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"Mental Readiness" and Gatekeeping in Trans Healthcare

« Préparation mentale » et contrôle d'accès dans les soins de santé trans

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Abstract

Gatekeeping refers to clinicians' strict application of eligibility criteria to determine a trans patient's "fitness" to engage in medical transition, resulting in significant barriers to gender-affirming care. Gatekeeping often uses "mental readiness" as a prerequisite to medical transition, which contributes to patient distress and systemic discrimination. Changing international trans health guidelines (the new World Professional Association for Transgender Health Standards of Care version 8) recommends clinicians shift from a gatekeeping model towards an informed consent model, which improves access to care. This commentary offers recommendations on how clinicians can reconsider existing "mental readiness" frameworks around medical transition to facilitate improved access to care.

Keywords

access to care, gatekeeping, gender-affirming care, informed consent, mental health, transgender, transition

Mental Readiness and Gatekeeping

The World Professional Association for Transgender Health (WPATH) Standards of Care (SoC) version 7 (v7), published in 2012, created a set of international guidelines to guide healthcare providers in supporting transgender and gender diverse (trans) individuals access gender-affirming care (GAC).[1] GAC is defined as inclusive of interpersonal, psychosocial, and medical interventions that affirm one's gender.[2] This version incorporated more research and provided guidance on supporting trans people beyond gender-related diagnoses and medical transition (i.e., gender-affirming hormone therapy and transition-related surgeries [TRS]) compared to the previous 2001 version.[1] It moved towards depathologizing trans identities by clarifying that not every trans person experiences "gender dysphoria" (i.e., discomfort or distress from an incongruence between a person's gender identity and their sex assigned at birth) and normalizing non-binary gender identities.[1] It also arguably had more accessible criteria for medical transition, such as reducing or eliminating requirements of psychotherapy and documented "real-life experience" of one's gender role to access hormones and surgeries.[1] The SoC v7 moved away from paternalistic care towards greater patient autonomy, though some barriers to accessing GAC remained.

The SoC v7 recommended readiness criteria for accessing medical transition, which included "Persistent, well documented Gender dysphoria" (p. 104) and "If significant medical or mental concerns are present, they must be reasonably well controlled" (p. 104).[1] These criteria have contributed to problematic gatekeeping in trans health, which refers to clinicians' strict application of eligibility criteria to determine a trans patient's "fitness" to engage in medical transition,[3,4] resulting in significant barriers to GAC.

Gatekeeping occurs as the guidelines don't clearly define "well controlled" mental health[1] and clinicians are concerned

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about doing harm, particularly fearful of transition "regret",[4] lending itself to clinicians being hesitant about facilitating access to care for fear of transition regret if the readiness criteria are not strictly followed.[4] A lack of robust trans health medical education[2] compounds the problem. However, there is no evidence that strict adherence to the WPATH criteria prevents regret.[4] Furthermore, the WPATH recommendation for clinicians to document a gender dysphoria (GD) diagnosis (as per the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5]) worsens the problem of gatekeeping.[3] Critics have argued that the psychiatric diagnosis of "Gender dysphoria" contributes to the already frequent pathologizing and dehumanizing of trans people[3] while giving clinicians authority to essentially determine whether someone is "trans enough" to access care.[3,4] Gatekeeping creates a high bar of mental health "readiness", which can lead to clinicians deferring GAC, potentially indefinitely.[4] In turn, trans people are required to appear "ready" to access GAC in a narrow clinician-centred (rather than patient-centred) way.[4]

Changing Trans Health Guidelines

The draft version of the upcoming WPATH SoC version 8 (v8) clarifies the circumscribed role of mental health assessments prior to medical transition, which is to distinguish GD from other mental health concerns and "ensure that any mental health conditions which could negatively impact the outcome of gender affirming medical treatments have been assessed, with risks and benefits discussed, before a decision is made regarding treatment" (p. 3).[5] This is much more in line with the informed consent model, where access to interventions is based on standard risk–benefit discussions, which clinicians use with other medical interventions (i.e., before recommending any medication or surgery).[6]

The SoC v8 is not yet finalized at the time of writing, but clinicians can shift towards the new guiding principles by first recognizing that there are no mental health diagnoses which, in and of themselves, are a contraindication to medical transition.[5] Sometimes, clinicians have set up high thresholds for accessing medical transition for those with certain diagnoses, such as borderline personality disorder (BPD), autism spectrum disorder (ASD), body dysmorphic disorder (BDD), dissociative disorders, and psychotic disorders.[4,7] These diagnoses can exist alongside GD.[7]

A careful gender history assessment can usually clarify differential diagnoses.[7] GD involves wanting to change anatomical characteristics to be congruent with one's gender identity, whereas BDD involves wanting to remove a body part due to a perceived flaw.[7] Gender-themed delusions in psychosis usually exist exclusively during acute psychotic episodes,[7] so longitudinal engagement and communication with the treating team can help clarify someone's gender identity independent of psychosis.[5,8] Clinicians concerned about unstable self-identity with BPD or dissociative disorders can assess the history of gender identity development carefully for persistent gender identity over time.[9] GD and ASD co-occur at increased rates and those with ASD may benefit from more time for discussion, transparency around the process, stepped changes, and adapting to any communication needs.[10] In rare instances of persistent difficulty clarifying the diagnosis, referral to psychiatry may be warranted.

The SoC v8 clarifies that a mental health assessment can improve transition outcomes.[5] It describes how the loss of social support, and the physical and financial stress from medical transition can worsen pre-existing mental health problems,[5] so it is important to offer treatment of mental health symptoms while facilitating access to medical transition.[8] While historically clinicians have treated mental illness before GD, the most recent guidance is to offer concurrent treatment of both.[8]

Clinicians often have concerns that hormone therapy will destabilize mood, but the effects are usually subtle.[7] Testosterone may rarely precipitate psychosis or hypo/mania, but this is associated with supraphysiological testosterone levels.[11] These concerns can be addressed with regular monitoring of both mental health symptoms and testosterone levels while titrating testosterone.[7,11] Transdermal testosterone results in a steady serum level and may be preferred in patients with a significant psychiatric history.[11] Feminizing hormone therapy has been associated with fatigue related to androgen suppression, so after ruling out other potential causes, clinicians can consider low-dose testosterone (patch or gel) to supplement the feminizing hormone therapy to address fatigue.[11] Individuals experiencing anti-androgen medication-related depression may benefit from switching to a different anti-androgen.[11]

A delay in medical transition could be considered in rare cases of strong evidence that medical transition would lead to serious safety concerns or could not be accessed safely.[5] This may be in the context of severe mental health symptoms that render someone unable to engage in steps of transition, capably consent to treatment, or manage post-TRS aftercare even with support.[5] In such cases, we recommend clinicians work actively with patients to address those mental health concerns with the goal of facilitating safe access to medical transition. Psychiatric consultation and ongoing care may be indicated. It is also important to assess and engage a patient's coping mechanisms and social supports to facilitate safe access to medical transition.[7] Importantly, delaying access to medical transition has been associated with worsening mental health symptoms, including depression, anxiety, and suicidality[12]; so clinicians should only defer access in rare and clear cases of concern. Patients often experience denial of access as quite distressing, which can lead to acute mental health crises, which then clinicians may inappropriately cite as a reason not to proceed with medical transition, leading to a cycle that worsens distress and health.

Conclusion

Gatekeeping is a form of systemic discrimination in the healthcare system as it makes access to GAC harder than accessing other healthcare. Trans patients can benefit from

providers who help them navigate systemic obstacles and advocate for access to patient-centred GAC that considers mental health as part of an informed consent model rather than a gatekeeping model for trans health.

Author's Contribution

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