# Audio file

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# Transcript

This is probably a really weird question.

The podcast where a medical doctor.

And a doctor of history talk about sex history and the not at all weird questions we hear from patients, students and colleagues about our bodies and our sexuality.

I'm doctor Ronni Hayon and I'm professor Rebecca Davis.

And today's question is.

How do I know if I'm trans Part 2?

Welcome back to this is probably a really weird question.

Rebecca, why are we doing a part?

Two of this.

Question how do I know if I'm?

Grants because when someone goes into a doctor's office and, you know, broaches the initial question, how do I know if I'm trans?

And then an.

Incredibly empathic and well informed.

Dr like Doctor Hyeon helps them.

Figure out, you know.

Well, what do you want to do and?

What's your path?

Look like then it becomes a question.

Of medical treatment, of health care, right, because there's another side of it.

There are these other people who think they should be able to have some decision making authority over whether or not this person is trans.

Yes, for sure.

Anytime you're trying to access healthcare, this is.

At least in the United States, this is an integral part of how the care gets done.

So anytime you come in to see your doctor, there is a medical code that we use to tell your insurance company what we talk about, right?

So there is a if you have a sprained ankle, there's a code for that.

If you have psoriasis, there is a code for that.

There is no medical code for being trans.

We have a psychiatric code which is gender dysphoria and sometimes.

People aren't really excited about seeing that diagnosis on their chart for for lots of reasons that we'll get into, but that's what gets sent to the insurance company so that they know what we were talking about.

This brings up a very clear memory for me of the late summer and fall of 2016. Where for some.

Strange reason.

I could not sleep and I was waking up repeatedly throughout the night.

PS I don't have a sleep disorder, but my central nervous system is very anxious about fascism.

So that turned out fascist, like impending fascism turned out to be.

But there's there is no diagnostic.

Code for that either.

Knows the self.

Patient is anxious about impending fascism.

No, no code.

Oh yeah, well, you know, I think.

That many people have Hilarius.

Or not so hilarious experiences with coding and billing.

But one example that happens to trans and nonbinary patients quite often is they go into the clinic for some non gender related concern and inevitably the person who is seeing them either asks very intrusive questions about their gender identity.

And their process of gender affirmation or inexplicably uses gender dysphoria in the coding and billing for that visit.

So I have a a friend and a colleague who I think went into an urgent care clinic here locally for some respiratory concerns and got interrogated about their gender identity and when we were.

Talking about it, we.

Were talking about it.

Later, you know, kind of in the.

Community, there's this joke about like.

Trans broken leg syndrome and and I'd coined a new term which is trans borculo SIS.

Because obviously, your transness has influenced this respiratory complaint.

The bad case of trans borculo, SIS.

Oh, but that's terrible, I.

Mean it's you're terrible.

You're funny, but they but what happened is terrible.

It's terrible.

I mean you.

Kind of gotta laugh about it sometimes, 'cause.

Otherwise, you know, you just curl up and never show your face again.

But, you know, I think that this might be a nice way to kind of move into a conversation about the history of the gender dysphoria diagnosis.

So as I was saying earlier, there's no medical code for gender dysphoria.

There is a code within the DSM which is.

The book that contains all of our psychiatric diagnosis, right?

So if you're trying to figure out if somebody meets criteria for ADHD, for example, you can go to the DSM and it lists all.

All the symptoms and the length of time that you need to have displayed those symptoms and you can figure out if somebody actually meets those criteria or not.

So in 2013 the newest version of the DSM, the DSM 5, changed the name of this particular condition too.

Gender dysphoria and in order to meet the criteria for gender dysphoria, you someone needs to have a market difference between their own expressed and experienced gender and the gender others would assign to them.

And then it has to continue for at least six months and it has to cause clinically significant distress or impairment and distress could look like a lot of things.

It could look like feeling really preoccupied about getting rid of primary or secondary sex characteristics, right?

So either genitals or body hair.

Things like that, or a belief that you were born in the wrong sex and then the impairment piece is.

Finding it very difficult to function in social settings or work settings or other important areas of functioning because of this internal sense of disconnect between your own gender identity and the gender that others would assign to you.

Not everybody who?

Seeks gender affirming care or who would benefit from gender affirming care actually meets these criteria, right?

And I have, I would say in my own practice the number of patients that I see who truly meet these criteria and who are distressed and impaired.

I could probably count on one hand and the most often thing that happens is or.

The most common thing that happens is someone comes in and they say, hey, I'm trans or nonbinary.

Can you help me?

And I say yes, and everybody is very happy, right?

There's not a lot of distress at all.

It's just kind of, you know, gender, euphoria.

But prior to the gender dysphoria diagnosis, it was called gender identity disorder, right?

And, you know the the American Psychiatric Association said that they made this change in nomenclature to help avoid some stigma.

But also ensure clinical care for individuals who are trans or nonbinary.

So in in this statement that they that the EPA put out, they said very clearly.

And I quote, it's important to note that gender nonconformity is not in itself a mental disorder.

The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.

OK, that's very well and good, but overall, I I think.

What I have found and kind of after.

Marinating over this for a very long time, feel like the gender dysphoria diagnosis is pretty problematic, right?

So gender variance is not a psychiatric disease well.

If that's true.

Then why is it in our psychiatric diagnostic manual and as we talked about in the last?

Episode gender variance is a part of the human condition and just human variation. And sometimes it requires medical attention, but not always right? And just kind of for some context, homosexuality was in the DSM until 1973.

And then after that, they replaced it with sexual orientation disturbance.

And that diagnosis regarded homosexuality as an illness only if someone experienced great distress from being gay and presumably wanted to change.

And, well, that sounds remarkably.

Like the criteria for gender dysphoria, right?

And you know, I think.

So for folks who are not trans or nonbinary, it helps to kind of just take a moment and think about what it would feel like to have your identity understood through a disease lens.

Right 'cause, that's what this is.

This is a diagnosis that is in a psychiatric diagnostic manual.

I think so much around sexuality is framed as either normative or deviant.

Yeah, healthy or disease, diseased or disturbed and.

Right.

It is really there are so many examples of people having whole self images as adults formed around the sense that there is something wrong with them and these diagnosis are really powerful that I mean, first of all A plus.

I'll be your history professor for the day A+ work you get great report.

Thank you so much.

Just wait until you see my footnotes.

So well, when we said that, this podcast.

Grew out of.

Conversations between two nerds from summer camp 30 years ago?

We weren't kidding.

No, not at all.

Not at those of you who have now, who are.

Now frozen in in.

Fear at the history lesson that has been vomited all over you.

Well, listen, let me add to it just a little bit because I think that this whole question around how we.

Name what it is to be transgender and how that relates to the kind of health care a.

Person can get.

Is really important.

And the part of it that I want to focus on since you've given such a great overview of how physicians and psychiatrists.

Have defined it that activists have made a huge difference to the way that health care providers respond to transgender people.

You start in the early 20th century, a little bit in the USA, a little bit more in Europe to have the first surgeries, the first surgical interventions.

So Alan Hart, who I mentioned in the previous episode, is able to convince his doctor to recommend him for a hysterectomy.

There are people starting to have.

Just ectomy castration even attempts to implant ovaries.

There's all kinds of experiments with these different ways of affirming gender and also, you know, you start to really in the 50s, the 60s and into the 70s.

There are more clinics in the United States where people can go to get trans affirming care.

There's a tiny number of people, actually.

Getting this care.

Clinics start to word of mouth spreads news about the clinic.

There are publications there.

Are exposes in newspaper.

There's, but most people are turned away.

From it, it's.

Very, very rare.

And as the field develops, sort of leading up to everything, you were just describing physicians who are interested in this.

Kind of work.

Come up with criteria for whether how they will decide there's there's not yet any central organization that has said.

This is what permits you to provide trans affirming care.

In all of.

These different clinics, they come up with their standard.

And this is.

Incredibly similar to how.

Physicians and hospitals of that time were deciding whether a pregnant person could get an abortion.

They had criteria for whether or not in abortion. This is pre Roe V Wade, pre 1973. In most states it's completely illegal except for to save.

The life of the pregnant person, and so hospitals have their own criteria for deciding whether or not the patient.

Life is at risk.

OK, so so they.

Do this then for trans affirming care and there's a psychological evaluation.

They want people to take hormones Azure express their gender for a certain amount of time before they'll do anything surgical.

But ironically, one of the ways that physicians in the 60s and 70s are deciding whether or not a person.

Is a good case, right?

Is a good.

Is a good meets.

The criteria for trans affirming care.

Is if they would ultimately desire.

A heterosexual relationship. So so you're really trans. In other words, according to these physicians in the 1960s and 70s, if you want to become a trans man in order to have intimate sexual relationships with ciswomen, right? Or vice versa, right?

And so, you know, over and over again, what we see when we look into the history of sexuality is this sort of oppressive, insistent.

Normative assumptions about the differences between men and women, about the the normative Ness of heterosexuality, and so even as scientists are really in some ways in these physicians at the forefront of rethinking.

The differences between gender and sex, right?

Or and in some ways you think, oh, these are the cutting edge most broad minded physicians of their time.

They still use the desire for heterosexual intimacy as a criteria for doing trans affirming care.

Right. I mean, and maybe.

Maybe, perhaps not to the same extreme that.

You're describing but that.

That sort of gatekeeping still happens, right?

Just like.

Somebody wasn't considered really trans unless they ultimately hoped to be in a heterosexual relationship, right?

So sometimes there are clinicians who cleave very closely to the W path guidelines, which is the newest iteration of kind of what I think you were referring to, which is the Harry Benjamin guidelines, right?

So you know the W path guidelines are.

The World Professional Association for Transgender Health and it is a multidisciplinary organization of professionals globally who put together these guidelines that help clinicians.

Provide care to trans and non binary people.

I think the problem with any guidelines is that it's going to be by definition limiting, right?

And sometimes people feel clinicians or surgeons feel that they have to follow those guidelines.

To a letter when actually that's not true.

So for a long time, you know, there was a letter of support that was required from a mental health care provider to get hormones.

And actually, you don't have to do that, right?

Like, I don't do that.

I don't make you get a letter of support from a therapist to get the medicine you need.

So I use an informed consent model and, you know, just like I would for birth control or antidepressants, we sit down and we have a conversation about the risks and the benefits.

We talk about your.

Goals and if you understand the risks and the benefits and you feel that this.

Is the right treatment.

For you, then we do it right, like.

There's no reason.

To pathologize and gatekeep in that way.

You know, all this comes back to.

Earlier we mentioned differences between what gender is, what sex is, gender versus sexuality.

And I think we've become.

As as a whole, as a.

Society more comfortable with the idea?

Well, most of us at least comfortable with the idea that gender isn't a binary that there are.

Multiple expressions of.

But I think a lot of people get stuck on the idea that sex remains a binary, that there are biological so-called, you know, there's only two and we.

But we know that.

I mean, medical science tells us.

That that's not true.

And while we used to think that.

Sex is kind of biological and immutable, right?

That it's binary because we have these gonads and chromosomes and hormones and we used to tell people genders, and your brain is sex and sex is between your legs.

Oh God.

Truth, truth, right?

I mean, this is where this look at how far we've come.

So what we know now is actually that sex is a process, not an assassination. So there are more than 25 genes that actually affect sex development. And not only that, but sex manifestation can be shifted even.

After birth.

Right.

You know, there was this really nice article.

That will I.

Will link in our show notes today but.

They summarize some of these new findings in a really nice way by framing it as sex determination is a contest, and as a contest between two opposing networks of gene activity, and so changes in the activity or the amounts of molecules in these networks can.

Actually sway an embryo?

Towards or away from the.

Sex, that is.

Seemingly spelled out by the chromosomes, right?

So there have been some really interesting studies in mice that and interestingly mice the the mouse genome is quite similar to human genome, which is why we do so many studies on mice.

But what we?

Have what they found is that the goal has a gonad, right?

So that's either.

The ovary or the test?

Kind of teeters between being male and female throughout life, and the that identity of those cells requires constant maintenance. So in 2009.

Some researchers deactivated a specific ovarian gene in adult female mice, and after they did.

But they found that the granulosa cells that are the cells that support the development of eggs actually transformed into Sertoli cells, which are the cells that support sperm development.

Way yes dude.

So one gene they deactivated it and it completely changes the function of the cell.

Bodies are so cool.

It's fascinating, right?

And then two years later, a separate team showed the opposite, that if you inactivate a specific gene that it could turn testicular cells into ovarian cells.

It's awesome, right?

And so we need to kind of.

Let go of just the oppressive logic in general.

That that there is yes or no, male or female like the binary isn't helpful for anybody.

Right.

This is.

I mean I feel as if.

Every time.

Well, every time I have a conversation.

With you it.

I my mind.

It's blown.

And I also think that every time I learn more about.

Our bodies and about.

The sort of.

I'm going to say magical, and that's not not right.

This is science, but the.

Sort of incredible ways that.

You know, the complexity, the sort of amazing complexity of the ways that our bodies produce hormones and how those hormones affect us and the way that our brains work and how we exist in our bodies.

Right it.

It's so fascinating.

Right, if you really want to get into the weeds or take it to the next.

Level you know, actually both sex and gender are social constructs, right?

And so sometimes when I say that like, people are like.

Whoa, whoa, whoa, whoa. Like.

Penises and vaginas actually exist, right?

We know we can see them that they are.

They are body parts and obviously they can't be social constructs.

OK, yes, true, the physical tissue of the organs, right?

Those are not social, social constructs, but the language that we use to describe body parts is constructed, and so are the ways that we think about those body parts, right?

So there's nothing inherently feminine.

About breasts, it's just.

That that is.

The meaning that we have assigned to it, right.

The last thing I was going to say about like social constructs and sex and gender is that, you know, sometimes people will get a little airoli about.

The language being constructed and meaning being constructed.

But actually, you know these social constructs have repercussions, right?

Right.

And so these social constructs perpetuate pathology, pathologization and exclusion.

Of trans and non binary people, you know, I think it really strengthens the.

Audacity of the trans exclusionary radical feminist movement or the TERF movement where they this is a group of feminists who believe that trans women are not women, right?

And that biology is the ultimate determinant.

And so.

These kind of social constructs help perpetuate that sense of, well, you may feel like this gender, but you're really this sex, and nothing is going to change that, right?

And it kind of encourages debate about the validity and origins of transness.

Right.

This is a wonderful segue to what we're going to be talking about in our next episode, because the whole way in which the field of medicine has talked about human reproduction has been this very overtly gendered romantic tale of the.

Oh, you know ova just waiting there.

Like in her, like Rapunzel in her castle, or like a sperm to climb the tower, right, and and get to.

Ha ha.

There can be only one there.

Find her and there's only one.

Could be only one, yes.

There's only one and he and and of.

Course that is not.

How it works?

Right before we go, I want to make sure to note that I drew a lot of the information I shared today from this amazing book by historian Joanne Marowitz.

The book is how sex changed the history of trans sexuality.

In the United.

You can find all of the citations that I drew from to research this episode and all of our episodes in our show notes.

You've been listening to this is probably a really weird question, which is created, hosted and produced by Rebecca Davis and Ronni Hale.

You can learn.

More about us.

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