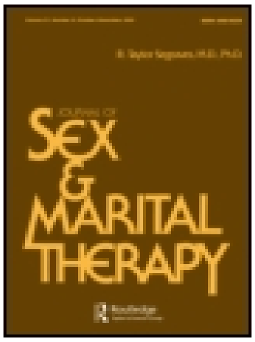

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Informed Consent for Transgendered Patients

Stephen B. Levine

Department of Psychiatry, Case Western Reserve University School of Medicine, Cleveland, Ohio, USA

ABSTRACT
The request of a transgendered-identified patient for psychiatric, medical, or surgical services creates ethical tensions in mental health professionals, primary care physicians, endocrinologists, and surgeons. These may be summarized as follows: Does the patient have a clear idea of the risks of the services that are being requested? Is the consent truly informed? While this question is starkly evident among cross-gender identified children contemplating puberty suppression and social gender transition and young adolescents with rapid-onset gender dysphoria, it is also relevant to young, middle-aged, and older adults requesting assistance. Many patients cannot tolerate detailed discussion of the risks. This article reviews the history of informed consent, presents the conflicts of ethical principles, and presents three categories of risk that must be appreciated before informed consent is accomplished. The risks involve biological, social, and psychological consequences. Four specific risks exist in each category. The World Professional Association for Transgender Health's Standards of Care recommend an informed consent process, which is at odds with its recommendation of providing hormones on demand. With the knowledge of these 12 risks and benefits of treatment, it is possible to organize the informed consent process by specialty, and for the specific services requested. As it now stands, in many settings informed consent is a perfunctory process creating the risk of uninformed consent.

Introduction

The provision of informed consent for medical interventions is now a widely accepted ethical responsibility of physicians (Lynch, Joffe, & Feldman, 2018). For most of recorded medical history, however, physicians assumed that they knew best, that deception was necessary to generate patient confidence, and that the physician would always act in the patient's best interest (Murray, 1990). These paternalistic ideas have eroded over the 20th century as court decisions sequentially defined patient rights. Informed consent now rests upon several principles of professionalism including physician honesty and respect for patients' dignity and autonomy in decision making (World Medical Association, 2017).

In routine medical care, as long as the physician observes no abnormal behavior or questionable communication, consent is assumed by the patient's acceptance of recommended care. In these situations of *a priori* consent, no documentation is required. When there is a risk of serious consequences from surgical, invasive radiological, medical, or psychiatric treatments, however, signed informed consent documents are required. Informed consent documents ideally verify that the risks and benefits of treatment and alternative approaches were explained, and understood and accepted by the patient. The documents provide legal protection for the physician and assurance that the patient has had a chance to ask questions and to decide. Problems arise when

CONTACT Stephen B. Levine ✉ sbl2@case.edu

patients do not speak the language of their physicians. When patients can be assumed to have adequate reasoning capacity to give consent, consent is legal even if a spouse or parent might not approve. Parents are required to provide informed consent for their children as long as the minor is perceived to have assented. Assent and consent are based on the idea that the circumstance is free of coercion, manipulation, or undue influence. Acutely intoxicated, psychotic, demented, driven, or intellectually deficient older adolescent and adult patients are thought to be unable to prudently weigh the risks of a procedure in terms of their life circumstances. They require a legally authorized representative to provide consent. Informed consent processes and documentation in the busy, practical modern medical practice are often perfunctory. Who provides the consent and how it is done varies considerably (Lynch, Joffe, & Feldman, 2018). These ideas form the basis for considerable ethical uncertainty among mental health professionals, endocrinologists, surgeons, and others who prescribe hormones.

Informed consent for transgendered patients

During the current young century, gender-specialist-determined guidance about informed consent has undergone modification as part of a larger, historically older social movement to depathologize all sexual identity variations—that is, atypical gender identities, homosexual and bisexual orientations, and paraphilias (Levine, 2005). Much of this change has been beneficial to minority groups. However, clinical work in the gender identity arena, which used to be based on symptoms and social, vocational, and educational dysfunction, is now based on sociopolitical concepts. Cultural forces have provided a new narrative about the vital importance of having strict consonance between one's sexed body and gender identity. A previous narrative recognized that all human beings were a subtle mosaic of masculine and feminine identifications. Degrees of cross-gender identifications were often more obvious within gay and lesbian communities than in heteronormative communities. Within about thirty years, body/gender incongruence has gone from being viewed as a rare psychiatric disorder, to a serious medical condition (for legal and insurance reasons [Levine, 2016]), to an increasingly common normal variation of gender identity development that, only when patients request, requires medical assistance (Reed et al., 2016). At the same time, the wish to change one's "sex" (a reflection of the binary view of gender) is increasingly being replaced by the wish to personally define gender as one sees fit (the nonbinary view of gender). Political policy informs clinicians that no gender adaptation is viewed as inherently problematic or a symptom of another developmental problem; the many forms of gender expression are only manifestations of human diversity (Drescher, Haller, APA Caucus of Lesbian, Gay and Bisexual Psychiatrists, 2012). Today these trans-supportive ideas are incorporated in educational, institutional, and corporate policies and increasing insurance coverage for medical assistance (Baker, 2017). Widespread discrimination and patients' fear of accessing health care continue, however, as does the clinical perception that many patients evidence significant emotional and adaptive problems.

Physicians and mental health professionals are caught in this state of cultural flux and left with considerable uncertainty about clinical management. Professionals fall into camps: strong advocacy (Coleman et al., 2011), distinct opposition (Mayer & McHugh, 2016), case-by-case decision making (Levine, 2018a), and avoidance of transgendered patients. These camps exist because science has not yet sufficiently advanced to render irrelevant these seeming political, moral, or psychiatric ideologies (Mueller, De Cuypere, & T'Sjoen, 2017). Scientific uncertainties have not slowed the provision of medical support for somatic transformation at urban specialized clinics that emphasize advocacy as a core component of clinical work (Hsieh & Leininger, 2014; Yarbrough, 2018, pp. 61–62).

The organizing variables

Four major variables shape the informed consent challenges: age of the patient; previous cross-gender life experience; services that are requested; and socioeconomic status. Gender dysphoria may first appear in childhood, adolescence, or adulthood. Each age group poses different questions about risk comprehension. The short and long-term risks that need to be grasped by patients are different when the issue is a new identity label, social transition, hormones, or surgery. For instance, an impoverished, runaway transgendered 18-year-old, a 40-year-old married professor who has only cross-dressed for masturbation, and a trans woman who is seeking her third cosmetic surgery since her vaginoplasty cannot be dealt with in the same way. In each of the diverse clinical circumstances, professionals have to balance honesty, beneficence, nonmaleficience, justice, and respect for patient autonomy—ethical principles that often conflict—in ways that can be openly discussed among their colleagues. Without discussion, their clash may cause unrecognized distress and negative reactions to all work with transgendered patients.

Is respect for autonomy the overriding ethical principle?

Until about a decade ago, professionals were required to assent to medical or surgical intervention after a thorough psychiatric evaluation, with or without continuing psychotherapy. Mental health professionals functioned as gatekeepers who made recommendations, by individuals or committee, about a patient's eligibility and readiness for social transition, hormone administration, or gender-conforming surgeries. With the revision in 2011 of the Standards of Care by the World Professional Association for Transgender Health (WPATH), a new *process model* of informed consent was encouraged. It asserted that patients know best what they need to be happy, generally meaning that patient autonomy is the singular ethical consideration for informed consent (Cavanaugh, Hopwood, & Lambert, 2016). This includes children and adolescents. The mental health professionals' roles in recognition and treatment of the highly prevalent psychiatric co-morbidities and decisions about readiness were deemphasized, particularly by the pronouncement that there is nothing pathological about any state of gender expression. Minority stress was invoked as the major cause of the associated psychiatric burdens. Nonetheless, the professionals' central concern for patients' futures and their families remain the same—do the patients understand what risks they are undertaking? Under what conditions can it be said that the patient's consent to treatment is sufficiently informed?

Helping patients to grapple with relevant questions

Professionals with various degrees, ranging from master's degrees, PsyDs, PhDs, and MDs, work with these patients at differing stages of the transition. Unlike other arenas of medicine where the physician has the responsibility for informed consent, all clinicians bear responsibility to discuss aspects of risk and alternative possibilities. All of these patients should be helped by their clinicians to grapple with four relevant questions. Their answers provide the professional with a judgment about how realistic the patient is being:

1. What *benefits* do you expect that the consolidation of this identity, gender transition, hormones, or surgery will provide?
2. What do you understand of the social, educational, vocational, and psychological *risks* of this identity consolidation and gender role transition?
3. What do you understand about the common and rare, short- and long-term medical and health *risks* of hormone and surgical interventions?
4. What have you considered the *nature* of your life will be in 10 to 20 years?

In some gender clinics, a large percentage of gender nonconforming patients are emancipated youth. They consist of runaways, disowned persons, or those who have aged out of foster care. They may be living hand to mouth on the streets and may be periodically homeless. Some of this group turns to criminality and/or sex work. They have a high prevalence of drug abuse and are at high risk for sexually transmitted diseases. How they synthesize the answers to these questions is much different from less desperate youth and older adults with more education and functional family relationships. Whatever the socioeconomic status of the patient, the professional cannot help but to form opinions about how driven, realistic, and contemplative the patient is when listening to the patient's answers.

Professionals grappling with more refined questions

Professionals have knowledge of, or beliefs about, the psychosocial benefits of consolidating identities, transition, hormones, and surgeries. Most highly experienced professionals can provide examples of adolescents and adults who are much happier living in their current gender. Their mental health and function in the world have improved. Such clinical experiences along with previous research about the value of gender-conforming surgeries enable professionals to balance their tensions between beneficence and nonmaleficence. The professionals' personal answers to these questions and their sense of the existing literature inform their decisions:

1. At what *rates* are the patient-expected benefits attained?
    a. What is known about who obtains and who does not obtain these benefits?
    b. How lasting are the benefits?
2. What have outcome studies demonstrated about the social, vocational, and mental health *risks* of transition?
3. What is the *rate* of returning to birth-assigned gender when transitioned before puberty, during puberty, late adolescence, or adulthood?
4. What have outcome studies established about the short- and long-term *rate* of complications of hormones on physical health for trans women and trans men?
5. What has my clinical experience established about the *rate* of these hormone risks?
6. What have outcome studies established about the short- and long-term risks of gender-conforming surgeries for trans women and trans men in terms of psychosocial outcomes?
    a. What measured parameters form the basis of the conclusions?
7. What have outcome studies established about the *rate* of somatic complications of the major surgical procedures employed for trans women and trans men?
8. What has my clinical experience established about the psychosocial and somatic outcomes of gender-conforming surgeries for trans women and trans men?
    a. What parameters of evaluation has this been based upon?
9. What aspects of gender dysphoria (incongruence) are and are not cured by medical interventions?
10. What accounts for any evident psychiatric diagnoses?
    a. Dysphoria about body?
    b. Internalized cultural tensions of being in a sexual-minority group?
    c. Inherent problem due to developmental forces other than gender?
    d. Acquisition of the new identity is associated with great fear of the future?
    e. Experienced discrimination?

It is apparent that the more these questions are refined, the more limited knowledge becomes. Thus, informed consent is based on a great deal of patient and professional hope about the future. A number of data sets have indicated significant concerns about premature mortality from medical and psychiatric conditions (Dhejne et al., 2011; Simonsen, Giraldi, Kristensen, & Hald, 2016) and ongoing functional limitations (Zeluf et al., 2016), substance abuse, depression, and psychiatric hospitalizations (Dhejne, Van Vlerken, Heylens, & Arcelus, 2016). Complications of surgery exist for each procedure (van de Grift et al., 2017).

Who bypasses informed consent?

Informed consent assumes that the patient or the family has involved a professional in the decision-making process. This is far from invariable. Some parents transition their child before puberty. Adolescents can readily obtain hormones on the Internet without seeing a physician. Some students use being at college away from home as an opportunity to transition without family knowledge. Poor trans women have been known to inject silicone into various body parts without medical help. Some individuals from all socioeconomic backgrounds are not actually dysphoric; rather, they are interested in transition without medical help as an adventuresome exploration of gender nonconformity.

Risks that transgendered patients should be informed about

Although the mental health professional would seem to be the professional who is best equipped to answer the question whether the patient is in a psychological state that can tolerate being informed about the risks, no physician is exempt from making this determination. This question is no less paternalistic than the assumption that competence in this arena is characterized by the commitment to advocacy. This widely promulgated idea is based upon the idea that science has already established what is best, ignoring facts to the contrary. The resolution of the existing tensions rests upon the professional obligation to introduce the relevant risks at various nodal points during health care. Respect for patient autonomy enables patients to make decisions; nonmaleficience requires that the professional discuss these risks.

The biological risks

1. Loss of reproductive capacity—infertility.
    a. **Children being considered for puberty blockade.** While this is not currently relevant to these patients and families, this long-term consequence will set in after a decade or two, when reproductive longings may emerge. Parents, who are just trying to allow their child a greater degree of happiness, may have a difficult time imagining their child as one day wanting to be a parent.
    b. **Older adolescents**. Adolescents may be only slightly receptive to weighing this risk to their future reproductive aspirations. The teenagers may claim irrelevance ("I don't want to be a parent"), speak of belief in the progress of medical science, or recall reading on the Internet about a trans adult's reproductive success. The young patient's passionate certainty is a barrier to informed consent.
    c. **Adults.** Depending on the age, relationship status, mental health, economic status, and past reproductive experience, this may or may not be relevant. In those with intact genitalia, reproductive capacities may return when hormones are discontinued.
2. Impairment in sexual physiological capacity for arousal and orgasm.
    a. **Children being considered for puberty blockade.** The professional first shares this with the parents, who may then be able to discuss this with their child, with or without the

   professional's direct assistance. Puberty-blocking hormone treatment keeps the child puerile, which may delay discussion of this matter further. Both professionals and parents may be resistant to bringing this up.

   b. **Older adolescents**. When cross-gender hormones are administered at age 16 after three years of puberty blocking, androgens can be expected to create more sexual drive, while estrogens can be expected to lower sexual drive in the same short time period. This does not mean masturbation and partnered sex are augmented or diminished, respectively, because interpersonal and psychological forces, including those undertaken to affirm one's new identity, also shape sexual expressions. Discussions of sexual physiology are far easier than discussing masturbation and partner experiences in detail.
   c. **Adults.** Biological males may expect lessening drive, erectile turgidity, ejaculate, and shrinking of testes and penis. Some may be rendered unable to sustain an erection, which may or may not become a problem with partners. Those with intense penile dysphoria may prefer anal penetration for mental arousal purposes when alone or with a partner and try to be inattentive to their genital state. Androgens seem to enhance the sexual lives of biological female patients, creating pleasing clitoral enlargement. Genital sensation after vaginoplasty, phalloplasty, and metoidioplasty may be markedly reduced despite advanced techniques to preserve sensation. Much has been written about the negative intrapsychic and interpersonal consequences of anorgasmia among cisgendered individuals (Graham, 2014; Perelman & Watter, 2013) that ultimately is applicable to the transgendered.

3. Shortened life expectancy. The reasons for this are varied and include infection (particularly HIV among low-economic status MTFs), cancer, cardiovascular disease, and suicide. (Blosnich, Brown, Wojcio, Jones, & Bossarte, 2014; Brown & Jones, 2016). Worldwide estimates of HIV infection rates among transgendered individuals are up to 17-fold higher than the cisgender population. Among trans-identified veterans at the Veterans Administration Hospitals, suicide is twenty times higher than control group; their reduced life expectancy of twenty years from all causes is similar to those with serious mental illness. Patients and professionals share the hope that as the world becomes more accepting, psychosocial stressors will be less destructive, health habits will improve, addictions will lessen, access to health care will improve, and transgendered people will live longer. As illustrated by the changes from one U.S. federal administration to the next, progress cannot be depended upon.
4. Biological sex cannot be changed. The belief in becoming a complete man or woman refers to socialization, not biology. Transgendered people can live in a new gender and feel comfortable doing so, but their genetic endowment leaves them potentially vulnerable to sex-linked illnesses.
   a. Hormones and surgeries help with gender discordance, but many individuals in the quest to appear more female-like continue to request further plastic interventions. Dysphoria about secondary sex characteristics may continue after each intervention, including depilation. At some point, a transgendered person accepts "how I am."
   b. Many trans men patients elect to live with their natal genitalia and accommodate in various ways that leave them vulnerable to gynecologic diseases such as ovarian cancer. In the same way, trans women patients may develop prostate cancer. This is a strong reason for ongoing medical care, which for many transgendered individuals is a difficult process.
   c. Trans men tend to be shorter than the average man. Over time, their smaller stature may pose a psychological burden. Similarly, tall or muscular trans women may be distressed about their size and shape.

The social risks

1. Emotional distancing and isolation from family members.
    a. **Children being considered for puberty blockade**. When a child's behavior is stereotypically like the opposite gender, parents, siblings, aunts, uncles, and grandparents tend to either passionately protect or distance themselves from the child. Often, however, what is observed is not discussed. It is common to have one parent deeply protective and the other one distant. Family structure varies widely—from single parents, to families in chaos, to mutually supportive parents. The classic Dutch work with these children not only excluded chaotic families but provided a great deal of support to those undertaking the experiment (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). Clinicians should anticipate that family members experience the gender-dysphoric child in different ways at different times, which can add to the child's challenges. Pediatricians and mental health professionals may intervene to help both the parents and the child discuss the issue well before puberty, despite the view of some activists that this constitutes "reparative therapy." Such sociopolitical arguments made by strangers to the families suggest that parents have no right to seek help for their concerns about their gender-nonconforming children (FightToGetHerBack, 2018). It is important for parents to be told that the majority of cross-gender identified children desist from their current identities after puberty (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Zucker, 2018).
    b. **Older adolescents**. Feelings of others grow stronger about trans children as these children grow older. Siblings tend to ignore them. Parents may deeply object to bodily transformations and the recurrent intensity of conflict with parents may lead to the adolescent running away. Such families are in need of professional help since family rejection or violence adds to everyone's burdens. Transgendered high school students may be both socially isolating and socially isolated, adding to the high incidence of suicidal ideation, depression, and substance abuse (Rotondi, Bauer, Scanlon, Kaay, Travers, & Travers, 2011; Rotondi, Bauer, Travers, Travers, Scanlon, & Kaay, 2011).
    c. **Adults.**
        i. *Married with children*. When individuals declare their transgendered identity after marriage and after having children, not only does divorce often ensue, but the newly identified parent typically finds that their adolescent and adult children do not want to be in their presence. Some trans adults are "disowned" by their children and spouse. Many trans adults discover that their married siblings do not want them to interact with their children, adding to the emotional cost of transitioning at various points in their lives. Initially the patient may angrily dismiss the conflicted family—"If they won't support me, I don't need them!" This attitude may take years to change.
        ii. *Unmarried*. In acting beneficently to support the transitioning adult, professionals come to realize that they are doing harm to the alienated family, which in the long run will likely harm the patient who loses family support. While medicine's focus is traditionally on the individual patient, this paradox does not disappear because doctors put the patient's needs first (Levine, 2018b).
2. Exchange of existing friends for friends from the transgender community.
    a. **Children being considered for puberty blockade**. As younger children may be the only student in school so identified, the child's social success depends on how he or she relates to classmates, neighborhood children, and cousins. While some of these children have friends of the opposite sex, isolation from peers becomes an increasing problem over time.

   b. **Older adolescents**. It is exceedingly rare to encounter a trans teenager who has not developed "friends" through the Internet, where they are often counseled that they are trans and directed to numerous websites that help them to stabilize their identities. Most have never met these friends. Since many privately transgendered teenagers have not disclosed to anyone in person, their friendship patterns in high school may sustain their self-esteem. Some of these actual friendships, as well as falling in love and having sex, cause them to rethink their identities. The return to their original gender may occur quickly, gradually, or fluctuate over several years. However the return occurs, families are much relieved. For others, sexual inadequacies within intimate relationships serve to consolidate their transgendered identities. Other adolescents are isolated from peers and highly symptomatic. It is a reach to think they only suffer from minority stress.
   c. **Adults.** Friendships are screened for support after transition. When it is not intense, the friendships tend to dissipate. Friendships via the Internet and within the local trans support communities are typical. Some newly transgendered adults have far better social lives within the LGBT community than they previously had. They form a new family with friends to replace or augment their family of origin. This is not the case for many previously socially phobic, autistic, schizoid, or chronically depressed individuals.
3. Greatly diminished pool of individuals who are willing to sustain an intimate physical and loving relationship.
   a. **Children being considered for puberty blockade.** When this idea is discussed, parents may inform the professional that it is their hope that puberty suppression and social gender transition now may enable their offspring to develop a socially attractive personality free of current problems. Love may then come and life may be fulfilling.
   b. **Older adolescents and adults.** Many older adolescents are happy just to have partnered sexual experiences; like many cis teenagers, they ignore the context. With maturation, the relationship context becomes important. The male-to-female in transition may soon realize that she is of sexual interest to a special group of men who are either interested in, or simply curious about, her trans status. While these relationships are initially exciting, they often end when the new woman realizes there is no interest in her as a person. It is important to discuss this pattern to help patients understand the experience of others and to better protect themselves from disappointment. Many are shocked and saddened to hear this. They may feel that they are an exception and this will not happen to them. It is sometimes useful to remind them that transgendered people, like most others, aspire to be loved in a kind, secure fashion but that most people in society should be expected to avoid them as love objects. The lower marriage rates of transgendered adults may reflect these factors (Yarbrough, 2018).
4. Social discrimination.

While many governmental and educational institutions, health-care facilities, large corporations, and professional organizations have policies against discrimination, patient advocates stress that their patients frequently experience discrimination and are traumatized by it (Campbell et al., 2018; Yarbrough, 2018). Those considering transition often reassure themselves that the world is becoming a more welcoming place. This is not a guarantee that *their* world will be welcoming. While some transgendered people have the self-confidence, intelligence, and moxie to deal with these painful situations, not all do. Transgendered individuals with limited education face lower-paying jobs. Discrimination against hiring is significant. Even educated, skilled individuals may be passed over for promotion or have trouble finding new jobs. Discrimination has overt forms such as name-calling, bullying, misgendering, and violence, and covert forms such as failure to be hired, promoted, or be rented an apartment. Many transgendered individuals do not feel safe in the world at large and in health-care settings (Stewart, O'Halloran, & Gates, 2018).

The psychological risks (mental health)

These complex categories of risk are subtly manifested in the short term and often have profound long-term consequences. In the short term, they may remain hidden by the relief afforded by transition, hormones, and surgery.

1. **Deflection from personal developmental challenges that would otherwise be mastered at appropriate times.** Although the biological and social risks of transition ultimately will cause feelings, conflicts, and psychological dilemmas that may produce distressing symptoms, the preoccupation with transition is so powerful a mental process that other developmental tasks—overcoming social anxiety, accepting one's sexual impulses toward others, learning in school, learning how to handle money responsibly, and mastering work tasks—can be ignored, disrupted, or rendered personally unimportant. While this is both an argument for early intervention and for delaying intervention, this risk is separate from the future consequences of minority stress. Humans, regardless of their developing sexual-identity mosaic, have fears, habits, and age-expected immaturities that must be outgrown in a timely fashion (Erickson, 1980). Transgendered individuals are not exceptions to the adverse consequences of developmental tasks that fail to be mastered (Connolly, Zervos, Barone, Johnson, & Joseph, 2016).
2. **Inauthenticity**. A person undertakes transition and its medical support in search of a better psychological and social life because that individual does not feel authentic living in his or her gendered body. While there are other dimensions of suffering with gender dysphoria, the key aspiration for change is gender congruence. But the long-term psychological risk derives from disappointment about belonging to a new gender. The patient's original aspiration is more objectively and subjectively assessed over time. The person may eventually recognize being neither male nor female, feeling inauthentic in the new gender (Levine, 2018b). This is not typically assessed in follow-up studies when the parameter of measurement is regret, yes or no. It is far too soon to have a clinical sense of the long-term outcomes among the young people who identify as gender nonbinaries.
3. **Demoralization**. When the high risk of depression, anxiety states, suicidal ideation and attempts, and applications for disability are considered by the professional, it is reasonable to ask patients what their hopes are for their lives in terms of work, love, sex, friendship, and family relationships. These questions tap into their dreams. It is apparent that such dreams are frequently disappointed among all people, but in asking these questions, the doctor and the patient may be able to focus on the patient's sense of reality.
4. **Outsider status.** Immersion in the LGBT, and particularly the trans community, can be initially wonderful socially, psychologically, and sexually. It helps to take up political causes of the sexual-minority communities because they create relationships and pride in rejecting the larger discriminating world. The new trans identity gives some individuals a life purpose—to improve the lives of others. Some can sustain activity in sexual minority communities for many years and build a network of long lasting friendships. Not all can, however. Even transgendered individuals can become tired of the rhetoric of their community over time. Outsider status in one's society reverberates with outsider status from family rejection (Campbell et al., 2018).

Difficulties communicating the risks of transition

There is an art to creating the process of informed consent. Simply reciting risks, as a surgeon does before gall bladder surgery, creates a perfunctory process. When it is done more earnestly with facts, it can create intense animosity—the professional can quickly become an enemy. Epidemiological facts—such as, suicide attempts in transgendered populations are twice as high as among lesbians and gay men and ten times higher than the general population rate—should inform the professional but need not be baldly presented to the patient. Risks need to be calmly stated within a relationship seen by the patient to be caring and concerned for the patient's current and future welfare. Many of the risks are easier planned for and avoided than overcome.

The process of repudiation of one's birth-assigned gender does not occur via an entirely rational, totally conscious process, whenever in the life cycle it occurs. The concepts of benefits and risks become relevant only when the person begins to contemplate transition. Within the mind of the patient, the ambition to transition encounters its understood drawbacks. This phenomenon is a bit of a temporary stop sign—a process of thinking about a life-altering, eventually irreversible, decision. When clinicians are cheerleaders for transition, their behavior indicates to the patient that this is the best solution that only requires a bit of courage. They may lead patients and parents to believe that there is scientific certainty about the wisdom of transition. This is *not* what the ethical principle of honesty means. The professional's responsibility is to expand the patient's views of the risks of what they are undertaking.

When the writers of WPATH's Standards of Care decided that psychotherapy was not necessary, they did not robustly address how a meaningful informed consent process should be accomplished. As the weighing of the pros and cons is best done over a long period of time, when and how is this to occur without a counseling process? There is much to suggest that the patient does not always know best—for example, post-transition depression, detransition, pre- and postsurgical suicide rates, and that researchers have concluded that postoperative patients need psychiatric care (Dhejne et al., 2011; Simonsen, Giraldi, Kristensen, & Hald, 2016).

Regular meetings for a number of months provide for an adequate informed consent process by the therapist. For patients who do not or will not have therapy, perhaps a three-session informed consent process should be required. It may be helpful to the field if someone would devise a Likert-scale questionnaire to explore the patients' appraisal of the biological, social, and psychological risks. Research on the questionnaire may then yield a cutoff score between those who are informed and those who are not. Predetermined outcome parameters may be compared to informed consent scores. With such a validated instrument, outcomes of perfunctory versus slower informed consent processes can be compared. Ethically, there is no controversy that informed consent is a professional responsibility. What is not widely agreed upon is how it should be accomplished, by whom, and when.

References

Baker, K. E. (2017). The future of transgender coverage. *New England Journal of Medicine*, *376*(19), 1801–1804. doi:10.1056/NEJMp1702427.

Blosnich, J. R., Brown, G. R., Wojcio, S., Jones, K. T., & Bossarte, R. M. (2014). Mortality among veterans with transgender-related diagnoses in the Veterans Health Administration, FY2000–2009. *LGBT Health*, *1*(4), 269–276. doi:10.1089/lgbt.2014.0050

Brown, G. R., & Jones, K. T. (2016). Mental health and medical health disparities in 5135 transgender veterans receiving healthcare in the Veterans Administration: A case-control study. *LGBT Health*, *3*(2), 122–131.

Campbell, M. M., Fresán, A., Addinall, R. M., Böhmke, W., Grobler, G. P., Marais, A., … . Robles, R. (2018). Experiences of gender incongruence and the relationship between social exclusion, psychological distress, and dysfunction among South African transgender adults: A field-study for ICD-11. *Annals of Clinical Psychiatry*, *30*(3), 168–174.

Cavanaugh, T., Hopwood, R., & Lambert, C. (2016). Informed consent in the medical care of transgender and gender-nonconforming patients. *The AMA Journal of Ethics*, *18*(11), 1147–1155. doi:10.1001/journalofethics.2016.18.11.sect1-1611.

Coleman, E., Adler, R., Bockting, W., Botzer, M. A., Brown, G., Cohen-Kettenis, P. T., … Zucker, K. J. (2011). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7th ed.). Retrieved from the website of the World Professional Association for Transgender Health: www.wpath.org

Connolly, M. D., Zervos, M. J., Barone, C. J., Johnson, C. C., & Joseph, C. (2016). The mental health of transgender youth: Advances in understanding. *J Adolesc Health*, *59*(5), 489–495. doi:10.1016/j.jadohealth.2016.06.012. Epub 2016 Aug 17.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One*, *6*(2), e16885.

Dhejne, C., Van Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry*, *28*(1), 44–57. doi:10.3109/09540261.2015.1115753

Drescher, J., Haller, E. & APA Caucus of Lesbian, Gay and Bisexual Psychiatrists. (2012). Position statement on discrimination against transgender and gender variant individuals. *American Journal of Psychiatry*, *12*, 37–38

Erickson, E. H. (1980). *Identity and the life cycle*. New York, NY: Norton.

FightingToGetHerBack. (2018, June 7). Why I supported my autistic daughter's social transition to a man. Retrieved June 7, 2018, from https://4thwavenow.com/

Graham, C. A. (2014). Orgasm disorders in women in Y.M. Binik, K.S.K Hall (eds.) *Principles and Practice of Sex Therapy*, 5th edition, New York: The Guilford Press. p. 89–111.

Hsieh, S., & Leininger, J. (2014). Resource list: Clinical care programs for gender-nonconforming children and adolescents. *Pediatric Annals*, *43*(6), 238–244. doi:10.3928/00904481-20140522-11

James, S. E., Herman, J. L., & Rankin, S. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

Levine, S. B. (2005). Reintroduction to clinical sexuality. *FOCUS*, *3*(4), 526–531.

Levine, S. B. (2016). Reflections on the legal battles over prisoners with gender dysphoria. *The Journal of the American Academy of Psychiatry and the Law*, *44*(2), 236–245.

Levine, S. B. (2018a). Ethical concerns about emerging treatment paradigms for gender dysphoria. *Journal of Sex & Marital Therapy*, *44*(1), 29–41.

Levine, S. B. (2018b). Transitioning back to maleness. *Archives of Sexual Behavior*, *47*(4), 1295–1300. doi:10.1007/s10508-017-1136-9.

Lynch, H. F., Joffe, S., & Feldman, E. A. (2018). Informed consent and the role of the treating physician. *The New England Journal of Medicine*, *378*(25), 2433–2438.

Mayer, L. S., & McHugh, P. R. (2016). Sexuality and gender: Findings from the biological, psychological, and social sciences. *The New Atlantis: A Journal of Technology & Society*, *50*, 10–143.

Mueller, S. C., De Cuypere, G., & T'Sjoen, G. (2017). Transgender research in the 21st century: A selective review from a neurocognitive perspective. *American Journal of Psychiatry*, *174*(12), 1155–1162. 2017 Dec 1. doi:10.1176/appi.ajp.2017.17060626.

Perelman, M. A., & Watter, D. N. (2013). Delayed orgasm in SB Levine, C. B. Risen, S. E. Altho (eds.), in *Handbook of Clinical Sexuality for Mental Health Professionals*, New York: Routledge. pp.150–163.

Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, M. B., … Saxena, S. (2016). Disorders related to sexuality and gender identity in the ICD-11: Revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*, *5*, 205–221.

Rotondi, N. K., Bauer, G. R., Travers, R., Travers, A., Scanlon, K., & Kaay, M. (2011). Depression in male-to-female transgender Ontarians: Results from the Trans PULSE Project. *Canadian Journal of Community Mental Health*, *30*(2), 113–133.

Rotondi, N. K., Bauer, G. R., Scanlon, K., Kaay, M., Travers, R., & Travers, A. (2011). Prevalence of risk and protective factors for depression in female-to male transgender Ontarians: Trans PULSE projects. *Canadian Journal of Community Mental Health*, *30*(2), 135–155.

Simonsen, R. K., Giraldi, A., Kristensen, E., & Hald, G. M. (2016). Long-term follow-up of individuals undergoing sex reassignment surgery: psychiatric morbidity and mortality. *Nordic Journal of Psychiatry*, *70*(4), 241–247.

Steensma, T. D., Kreukels, B. P. C., de Vries, A. L. C., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Hormones and Behavior*, *64*(2), 288–297.

Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(6), 582–590.

Stewart, L., O'Halloran, P., & Oates, J. (2018). Investigating the social integration and well-being of transgender individuals: a meta-synthesis. *International Journal of Transgenderism*, *19*(1), 46–58.

van de Grift, T. C., Pigot, G. L. S., Boudhan, S., Elfering, L., Kreukels, B. P. C., Gijs, L. A. C. L., … Mullender, M. G. (2017). A longitudinal study of motivations before and psychosexual outcomes after genital gender-confirming surgery in Transmen. *Journal of Sexual Medicine*, *14*(12), 1621–1628. doi:10.1016/j.jsxm.2017.10.064.

Wheeler, R. (2017). The history of informed consent. *British Journal of Surgery*, *104*(9), 1119–1109.

World Medical Association. (2017). WMA Declaration of Geneva. Retrieved May 25, 2018, from https://ama.com.au/position-statement/wma-declaration-geneva-2017

Yarbrough, E. (2018). *Transgender mental health*. Washington, DC: American Psychiatric Association Publishing.

Zeluf, G., Dhejne, C., Orre, C., Mannheimer, L. M., Deogan, C., Höijer, J., & Thorson, A. E. (2016). Health, disability and quality of life among trans people in Sweden—a web-based survey. *BMC Public Health*, *16*(1), 903. doi:10.1186/s12889-016-3560-5

Zucker, K. J. (2018). The myth of persistence: response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and gender nonconforming children” by Temple Newhook et al. *International Journal of Transgenderism*, *19*(2), 231–245. Published online May 29, 2018. http://doi.org/10.1080/15532739.2018.1468293