this framing is not unique to Priest’s argument. The medical establishment at large, including relevant academic literatures, has similarly marginalized nonbinary and GNC youth (Connolly et al. 2016). As Clark et al. (2018) shows, even though fewer nonbinary youth seek hormonal therapy than their trans binary peers (trans boys/men and trans girls/women), they are twice as likely to experience barriers accessing this therapy. This finding is echoed in Lykens et al (2018, 191), which describes nonbinary young adults as experiencing frustration and pressure to conform to binary gender narratives in order to access medical care. Given that Priest’s argument is entirely based on harm-reduction, and thus is beholden to

⁵ While Priest could modify the concept of ‘mismatch’ so as to explicitly concern the individual’s experience of mismatch, whatever it may be, Priest’s current illustrations of mismatch repeatedly rely on stereotypical social expressions of femininity and masculinity as matching (or mismatching) with female and male gender identifications.

evidence of negative health outcomes for youth who are denied access to PBT, these findings suggest an urgent need to recognize nonbinary youth's right to medical care such as PBT. As it stands, Priest's argument leaves nonbinary and GNC youth without claim to this care.

Moving on from this point, I have two further and related concerns about Priest's reliance on a 'mismatch' framework. First, it sets up harm reduction, as measured through a psychiatric diagnosis, as the sole justification for youth's access to PBT.⁶ This forces trans and GNC youth to rely on others' evaluations -- albeit those of medical professionals and not parents -- for access to PBT, rather than relying on self-evaluations concerning whether PBT would contribute to their flourishing. Second, for Priest, PBT is a needed step to reduce psychological harms that result from gender dysphoria. But why is psychological distress the lone gatekeeper for accessing PBT? What if PBT simply increased an adolescent's flourishing, without their having previous psychological distress?

Andrea Long Chu (2018) succinctly captures the dangers of this approach to trans medicine. If trans medicine "retains the alleviation of pain as its benchmark of success," Chu writes, it allows authorities (such as doctors, parents, or the state) to, "with a dictator's benevolence... withhold care from those who want it," including whenever they deem potential harms from denying this care insufficiently serious.⁷ Chu's point is particularly salient given medical professionals' history of discriminatory, humiliating, and dismissive treatment of trans patients -- a history that undermines confidence in their ability to assess these risks in a way that ultimately benefits trans patients. Chu's argument should, I think, lead us to question both whether medical professionals are trustworthy evaluators of trans and GNC youth's need for PBT, as well as whether psychiatric distress should be a prerequisite for their access to PBT.

⁶ Of course, one could run a purely harm-reduction argument for youth access to PBT *without* relying on the wrong body model. However, this model is aptly suited for a harm-reduction model, as the term refers to the models used in diagnostic practices, all of which take "discomfort" and/or "dysphoria" as a necessary marker of being trans. For more discussion, see Engdahl (2014).

⁷ Chu's focus is on denial of care when accompanying risks are deemed too high, but Chu's point also applies to cases where risks of *not* providing care are deemed too low to warrant providing care.

By focusing solely on harm-reduction as judged through the lens of psychiatric diagnosis, Priest becomes mired in a debate as to whether evidence that many trans children “revert back to their natal gender” defeats adolescents’ right to PBT. But Priest’s four arguments against this supposed defeater do not include the point that doctors, parents, and the state should not be, nor are qualified to be, “dictators” of adolescent bodies, particularly given that PBT does not result in permanent bodily alteration.

Pulling back to a larger point, I think this and broader discussions of trans medical care would do well to integrate an “informed consent model” of trans care alongside considerations of harm reduction, gender dysphoria, and gender ‘mismatch’ (Schulz 2018; Cavanagh, et al. 2016). On an informed consent model, access to gender-related medical interventions are not based on ‘fixing’ gender variance as a mental disorder. As Schulz (2018, 83) puts it, “[On this model], access to services is granted based primarily on the ability to consent to care, not whether or not the clients meets the criteria for psychiatric diagnosis.” In other words, this model recognizes an individual’s right to make decisions about their preferred gender expression, regardless of whether this expression clashes with cultural expectations, and independently of whether they experience psychological distress from gender dysphoria.⁸ With the additional framework provided by this model, it becomes clearer that trans, nonbinary, *and* ‘cis’ adolescents’ right to PBT is not only justified because it diminishes harms, but also because these youths should be given the autonomy to make a low-risk, impermanent decision regarding their preferred gender expression.⁹

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⁸ My position here is compatible with, but weaker than the line taken in Flanigan (2017), which argues that the right to informed consent justifies access to any pharmaceutical medication. While I agree with Flanigan that informed consent justifies access to treatment, and not only refusal of treatment, I here propose only the restricted claim that, given the history of anti-trans bias in the medical profession, an informed consent model provides epistemically more reliable justification for adolescents’ access to PBT than does the standard model.

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