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[00:00:00] **Ronni:** Welcome to This is Probably a Really Weird Question, the podcast where a medical

[00:00:15] **Katie:** doctor and

[00:00:16] **Rebecca:** a doctor of history talk about sex, history, and the not at all weird questions we hear from patients, students, and colleagues. Transcripts

[00:00:27] **Katie:** provided

[00:00:29] **Rebecca:** by

[00:00:31] **Katie:** Transcription

[00:00:33] **Ronni:** Outsourcing,

[00:00:35] **Rebecca:** LLC.

[00:00:42] **Katie:** The only thing that I want at the end of the day is for someone to look back and say, I made the best decision I could with the information that I had available.

[00:00:54] **Rebecca:** Ronnie, I have an exciting announcement. Ba ba ba ba ba ba ba ba! I have a [00:01:00] newsletter. And it's called Carnal Knowledge. Sign me up, I'm in. And, uh, We're going to put the link to subscribe in our show notes to keep it easy for you and it's through Substack if you're a substacker. A good friend of mine suggested that I name my newsletter Stacked.

[00:01:17] Oh,

[00:01:18] **Ronni:** nice.

[00:01:21] **Rebecca:** I decided not to because it is a professional project of mine, but. So

[00:01:26] **Ronni:** carnal knowledge is better than stacked?

[00:01:30] **Rebecca:** I think so, I think so. So carnal knowledge and what I'm doing in it is I'm taking one of the many issues in our life today that is about sex and sexuality and talking about some of the history behind it.

[00:01:44] So I've done a few posts the last few weeks about the history of IVF and artificial insemination. By the time listeners hear this, I will be getting ready for some posts about the conservative war on what they are calling recreational sex. Oh. And [00:02:00] some of the history behind that. Yeah. Like

[00:02:02] **Ronni:** sex that is specifically not with the aim towards

[00:02:05] **Rebecca:** reproducing?

[00:02:07] Yes. And whether or not that applies to, to. married couples is unclear. I think it would depend on the person talking about it because some of these folks are also anti contraception. So it's wild. But the newsletter is free so you don't have to buy a subscription. I'm pretty excited to get it started.

[00:02:24] **Katie:** Woohoo!

[00:02:26] **Rebecca:** I'm excited to read it. So, Ronnie, we have another superstar with us on this episode of our podcast. We have Katie Dalk with us. They are a psychiatrist and an expert on LGBTQ psychiatry. So, Katie, would you please introduce yourself to our listeners and tell them a little bit about who you are and what you do?

[00:02:48] **Katie:** Sure. Um, so Katie Dalk, I use she, her, and they, them pronouns. Um, I identify as a queer person and, um, a psychiatrist who's been focusing primarily on LGBTQI [00:03:00] plus mental health, uh, oh goodness, for I guess about the past decade or so. I'm based in the Philadelphia area. I work for the university of Pennsylvania.

[00:03:08] And I'm really interested in trying to, like my mission, I think, in life has really been to try to make health care safer for queer folks, in particular mental health care safer for queer folks, and I'm really interested in trying to figure out how we can bring together great clinical practices, affirming research, and protective policies to try to make queer people and queer populations healthier.

[00:03:35] **Rebecca:** That's terrific. You do research as well as clinical practice? I do. And so what's your main interest in the research that you

[00:03:42] **Katie:** do? Yeah, so for my, kind of for myself, I use queer as a really kind of broad umbrella term. And, um, when I break that down just to be like explicit about my research. Positionality with all of this, I identify as a bisexual person and I also identify as an intersex person.

[00:03:59] Um, so when I [00:04:00] was about six years old, I was identified as having an intersex variation called androgen insensitivity syndrome. And had a series of healthcare experiences, both medical care and mental health care. As a young person and an adolescent and a young adult that were pretty positive and a number of experiences that were really actively unpositive or negative, um, and even traumatic in some cases, and probably the biggest thing that helped me work through and understand those experiences were.

[00:04:33] Getting connected with my community through peer support spaces and also finding this combination of community wisdom and scholarship to be able to understand why the things that happen to us were happening to us. And so the scholarship work that I'm involved in right now is really oriented to trying to make sense of the experiences that folks in [00:05:00] intersex communities are having, and to try to help shift medical practices in a direction that's more in alignment with what people need and want.

[00:05:09] The specific question I'm the most interested in right now is what we can learn from work that focuses on LGBT populations and apply it to intersex folks in particular. For example, research on minority stress, like the experiences of discrimination and harassment, victimization, internalized negativity, that, that really drive mental health problems for LGBT people, like do the same kinds of things.

[00:05:35] Affect the mental health of intersex folks. So that's, that's really where my world is, is trying to figure out like, how do we take what we already know, adapt it to this population of people about whom we don't know a whole lot. Mm-Hmm. and try, try to make healthcare better and safer. Very cool.

[00:05:54] **Rebecca:** So are most of your patients then members of the intersex

[00:05:57] **Katie:** c.

[00:05:59] No. So, [00:06:00] um, so to be totally transparent right now, I'm in my new position. I'm, I'm doing a lot more administrative work and clinical work, but that's just for the last six months or so. And really, over the course of my practice, what I focused on is treating LGBTQ people sort of broadly and of the patients that I've taken care of intersex folks have been, I've seen a number of intersex folks in practice, but it's been a relatively small group of folks.

[00:06:25] Which I think doesn't surprise me a whole lot because a lot of intersex adults in particular are very reluctant to access healthcare and tend to access really only the healthcare they, they absolutely have to. So I just, I just don't think as many people have found their way to me as, as they could have.

[00:06:47] Um, but the other thing that's been interesting is, you know, over the course of the years I've treated patients who referred to me for completely unrelated reasons, you know, a couple folks who came to see me for help, for example, navigating a gender transition who [00:07:00] over the course of treatment, I learned that they also had an intersex variation.

[00:07:04] Oh, wow.

[00:07:06] **Rebecca:** So, I mean, one of the things that comes up as a theme for us in the conversations that we have is how common it is for queer people to have negative experiences of healthcare and sort of the disparities in healthcare outcomes that that leads to. And one of the reasons we were excited to bring you on and have this conversation with you is that psychiatry has a bad reputation, it's got a bad rep, um, for being I mean, one of the most famous oft told stories of gay liberation and something that Ronnie and I have talked about before is changing the DSM, you know, had the vote in 1973 to get homosexuality moved out of the DSM as a list of sort of mental health pathologies.

[00:07:48] But of course, it's a very complicated legacy there. So, like, in your own years in training and practice. Have you seen, are the attitudes still changing? Like, do you feel [00:08:00] like this is now a settled issue in professional psychiatry? Or is it, like, is what you do controversial among your colleagues? Or is it pretty much accepted and mainstream now to provide, you know, these specific kinds of mental health care?

[00:08:14] **Katie:** That's a really interesting question. And I'm, I'm laughing because I, as a medical student, the, the first psychiatrists that I met were all queer. And so I thought of psychiatry as being like super gay, actually. And it wasn't until I really, like, started to learn that history and learned that the residency program that I was in at the University of Pennsylvania had actually fired John Fryer, who was, you know, Dr.

[00:08:43] Anonymous, who testified at the APA in 1973, because he was gay. It was pretty shocking to me to actually realize that, you know, at that time, I guess it was, you know, 35 or so years before, you know, things had been so dramatically different. And [00:09:00] I think, you know, my experience in the field is that it is, it's one of the most queer inclusive disciplines in medicine.

[00:09:09] You know, the American Psychiatric Association had the first professional organization for LGBTQ physicians, what was then called the Association for Gay and Lesbian Psychiatrists and is now just AGLP. And I think at the same time, you know, I was learning about this and training in an era where all my attendings, my, my teachers had been taught to pathologize non normative sexualities.

[00:09:33] I saw that change pretty quickly, right? That like, even by the time I was finishing my residency program, people looked uncomfortable when they were talking about some of these older theories about perversions and psychosexual development. Where I think we have a lot more kind of tenacious stigma and bias in psychiatry, though, is in particular with respect to gender diversity and trans experiences.

[00:09:57] So I think as a whole, people in psychiatry are pretty [00:10:00] on board, like the general population, are on board with the idea that homosexuality and bisexuality are normative parts of human experience. that when people are experiencing mental health problems, it's because they're experiencing bias and stigma in the world.

[00:10:16] Having the same orientation to trans experiences has been a slower transition, and I'm not sure sort of why that is, although I think some of it may be stigma and sort of, you know, Just how tenacious cis normativity is, but I do also think trans people who are interacting with psychiatrists are just suffering so much that their providers sort of cast about to try to find any explanation for, for why they're suffering.

[00:10:45] And it, it kind of reinforces some of those narratives, even though people are also wrapping their heads around this newer evidence saying it's, it's not innate to the person, it's still minority stress. And then you have this other layer of. gender incongruence or gender [00:11:00] dysphoria that, that's contributing.

[00:11:01] **Ronni:** You know, one of the, one of the things I've been thinking a lot about is it was just match day, as you know. So for those of you who are listening who don't know what match day is, I think of it as kind of like, it's like a, basically a computerized matchmaker slash Yenta for medical students, right? So you like go and you interview at all your residency programs and then you make, you enter this list of who your top programs are, right?

[00:11:25] So, number one, whatever, University of Chicago, number two, University of Wisconsin, number three, Penn. And then you put in your list into the computer, and then all of the programs also make their own rank lists of who their number one candidate was through however many people they rank. And then this big, uh, computer in the sky matches you with with a program, and that's where you just go, right?

[00:11:49] So you find out where you're going in March, and then usually in June, you are somewhere new. And so I've been thinking a lot about medical students, right? Because I'm [00:12:00] getting, I'm sure this happens to you as well. Like, it is a, it's a huge amount of minority tax around this time, you know, in the interview season when people are like, I'm a queer or a trans person and I want to, you know, like, What can I learn?

[00:12:14] And what is it like taking care of queer and trans people in Wisconsin, which is certainly in the middle of the country. And I have found that these kind of like, in family medicine, I think also similarly, it's a pretty queer friendly specialty. As long as you're not in a super small town, and this is a huge topic of interest among medical students right now.

[00:12:39] So I feel a little bit like the kids are going to be all right. You know, I feel like the trend is towards justice and equity and the vast majority of applicants that I'm meeting now are really interested in this aspect of health care. You kind of, like, started to talk a little bit about the shifts that you have [00:13:00] seen in your own career.

[00:13:01] What are some of the, like, most important issues? that you're seeing in psychiatric care of like queer and trans people right now?

[00:13:11] **Katie:** Yeah, I, I think you're right, Ronnie. I just wanted to say that I totally agree with you that the, the kids are all right. And it gives me a lot of hope for the future. And I think at the same time, you know, I also really want the kids to have a, I shouldn't, I shouldn't keep saying kids because it's, you know, whatever, infantilizing, but But I also want all of us to have a kind of multi generational and long view on these conversations too, because I do think where I see a lot of newer, you know, medical students and physicians kind of struggling is like being able to engage more senior people in some of these conversations.

[00:13:43] And there's, it's hard to do that when you just reject whatever someone's position is. But anyway, I think with respect to queerness in psychiatry, the biggest challenge that people are really struggling with is understanding what psychiatrists can and should do for trans populations. [00:14:00] We're in this really interesting and tough moment where, for a variety of reasons, we've had this sort of progressive depathologization of trans experiences, but we haven't demedicalized.

[00:14:17] Trans experiences and so what happens is you have people coming in and saying there's nothing wrong with me I'm not sick, but I still need a doctor and as a psychiatrist people often come to me and say there's nothing wrong with me I'm not sick, but I need you to tell other people I'm not sick so that I can have surgery or hormones or whatever the case may be and just to say, you know not all trans people want all interventions, but Honestly, it's a source of moral distress for me where I, I would very much like people to not need my help at all, but I also know that they do.

[00:14:54] And so I'm trying to, I think for myself, trying to figure out how do I use that sort of [00:15:00] power and authority responsibly. And I see my colleagues struggling with the same kinds of questions, although not always Transcribed So much in those terms, but like on a regular basis, I get questions from people saying I have a patient who wants to have a hysterectomy.

[00:15:17] I don't know how to do that evaluation. Can you tell me how to do it? Or can you help me get connected to someone else who can? Every time those, I feel like a little part of me dies, actually, that, that people that we still think of this as being so special that psychiatrists sort of can't do that.

[00:15:34] Patients as part of the regular course of treatment, but also that patients still need us. To do those things for them, I think is tough, but I think at the same time, like, it's really hard to even have these questions right now because of the political moment that we're in. Because as soon as we say anything about.

[00:15:53] Well, maybe psychiatrists shouldn't be involved in this care at all. You have a very strong narrative [00:16:00] on the political right of people saying, well, you can't have it both ways, right? Like you can say people need treatment, but if you're saying they're not sick, then maybe they don't really need treatment.

[00:16:11] But if you're saying they do need treatment, that they must be sick. So we must have to like, at the end of the day, it gets worked in this really sort of tortuous way into invalidating people's entire experiences. And so I think I see a lot of psychiatrists struggling with that too, and some people are like, well, maybe I just need to stay the heck out of this altogether, particularly I would say folks who are working in pediatric and adolescent settings where that, you know, that conflict is at a fever pitch right now.

[00:16:38] **Ronni:** Yeah. And I think what you were describing earlier with that kind of like tension between kind of wanting to disrupt a system, but also still being complicit in it, right, is a really difficult balance. And Rebecca and I have talked about this before about how like, I love this part of my job. And I think being on the medical [00:17:00] side, right, where I can, in some ways, in some ways depathologize it, right, because I am here basically to provide people the care that they need.

[00:17:08] We'll tell people, you know, you don't have to actually prove that you're trans enough for hormones. I just want to provide you the care that you need. And also, I'm working within this system that requires me to pathologize people in order for folks to get the care that they need. And, you know, I feel very also torn about the specialization aspect, right?

[00:17:29] Because on the one hand, the only way the revolution is going to happen is if everybody does this work, right? If we all see it as part of our collective effort. And also, like, I don't want everybody hanging up a shingle and saying that they can provide, you know, adequate LGBTQ health care and then have folks walk into a situation that's unsafe.

[00:17:50] I feel like there are all these really tenuous balances that we're trying to

[00:17:54] **Katie:** figure out. I 100 percent co sign everything you just said. Those are my [00:18:00] existential quandaries right now. It's really

[00:18:05] **Ronni:** hard. And especially, you know, I think also now when we're, so many people are under threat for providing care, like you said, for young people.

[00:18:13] And, um, it is, it's definitely not where I thought my LGBTQ health career was going to be

[00:18:20] **Katie:** five years ago. Yeah, absolutely. In

[00:18:23] **Rebecca:** preparation for our conversation, I read this terrific, uh, article by Abram Lewis about the anti psychiatry movement. And he quotes a gay student in Iowa saying, uh, in 1973, Utopia at last, the APA has waved its magic wand and cleansed us.

[00:18:41] Oh, joy of our dark and horrible sickness, you know, sort of dripping with sarcasm. This idea of like, Who are these people to say whether or not I have a mental health condition or who I am? Like, that it's too little too late, or who cares what those psychiatrists say about us? That, you know, [00:19:00] liberation and redemption aren't going to come through some sort of Hierarchical, you know, deeply established professional organization.

[00:19:09] And there was also, though, this strand, the radicalness of which, to me, feels impassable in our current political moment, which was to say, no, we're all crazy. And I use that word crazy, I'm sorry, in the context that it was used at the time, that, you know, you know what's insane? It's mainstream, straight, you know, and that maybe I am mentally unstable, but I embrace my, you know, the sort of whole anti psychiatry movement of the 60s and 70s.

[00:19:34] I embrace my, my eccentricities, my instabilities, and I refuse any kind of treatment. And a lot of sort of gay liberationists and feminist folks sort of saying the whole project of diagnosing mental health and treating mental health are fundamentally oppressive and anti liberationist. And, you know, what we need to do is embrace and celebrate all of these, you know, let's call them [00:20:00] eccentricities.

[00:20:00] Let's call them different ways of understanding reality or operating in relationship to reality. And then I'm thinking about the work that the two of you do and sort of trying to help people who are at the crossroads of all of these various discourses. One is like, are these treatments necessary and is there any value in them?

[00:20:18] You know, what kind of provider do I have? Is it a provider who's on board and trained and understands the issues? And why should my mental health have anything to do with whether or not I get the medical care I need, right? Sort of this, it just sounds so fraught. And I think it has been for multiple generations.

[00:20:38] Sometimes I, you know, I think about it in relationship to the history of disability, right? That somehow these are disabling conditions that therefore require special treatment and sort of, sort of need to be set aside. So I don't know if, I mean, I just sort of blabbed a bit about history, but. I suppose folks who are super anti psychiatry just never make their [00:21:00] way into your office to see you at all, or do you encounter people who have this, not, it's more than skepticism, it's like hostility, it's frustration with the whole premise of psychiatry as a profession that would have anything to offer them.

[00:21:17] Does that ever come up, or have you ever encountered that? Yeah, I mean,

[00:21:21] **Katie:** absolutely. The other piece of being a psychiatrist, right, is that I also see people who are in treatment involuntarily. And I can legally commit people to involuntary treatment. And so I think this is an area actually where You know, as a psychiatrist, I feel like I have a little bit of an edge over some of my colleagues and thinking critically about how I'm using my power in my clinical work because the state puts checks and balances on that power and we have to be constantly saying, you know, this is a thing that we want to do for this person because we think it's right.

[00:21:58] Does it actually meet the [00:22:00] legal criterion for it? It's always interesting to me, especially as someone working within intersex advocacy to say to. Healthcare providers, you know, you've been doing something wrong for 30 years. And for a lot of physicians, it's like the first time anybody's ever said that to them.

[00:22:14] But I, like, I hear that all the time, you know, like on a daily basis, people, people get very upset with the kinds of treatment we offer them or require them to participate in. I think for most of the patients that I see in outpatient settings, it's, it's also there, but it is more subtle. And I think the way that it plays out for people.

[00:22:35] It's sort of of the form of, I know that I'm suffering, I don't know why I'm suffering, and I don't want you to be the one who's going to fix it, but I just don't know what else to do. And I think you're right, I think it has something to do with ableism, I think it also has a lot to do with capitalism, right, like, you know, the sort of modern psychiatric industrial complex, if I can use that language, like, really came about, like asylums were initially developed for people who just [00:23:00] couldn't work.

[00:23:00] Or didn't work because they had disabilities or because they were poor, they were housed together and, you know, my forebears is like sort of progressively separated people into these different categories of physical disability, mental disability, intellectual disability and poverty to try to figure out how to support them.

[00:23:20] And then the other thing I should say is that in addition to being very mindful of the 20th century approach to queerness, I'm also very mindful of the 20th century approach to pathologizing distress that people were experiencing because of racism or distress that people were experiencing because of misogyny.

[00:23:39] Right? Like, My great grandmother was institutionalized because she had a nervous breakdown when she found out my great grandfather was being unfaithful to her, right? Like there are so many stories like that throughout psychiatry in the 20th century. And so when people come to me and they're saying something like, I don't know if I can trust you or I don't know if what you're [00:24:00] doing is even helpful.

[00:24:02] You know, I just sort of have to sit back and say like, you're right. I'm not sure either. I have some scientific studies that I can point to that can. Give me some guidance on the direction that we go. But at the end of the day, the most important thing is that you feel like you're as in control of this process as possible.

[00:24:18] And so I think the two frames that really helped me the most are taking a trauma informed care lens and, and asking, you know, what happened to you, not what's wrong with you. And really trying to center autonomy and informed consent to the greatest extent that I can. And then to, I think some of what Ronnie is talking about is really trying to clear the whole relationship, right?

[00:24:39] Like, It's not I'm I'm the person with the pen who signs the prescription. It's you and I are here together. We're co creating these goals and understanding what our relationship is to each other in a way that is certainly mindful of but also actively rejecting a lot of those structures that are imposed on us.

[00:24:58] It's really just trying to take [00:25:00] like a yes and approach to a lot of this and really just trying to meet people where they are and acknowledging that like, the, the, we have a lot of baggage behind us in the process.

[00:25:13] **Ronni:** This is a really good time for us to hearken back to a previous guest, Sammy Schalk, who wrote an amazing book called Black Disability Politics.

[00:25:21] Um, and I don't know if you've read it, Katie. It is. It is brilliant, and it actually talks about a lot of the issues that we're talking about now around kind of activism and the lack of autonomy when people with disabilities are seeking care. It's, it is a brilliant book. You should all go out and buy it.

[00:25:39] It is also available on free open access, but we like to support our, our local

[00:25:43] **Rebecca:** academics. You know, I'm thinking too about how one of the criticisms of the move to revise the DSM, the Diagnostic and Statistical Manual for the American Psychiatric Association in the 1970s was that this is about [00:26:00] normalizing, right?

[00:26:00] This is about saying these people aren't insane. They are sane. They have a normal brain. They have a normal psyche. And there were a lot of radicals who sort of rejected that. So there were some advocates who were arguing for the quote unquote normalness of gay men and lesbians by pathologizing transgender people or people who cross dress, and sort of saying like, you know, straight people are just as likely to do those things as gay people are.

[00:26:30] And so by using, you or looking at people who are invested in kink or people who had paraphilias that sort of creating these other categories of the other of the sexually deviant person in order to make space for themselves as like quote unquote sexually normal or psychologically normal. And I just as I sort of struggle to understand what's going on with the WPATH and the, all of these different guidelines, is there a way in which [00:27:00] trans identity is still more medicalized or psychologized than other kinds of queer identities?

[00:27:07] Is it, is that true or has that changed and is that no longer

[00:27:13] **Katie:** Yeah, I mean, I, I would certainly be really interested to hear Ronnie's thoughts about this too. I think absolutely transness is pathologized and medicalized way more than almost any other sexual and gender minority experience. I do think intersex.

[00:27:32] bodies and experiences are also very heavily medicalized, right? We look at someone who is born with any variation in their sex anatomy and they get labeled with a medical diagnosis and they have to be treated, you know, that variation needs to be normalized and corrected. Although. There have been some trends towards changing that, it's still very heavily medicalized.

[00:27:53] For trans people, the pathology is, is really still psychological and I think that's, that is still the [00:28:00] major mechanism by which we invalidate trans experiences by saying to people, it's all in your head. And, you know, I think an example of this and, and this, it's a complicated thing, you know, having worked in gender care settings.

[00:28:13] with adolescence, like I take very seriously and the folks that I work with take very seriously, that these are big decisions and you want people to make the best decision with all the information they have available and to do that in an appropriate amount of time for them and their family. But like some of the language in the WPAS standards of care are like you have to actively rule out any other possible contributor to mental distress.

[00:28:39] before you can start gender affirming hormone treatment for an adolescent. And it really, it has this sort of subtle way of again, suggesting this is all in your head. I think on one more example of this is, um, when you look at some of the gender affirming care bands, actually all of the gender affirming care bands around the country, they all have exceptions [00:29:00] for intersex variations, right?

[00:29:01] So they'll say you can't do gender reassignment surgery or gender affirming surgery. You can't prescribe these hormones unless someone is born with Or has a disorder of sex development. I'm using this language intentionally, right, that they have. The term that's been used a lot is unresolvably ambiguous genitalia.

[00:29:21] It's sort of in one fell swoop, legislatures have said, trans people are sick in the head, intersex people are sick in the genitals. So you can enforce, you know, treatment on intersex people and deny treatment from trans people.

[00:29:38] **Ronni:** Yeah, I co sign everything that you just said as well, right? It's like, in some ways I feel like it's okay to, to force medical treatment upon intersex children because it's like, air quotes, not their fault, right?

[00:29:50] Like they were, they were born that way. They can be fixed when there's really nothing that needs to be fixed, right? I mean, if there's something that is, [00:30:00] dangerous, right? Because some of these kind of differences in, um, sexual development can cause really dangerous electrolyte abnormalities, right? So the minerals and salts in your blood.

[00:30:09] And so certainly we want to make sure that we're keeping kids safe and giving them the medications they need in order to, like, live healthy, happy lives. But yeah, it's the pathology, just like you said, it's either like, you're sick in your head or you're sick in your genitals and we will accept this medical illness, but not this other thing that we have decided is a mental illness when I don't know that like, intersex is completely devoid of social construction, right?

[00:30:38] It's like, everything that we talk about has some, some amount of social construction, right? Because the language that we use creates meaning and, you know, we don't often hear, sometimes we talk about opposites, right? We're like, The opposite of transgender is cisgender and the opposite of homosexual is heterosexual and we don't often talk about [00:31:00] the opposite of intersex, but there is also like there's a flip side of the coin, which is endosex, right, which I don't know if that's something that you want to talk about or

[00:31:08] **Katie:** define.

[00:31:10] Yeah. So I, I appreciate you saying that Ronnie. And I think, I think of sex as being very socially constructed, right? Like even just when you think about the different ways we use sex, we use it as a verb, we use it as a, as a noun, as an adjective, it's like we use it in totally different contexts. And when you actually look at sex development, it's this really complicated multi step process that starts around week seven and embryological development.

[00:31:37] And people end up with this sort of array. Of sex characteristics or a matrix of sex characteristics, and, you know, much of the time, everything lines up in the way that we're all taught in high school biology, but, you know, for up to 1. 7 percent of the population, it doesn't. But that doesn't even account for like, you know, if a person has a hysterectomy [00:32:00] later in life, that person doesn't become intersex, even though we define someone who has a vagina but is born without a uterus intersex.

[00:32:10] There is really like sort of strong social construction there. Um, and the term endosex is a term that we use. I think partly as a way of throwing into sharper relief, just how socially constructed that is. But it's also a way of pushing against some of the pathology because otherwise people will say, well, intersex people are like this and normal people are like this.

[00:32:31] So endosex becomes a way that we can talk about those differences that are really important and salient. For people's, you know, physiologies and biologies and psychologies without always implying that they're, they're what's abnormal.

[00:32:46] **Rebecca:** I was thinking back on a conversation we had. Last season or the season before was podcast superfan Lizzie Reese, and just sort of thinking about the troubled history of medicine and intersex [00:33:00] conditions, and the whole sort of history of trying to enforce two sexes and enforce heterosexuality, how these two things have sort of come along together.

[00:33:12] With all of these legislative developments going on around the country with, you know, the legislation like you were mentioning. People on the right will make these sort of grotesque allegations about, you know, we just can't teach this to, we can't teach this to young children. We can't teach them to be queer or trans or whatever.

[00:33:30] And, you know, historically, it's been exactly the opposite. It's been generations of teaching people how to be cisgendered and straight and, you know, heterosexual and this history of like, surgically intervening on infants to try to make their bodies conform to a certain kind of body. And so I'm, I'm just always, I'm, I don't know how to get that message out there, but it's like, no, no, no, if we're quote unquote grooming anyone, [00:34:00] we are so powerfully trying to teach young people to be straight and to only think that there are two kinds of bodies and you have to be in, you know, one or the other, and whichever one you're born, you're told you are at birth.

[00:34:13] That's what you are forever. And I mean, I don't know, I see your description of the kind of care that you offer as I would imagine for so many of the people who come to see you and that you interact with is sort of this like oasis, like finally getting into a space where like, Oh, it's who you are, right?

[00:34:32] Like, let's just take this whole person. I think about, you know, Ronnie's clinic this way too, of just in this context where you're constantly being told that you're, there's something wrong with you, right? To get to a healthcare setting where bad things have happened to you, right? But there's not inherently anything wrong with you, um, I have to imagine is pretty sort of revelatory for a lot of people.

[00:34:58] A lot of these folks. [00:35:00] Yeah, I mean,

[00:35:01] **Katie:** I think it can be and I, you know, it's the thing that like, it's what brings me joy and working with people right to like, like nobody wants to go to the doctor, like ever, but like, to be able to be part of liberation and freedom and joy is like this incredible privilege and honor.

[00:35:23] You know, I think at the same time, like, It's also still so complicated, right? Like the folks that I'm treating sort of by definition are experiencing trauma in some form, you know, whether it's, it's victimization and the, and the way that we think about is quote unquote real trauma, or it's more of the kind of chronic strain trauma of being part of a minoritized group.

[00:35:48] And that means that. Even feeling safe can feel unsafe to people, right? Like when they start to let their guard down, that makes them anxious because it means it means they're vulnerable [00:36:00] and something bad can happen. I also have had a number of experiences. I was the last time I was doing a lot of this work last year was in central Pennsylvania and Harrisburg.

[00:36:09] And so I'm seeing folks from a lot of rural counties and, you know, some urban and suburban areas. And People came to see me because, you know, I was the person to go to for the thing, and they felt unsafe with me because I was like, my office was like too gay, right? Like it was, there was some worry that I was going to, impose on them my view of what it means to be liberated or to be to be whole, right?

[00:36:38] Like one example that's coming to mind is a, as a person I treated who identified as gay and experienced a lot of conflict and strain around this because they grew up in an evangelical church and that was their entire identity and to claim gayness meant to reject evangelism and their entire community.

[00:36:58] And I didn't want that for them [00:37:00] either. So it was really the, the, the job was to try to find that balance, um, or, you know, parents who would bring their kids to see me and were really worried that I was going to be pushing their child too far, too fast in a specific direction. And so the way that I tend to think about this is this idea that like, That stigma finds a way, right?

[00:37:19] So even if you block one mechanism, it's going to come up in another mechanism. And you can't, you can't be all things for all people at all times. And part of queering the whole thing is actually to take a step back and say, I might think I'm getting this right, but I'm probably not. And, you know, let's figure out where I'm messing up next together.

[00:37:39] I don't know. Does that make sense? It's messy.

[00:37:44] **Ronni:** I think there's a certain like, like a moment of zen, right? When you first start out, I feel like you get to this place where you're like, Oh my God, I don't know anything. I don't know anything. And then you maybe start feeling a little bit more confident. And then you still have all of [00:38:00] this, like, maybe you still have this undercurrent of imposter syndrome.

[00:38:03] And then at some point you just accept it. You're just like, you know what, I just, I just don't know everything and I can't have any idea what your experience is. I agree that it is an enormous honor. I have like this niche practice of like welcoming people back into the healthcare system who have not been doctoring for a really really long time.

[00:38:22] Sometimes for decades because they've been harmed by the healthcare system. And you know, I have a couple patients, this is going to sound a little like out there, but I have eight patients. I have one patient in my practice who I have listened to their heart once and otherwise, I can't touch them because they cannot be touched.

[00:38:42] And so we're figuring it out. Is it the kind of medicine that I would ideally be practicing? No. But does this person now have a place where they can come if they don't feel well? Yeah. And I think that's, that's kind of a, that's a win. So I

[00:38:55] **Rebecca:** was wondering if we could return to the, the question that opened this episode [00:39:00] and ask you, can I trust my psychiatrist?

[00:39:04] And I don't know if any patient, potential patient, colleague, anyone else has ever posed it to you quite that bluntly, but, um, what would you say to an LGBTQIA plus person who asked you that question?

[00:39:20] **Katie:** Yeah, so all my trainings and my instincts would motivate me to pull a classic shrink move and flip the question back on them, right?

[00:39:28] And be like, how do you know you could trust your psychiatrist? And I, you know, I say that a little bit glibly, but I do actually think that It's one of these things where I do find it's most helpful for people to tell me what helps them feel like they can trust someone and it's different for for every person, you know, like some people will say, I need to know that I can get a hold of you when I need to get a hold of you.

[00:39:53] Other people will say, I need to know that I, you're listening to me or something like that. that you're not going to force medication on [00:40:00] me or you're not going to jump to conclusions about me. At the end of the day, the way that you know that you can trust your psychiatrist is if you feel like they're listening to you, if you feel like they're hearing you, and you feel like they are treating you as a person, While still utilizing their, you know, their training and expertise to offer you good care.

[00:40:21] And, you know, I do think, unfortunately, there are still a lot of psychiatrists who don't feel comfortable treating transgender people in particular. Most psychiatrists have become pretty comfortable treating lesbian and gay and bisexual folks. But you can ask point blank, like, you know, what's your level of knowledge and experience here?

[00:40:40] And if you're not getting the vibe and the answers that you need. It's sort of time to look elsewhere. I think the other thing that I need to say sort of very directly too is that I think a piece of the homosexuality and the DSM story that we don't talk about a lot was that the American Psychiatric Association and the American Psychological Association were both [00:41:00] proponents of conversion treatments in the 1950s and 1960s.

[00:41:04] And those were mainstream treatments for a period of time. They're no longer mainstream treatments by any stretch of the imagination. You know, all the major mental health organizations of all credentials have recognized they're ineffective and harmful, but there are a lot of licensed and unlicensed providers out there who offer those services.

[00:41:25] And you can know for sure that you can't trust a provider if they tell you That you shouldn't be gay, or you shouldn't be trans, or they can make you not gay or trans. Even if that's what you think you want, there is no evidence that that works. And there's a lot of evidence that it's harmful. So I feel very confident saying that for sure.

[00:41:43] You say

[00:41:43] **Rebecca:** that much more diplomatically and professionally than I've said to my undergraduates when I teach my survey course and we get to this topic, and what I've said to them is if you're ever in a provider's office and they say they can change your sexuality, run, do not walk out of that provider's [00:42:00] office as fast as you can.

[00:42:01] They will harm you. Yeah, well, part of, part of what we see is that right as this change is happening in professional psychiatry and psychology in the 70s, Christian, sort of evangelical Christian psychology is holding up those 1950s and 60s. psychiatrists who were at the forefront of conversion therapy and saying, oh no, these are our heroes, these are our guys.

[00:42:24] And they open all of these quote unquote, you know, treatment centers or conversion retreats. And that is where, as far as I understand it, that remains mainstream today. So, um, which is complicated because I think there are a lot of sort of Bible believing Christians or sort of very theologically devout evangelicals who really do seek out a Christian counselor.

[00:42:51] And so I would imagine that if that's what you're looking for, you would need to be even more careful about making sure what kind of Christian counseling [00:43:00] that was being offered now that sort of, it seems that mainstream secular mental health has, has almost entirely moved away from that.

[00:43:07] **Katie:** And you know, I've worked with a number of faith based counselors who would never offer something like that to a person they were working with.

[00:43:16] Cause they, number one, cause they know it doesn't work and it's, you know, unethical, but also number two, because they, they often will take the view that, you know, God makes no mistakes. And part of the task is to find what's divine and sort of godly in all of us. So I, you know, I also want to be really careful about not painting everybody with, with a, with a broad brush because at Harrisburg Pride, for example, the sort of single most common like vendor and air quotes were faith based and affirming.

[00:43:45] church organizations. And so there's a lot of really wonderful resilience and acceptance and affirmation and in Christian communities around the country.

[00:43:53] **Rebecca:** Oh, sure. I think my point was more that the vetting process, you would need to make sure that which kind [00:44:00] of, you know, direction they were, they were headed.

[00:44:02] Absolutely.

[00:44:02] **Katie:** Yeah.

[00:44:03] **Ronni:** You know, and this is a little bit off topic. One of the things that. You were mentioning before you kind of, we're talking about autonomy and how you and maybe that, you know, certainly I also have the power to say that somebody is not able to make their own decisions, right? Like I can activate people's power of attorneys.

[00:44:23] And one of the things that comes up not infrequently is transness or queerness in the context of pretty serious mental illness. And how do we parse that out, right? And Oftentimes, what I'll say is like, you know, somebody is allowed to actually be bipolar and also trans, right? And so those two things can coexist.

[00:44:46] But I think a lot about autonomy. And I think a lot about folks deciding that they don't want to be on their medications anymore because they feel terrible when they're on their medications. And you know, the consequences down the road that that has that they experience when they [00:45:00] stop their medications.

[00:45:00] I don't know if you want to like wax philosophic about autonomy a little bit.

[00:45:05] **Katie:** Yeah, you know, I think being trans and having a serious mental illness diagnosis. It puts people at the intersection of two heavily stigmatized and oppressed groups and and it shows up right there's some nice evidence that trans people with SMI or serious mental illness experience transphobia when they're in mental health treatment settings.

[00:45:27] And that they experience ableism when they're in LGBTQ spaces. You know, like these are folks who literally often feel like they have no home, they have no place, they have no support. And in psychiatric settings, at least, when it comes to these questions about gender affirming treatment, the way that we, like, operationalize that stigma is to say, well, you either can't make this decision for yourself or you have to do certain things.

[00:45:55] In order to be, quote unquote, stable enough to make these decisions for yourself. [00:46:00] And I've treated, I think, one person over the years who had a psychotic illness and had delusions that they were not their assigned gender when they were really psychiatrically ill. And when they weren't as ill, they identified with their assigned gender, but they also identified as queer the whole time.

[00:46:19] So, it was like. You know, it wasn't like this sort of came out of total like nowhere for the person and I guess the way that I think about this is to really say, you can always find autonomy and a person can always give informed consent. The question is for what? And part of the task is to with the person kind of scaffold.

[00:46:39] The decisions that they are in a good position to be able to make that they would make under any circumstance over a lot of time based on where they are in that moment. And so if a person is has a bipolar disorder and is in a severe depression and decides that the only thing that's going to save their lives is.

[00:46:59] You know, [00:47:00] to move from Wisconsin to California, you might say, okay, well, like, let's really think this through. What are the pros and cons of this? Would you make that decision to move to California if you weren't in this depression? And if they can't answer that question, you say, well, why don't we like plan a trip to California and see, sort of see what that looks like.

[00:47:18] And so that's the strategy that I've tried to take with folks where we've said, okay, like, maybe now's not the time to make a permanent decision given what your current mental state is, but let's really look at like, What are some of the social things that you can do to affirm your gender? What can I do to work with your case manager and your group home staff to get them to be more consistent with your name and pronouns?

[00:47:40] How can we make sure that people are going to call you what you want to be called when you get into the hospital? What can we do to maybe start some medications that are gender affirming? That are going to help reduce some of your distress while we work on your mental health stuff so that you can make a really good decision when you're feeling better overall, because that's the other piece of it is that, like, [00:48:00] oftentimes the gender dysphoria really ratchets up the distress and can make the mental illness look worse than it actually is too.

[00:48:07] And something like, you know, stopping someone's period or starting an androgen blocker can reduce someone's distress enough that you can make a much more thoughtful decision without as much distress in the picture. I'm noticing that I feel really uncomfortable even having this conversation with you all because I'm like.

[00:48:23] using all of this ableist language, but it is, um, it is a really complicated thing. And I think the only thing that I want at the end of the day is for someone to look back and say, I made the best decision I could with the information that I had available. And when people are so ill that they can't think the way they would when they were feeling better, it's just really hard for everybody to feel confident that they're making that kind of a decision.

[00:48:48] That's really beautifully

[00:48:49] **Rebecca:** said. I just was thinking that that's such an affirming way to think about. anyone, like anyone's journey, that you just, we're all just trying to make the best [00:49:00] decisions we can with the information we have. And we might make mistakes or sort of veer off in a, in a direction we didn't really want to go, but that we just keep trying to, I don't know, I don't know that in terms of whether or not that's ableist language, I actually find it to be a pretty universal message about the human condition that we're all just, we're all just trying to figure it out one day at a time.

[00:49:25] Thank

[00:49:25] **Ronni:** you.

[00:49:26] **Rebecca:** Sure. I've just, I have loved talking with you and hearing your perspective on it because what you're suggesting is a totally different vision of queer psychiatry than I think I'd ever really learned about. The history of it that I read is often pretty rough going, right? That it's not an affirming story for women, for queer people.

[00:49:51] So. It's, I'm really inspired by your description of your approach to all this. Do you have anything else you'd want to tell our [00:50:00] listeners or anything you want to give a plug for?

[00:50:02] **Katie:** I think just the big thing that I wanted to say is that, you know, and I know Ronnie mentioned this before, but there are more and more queer people going into medicine and going into psychiatry.

[00:50:14] A lot of the things that I'm talking about, I've learned from other folks and other folks are teaching across the country. And so, you know, I think just to say that if you live sort of anywhere near a relatively big city or academic center, chances are there are people there who are. thinking about psychiatry in these kinds of ways.

[00:50:35] There are some great resources in particular through the National LGBTQIA plus Health Education Center about affirming mental health resources that I highly recommend. And yeah, just thanks very much to you two for having me and for, for doing this work in this way. I appreciate it. Oh, our pleasure.

[00:50:52] **Rebecca:** Well, thank you so much.

[00:50:57] **Ronni:** You've been listening to, This is Probably a [00:51:00] Really Weird Question, which is created, hosted, and produced by Rebecca Davis and Ronnie Hyon.

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[00:52:00] **Ronni:** and keep on asking those questions.