

Commentary

Medicine as constraint: Assessing the barriers to gender-affirming care

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In this commentary, we describe the way in which science has been used to constrain transgender peoples' access to gender-affirming care. The required diagnosis of gender dysphoria is rooted in both the historical assumption that psychological distress is an inherent aspect of being transgender and the incorrect notion that gender-affirming care is a panacea for the mental health issues that transgender people may experience, regardless of whether these mental health issues are related to their being transgender. We provide recommendations for how to address these barriers to care moving forward.

Historical background

Seminal work in twentieth century sexology played a major role in shaping notions about sex and continues to inform policies regarding access to gender-affirming care. We provide a brief overview of some of the major theories that have predominated the field, many of which have caused significant harm to the healthcare of transgender people in the United States and have since been discredited. We highlight those ideas that continue to have ramifications on contemporary notions of gender identity and still shape access to gender-affirming care.

In 1949, sexologist David Cauldwell theorized that distinct “biological” and “psychological” sexes were discordant in transgender people, indicating a psychological condition. John Money, Cauldwell's contemporary, shared his view regarding the misalignment between “biological” and “psychological” sex. Yet Money, unlike Cauldwell, supported the idea of medical intervention and genital modification surgeries.¹

Money, who worked with intersex children (also termed those with differences of sex development) in the 1950s, introduced a multi-stage model of gender identity development. Because gender identity was thought to develop early in life, surgery on the genitalia of intersex children was considered urgent. Money's model codified gender identity norms and

perpetuated gender expression stereotypes by encouraging parents to consent to surgical modification of their children's genitalia in order to conform them with their assigned sex.² Further, by centering penile-vaginal intercourse as the framework from which to establish gender identity, Money's model implicitly linked gender identity with sexual orientation.

Harry Benjamin pioneered the work that increased access to gender-affirming surgical procedures. His practice of determining eligibility for procedures, however, stemmed from a biased notion that aimed to identify “true transsexuals”, whose gender expression required physical changes to their bodies, as opposed to cross dressers (“transvestites”) and “homosexuals”.³ Codification of Benjamin's framework into clinical practice influenced medical care in other ways: individuals had to both exhibit distress related to being transgender (often through explicit hatred of their genitalia) and convince clinicians that their distress had been present from an early age in order to receive gender-affirming care. Clinicians used criteria that evaluated how individuals assimilated into assigned gender roles, with many decisions relying on stereotypical intuitions about how an individual would appear to others after surgery. Those who were sanctioned for surgeries were highly encouraged to integrate and avoid people with diverse sexual orientations or gender identities.¹

Such criteria precluded many from receiving the diagnosis of “gender-identity disorder”, which was required to receive care. Tight regulation of access drove a highly rehearsed narrative of the “true transsexual”—similarly themed stories that were known to meet criteria for care at gender clinics.⁴ Standardized diagnostic guidelines codified aspects of these criteria in 1980 with the inclusion of the childhood “gender-identity disorder” and adult “transsexualism” under “psychosexual disorders” in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III. This move established being transgender as a psychiatric condition.¹

Benjamin's model was influential in shaping the diagnostic criteria for “transsexualism”, which required “a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex”.¹ This history still resonates in clinical care today as access to gender-affirming care often requires a diagnosis of “gender dysphoria” in the DSM-5, which includes “a strong dislike of primary or secondary sex characteristics” as one of its potential diagnostic criteria.⁵

Framing gender-affirming care as a treatment for a mental health condition

The World Professional Association for Transgender Health (WPATH) Standards



of Care (SOC) recommend that transgender individuals seeking gender-affirming care (hormone therapy, breast augmentation surgery, genital surgeries, etc.) obtain referral letters from mental health professionals that document their persistent gender dysphoria. The criteria for well-documented dysphoria shift the mental healthcare provider's focus from addressing a patient's psychological well-being and psychosocial readiness for care to validating a patient's gender identity.⁴ This leads some transgender patients to convey non-existent distress about their bodies in order to legitimize their treatment.

In a study that assessed barriers to gender-affirming care, some participants shared that it was common for their healthcare providers to ask questions that perpetuated the belief that only two gender identities exist. Adherence to a binary gender-identity model became the basis by which these transgender individuals were denied care, as their interview answers failed to align with their healthcare providers' assumptions about gender identity.⁶

In establishing a diagnosis for gender dysphoria, WPATH's SOC recommend the use of the DSM-5. This creates a paradox for transgender patients: to meet the criteria for gender dysphoria, patients must exhibit distress while simultaneously maintaining an appearance of mental capacity and fitness that would not disqualify them from receiving care.⁷ Thus, some transgender people experiencing mental health issues must choose between procuring gender-affirming care at the expense of their mental well-being and disclosing significant mental health details at the expense of being labeled unfit for gender-affirming care.

When a patient seeking gender-affirming care does exhibit significant medical or mental health concerns, the SOC states that they must be reasonably well-controlled.⁸ While it can be argued that this criterion encourages individuals to adequately address mental health concerns, it fosters a clinical environment where patients withhold or de-emphasize their mental health concerns for fear that practitioners will deny them gender-affirming care.^{4,6} Furthermore, in the absence of a standard definition, providers may set their own criteria for what

constitutes "well-controlled" mental health. These standards often vary depending on the patient's desired treatment. The variable definition of "well-controlled" mental health calls into question the utility of the mental health screening, which should be further scrutinized.

The recommendation that transgender individuals receive a diagnosis of gender dysphoria to access care assumes that psychological distress is an essential aspect of being transgender. A study analyzing the implications of categorizing transgender care under the label of mental and behavioral healthcare found that approximately 11% of transgender respondents seeking hormone therapy did not experience psychological distress. Importantly, over half of the participants who reported having psychological distress attributed it to the social rejection they experienced because they were transgender, as opposed to a mismatch between their gender-identity and their anatomy.⁹ These findings suggest that distress is not an intrinsic part of being transgender. Rather, many of the mental health conditions that arise in transgender patients are rooted in the social conditions under which they live. Removing a diagnosis of gender dysphoria as a requirement for care could begin to quell the incorrect assumption that gender-affirming care is a remedy for all mental health issues that a transgender person can experience. A model that instead centers on patient readiness could allow transgender individuals to both seek desired gender-affirming care as well as confront mental health issues, related or unrelated to their being transgender.

The centering of the gender binary within gender-affirming care

Use of the DSM-5 criteria for gender dysphoria is further problematic because it considers being transgender within a binary framework. While the latest DSM revision acknowledges the gender identity spectrum, the WPATH SOC criteria requiring a diagnosis of gender dysphoria from a mental health professional envelope transgender people in recognizability politics.¹⁰ A 2018 study reported that in some instances, therapists only allowed binary transgender people to begin

gender affirming hormone therapy, affirming only the experiences of those patients who fit into a binary gender identity framework.⁶

In the context of genital gender affirming surgery, a 2017 study demonstrated that a patient's specific gender identity had a significant impact on their value of undergoing vaginal removal surgery or a procedure to create a penis that was "passable" in different social contexts. These criteria were found to be more important to patients who identified as "male" versus those identifying as "mostly male", "inter-gender", or "non-binary."¹¹ These findings raise the question of whether gender-diverse individuals who do not identify as "fully male" or do not prioritize vaginal removal or construction of a passable penis will meet a threshold for distress and therefore be recognized as enough of a specific gender to gain support from providers for any type of gender-affirming care.

While current options for customization allow care regimens to be personalized to each patient's personal needs, some providers may operate from a framework that relies on binary assumptions about gender identity. Although customization of care is necessary for some patients, many transgender patients are often coerced into conveying narratives that reduce their lived experiences to binary categories to access treatment.

Determination of medical necessity

The DSM-5 includes language for gender dysphoria that might lead healthcare payers to support only that which is believed to relieve dysphoria. These practices were quantified by a 2021 study that looked at amendments to insurance company requirements for coverage of gender-affirming procedures following regulatory changes in 2014 by the United States Department of Health and Human Services (HHS) that prohibited insurance discrimination for transgender individuals. The study concluded that insurance companies increased requirements for patients to meet a standard of medical necessity for care (adding requirements for legal name changes, imposing more stringent standards on mental health screenings, etc.) following the passage of the HHS protocol.¹²

Currently, there is no universally sanctioned definition of “medical necessity”, but in clinical practice for gender affirming care, it is often guided by a historical consideration of what is “necessary” for an individual to fit within the gender binary—predominantly, genitalia that align with the patient’s gender identity. Insurance companies more consistently offer coverage for phalloplasty, vaginoplasty, and mastectomy operations over hair removal, facial feminization, thyroid chondroplasty, and facial masculinization procedures. This pattern in differential funding exists even though the latter procedures are ones that many transgender individuals view as necessary for expression, comfort, and safety.^{13,14}

Designating genital-modification surgeries as more “medically necessary” for transgender patients is reminiscent of the now discredited sexology theories from the twentieth century that prioritized genitals as the major marker of gender identity. Healthcare payers preferentially categorize surgeries as “medically necessary” because historical models have advocated the view that they will remedy the psychological conditions transgender people experience. However, gender-affirming interventions should be viewed as medically necessary outside of a mental health framework. While transgender people may feel distress about their physical body, we must acknowledge that much of their mental health morbidities stem from the social ramifications of living as a transgender person or from circumstances unrelated to being transgender. Viewing gender-affirming care as a mental health intervention both limits access to necessary services and conceals the complexities of the mental health conditions that transgender patients face.

The inconsistent landscape of criteria across different healthcare payers complicates the ability for those seeking gender-affirming care to meet eligibility requirements for coverage. For example, Medicare, one of the nation’s largest public healthcare payers, makes approval decisions for gender-affirming care coverage on a case-by-case basis, using opaque standards hidden from patients and their healthcare providers. The Centers for Medicare & Medicaid Services further reaffirmed these prohibitive stan-

dards in 2016 when they published a memorandum that rejected calls to establish a National Coverage Determination for gender-affirming surgery.¹⁵ There is, however, evidence that legislative regulation of insurance coverage could be beneficial. A 2020 study found that top insurers in states that prohibited transgender exclusions in private insurance covered a statistically significant number of additional gender-affirming services when compared with policies of top insurers in states lacking prohibitions against explicit transgender exclusions.¹³

Moving forward: Recommendations for reform

Moving forward, we recommend discontinuing the use of the gender dysphoria diagnosis in the DSM-5 as an inclusion criterion for accessing gender-affirming care. Separating being transgender from the receipt of gender dysphoria diagnosis will place clinical attention on a patient’s readiness for medical intervention, instead of on their ability to validate their gender identity. A 2020 study prioritizing patient-readiness in determining eligibility for vaginoplasty supports such a model. By shifting focus from patients’ displays of distress, the criteria in this study increased the accessibility of gender-affirming care by approximately 40%. Moreover, the study exposed the inadequacy of existing surgical readiness criteria, suggesting that they place an undue burden on transgender patients seeking surgery to prove gender identity, while simultaneously ignoring important psychosocial concerns that may affect the surgery’s success.⁷

Many clinicians have adopted these changes and have shifted their clinical practice away from guidelines informed by historical notions of gender identity now recognized as invalid. Elements of these notions, however, still exist in the current framework for gender-affirming care access. These ideas shape who can access care and how both clinical and societal levels view gender identity.

Guidelines and healthcare payers should instead follow the example of the International Classification of Diseases (ICD)-11, which will no longer categorize transgender-related healthcare under the umbrella of mental and behavioral disorders. While there are indications that

WPATH SOC 8, anticipated for release in 2022, will integrate some of these changes, actual implementation will be slowed by largely bureaucratic processes of healthcare payers. And unlike statutes or legislation, WPATH guidelines would not enact a legal obligation to make the necessary changes to improve access to care. We also advocate for a broader understanding of what is considered medically necessary among gender-affirming surgeries. Differential coverage of gender-affirming surgical procedures by healthcare payers suggests an approach to gender-affirming care through a cisgender lens. Instead, procedures should be prioritized as medically necessary if they are critical to personal safety and to alignment between body and gender identity.

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AUTHOR CONTRIBUTIONS

A.K., U.O.A., and J.D.S. conceived this commentary. A.K. and U.O.A. analyzed the literature and drafted the text under J.D.S.’s supervision. All authors revised the text and approved the final version.

DECLARATION OF INTERESTS

The authors declare no competing interests and no external funding sources.

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