

Protecting the Vulnerable: A Call to Uphold Ethical Standards in Treating Gender Confusion

By Jennifer Bauwens, Ph.D.

For almost a decade, I have been teaching research and program evaluation skills to graduate students seeking a career in human services. During this time, I also taught advanced clinical courses on traumatic stress and abuse. The students enrolled in my clinical courses were always much more engaged in classroom discussions than those in my compulsory research classes. After all, these students were working towards a master's degree in order to work with humans, not data. Needless to say, I had to work a lot harder at engaging students in my research classes. My class prep for a research course often involved a vigorous search for any and every opportunity to inject humor into a snoozer of a topic, like ensuring statistical conclusion validity.

For this reason, I was always grateful for the point in the semester when it was time to cover the module on research ethics. Although the study of ethics might not sound terribly exciting, these classroom discussions were invigorating compared to the other research course modules. In this lesson, we covered many of the historical studies that led to present-day regulations for the treatment of human subjects. A few of these standard examples included the deceitful research protocols imposed on African American men in the Tuskegee Syphilis Study, the atrocities outlined in the Nuremberg trials, and many other accounts that were, in some instances, patently evil, and in other ways, grossly misguided.

The Importance of Ethics in Human Research

The purpose of the ethics module was understanding the historical mistreatment carried out in the scientific community in order to avoid future harm to research subjects. For this, we turned to the Belmont Report in 1979, which highlights three ethical principles central to the treatment of research participants. While these principles are specific to scientific inquiry, there is much overlap between research ethics and the foundation of many human services professionals' ethical codes for how we engage in practice. These three ethical principles demand participants be treated with beneficence, justice, and respect.

First, the ethical principle beneficence carries the idea of minimizing risk or harm while maximizing the benefits of a study outcome. Importantly, *beneficence* underscores the obligation to “do no harm.” Equally important is the principle of *respect*, which is the idea that research subjects should be treated courteously, without any type of coercion to participate, and given protection and the right to self-determination whenever a person is capable of making their own choices. Additionally, enough information should be given to the study participant to ensure involvement is truly voluntary. Lastly, *justice*, as it relates to ethics, requires research participants be treated with equity in the distribution of care, with fairness, and without exploitation.

As I shared these ethical principles with my students, we then applied them to their own research interests, noting that the invasiveness level of their proposed studies was directly related to the number of ethical safeguards they should be factoring into their



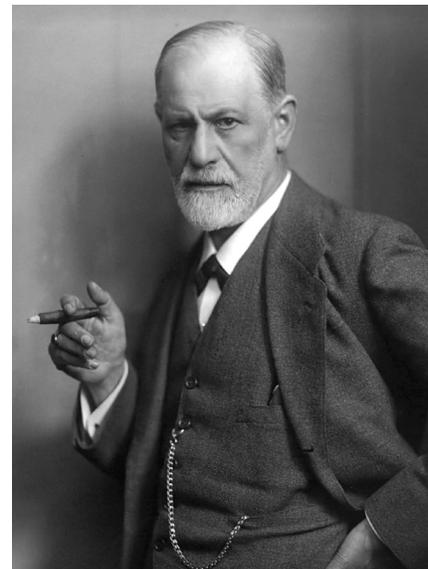
investigation. Likewise, should my students propose a study with a vulnerable population (*i.e.*, children, prisoners, etc.), their research protocol will necessarily undergo a stricter review process by an oversight committee to determine if these the aforementioned ethical principles were met and participants were kept from harm.

To further illustrate the need for ethics, we extended these ideas to a few interventions and studies conducted in the field of psychology. We covered practices like the lobotomy, which existed before our current ethical standards were established. The lobotomy was a psychosurgery that gained popularity around the 1940s and early 50s. This once revered and Nobel Prize-winning practice was thought to help mental disorders by severing parts of a person's frontal lobe. The surgery was often performed on groups we now deem as vulnerable and in need of greater protections, such as prisoners, those with mental illness, and even minors—the youngest of which was a twelve-year-old boy. Most famously, Rosemary Kennedy, the sister of John F. Kennedy, underwent the surgery and was reportedly left speechless with a greatly reduced mental capacity.

In this example, the use of the popular surgery highlights the need for extra caution, particularly when using a medical intervention to treat a psychological condition. Imagine, what if there was a greater measure of accountability that was required for this practice? What if beneficence, or doing no harm to patients, had been adhered to? Unfortunately, it took a number of failed surgeries and many ruined lives before this aggressive intervention was marked as unacceptable and that the risks associated with the surgery far outweighed the benefits for most patients.

Sigmund Freud's Ethical Dilemma

Another example I often shared with students underlines both our need to operate from good research ethics and integrity when engaging in research and psychological practice. This case comes from the father of psychology, Sigmund Freud, who was both a researcher and a clinician. Sigmund Freud and others (e.g., Charcot, Janet) were a few of the first researchers to observe and describe trauma symptoms in their patients. These neurologists, including Freud, offered descriptions of traumatic stress that had not previously been outlined prior to their observations in the late 1800s. In fact, many of our current conceptualizations of trauma came from their work. We now name their observations as *posttraumatic stress* and *dissociation* and give these symptoms place in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).



Sigmund Freud

Freud was also one of the first researchers to accurately deduce that his patients' symptoms were an artifact of "premature sexual experiences."¹ This was a considerably controversial but accurate finding. In her seminal book on trauma, Judith Herman noted that Freud soon became aware of the enormous social consequences of his discovery.² If he carried on with his theory about the etiology (cause) of "hysteria," or trauma

symptoms, the personal and social implications could be staggering. Should the members of the ruling or bourgeois class be accused of committing heinous sexual violations against children, Freud's credibility might come into further question. Similarly, how would society handle the truth about their leaders?

Freud's response was to yield to the pressure. He eventually pivoted from his original theory about the cause of trauma symptoms. In his denouncement, great harm was done to those who were in his care. His patients had finally found a trusted confidant who wanted to understand their traumatic narratives, but they soon found that he had invalidated their experiences. Freud's next move was to outline an explanation that denied an etiology of sexual abuse and reframed his patients' trauma symptoms as stemming from sexual wishes and desires.

Again, although our current standards were not at play during this time period, retrospectively, it is easy to see from these examples that there is a clear need for ethical guidance in both the research and clinical domains. For Freud's patients, there's very little evidence to say that the principles of beneficence, respect, or justice were upheld in his actions towards his patients or his theoretical progression on trauma. In short, his patients were disrespected and left without *justice*.

Freud's story speaks to us about the vulnerability of science, in which a researcher can create a theory that has been influenced by what is popular and politically advantageous. As we look back at history, we can see several noteworthy consequences of Freud's intermingling of science and politics: true scientific inquiry into trauma and abuse mostly stopped for decades; the reality of trauma and abuse was, again, largely denied by society; and trauma victims were essentially blamed for their traumatic symptoms for many years that followed Freud's theoretical shift.

The Proliferation of Gender Confusion and the Targeting of Minors

After sharing these stories with my students, I would end our unit on ethics with a question and an admonishment. I noted, "isn't it easy to look back in history, void of social context, and characterize the mistakes of others as backward, bigoted, and perhaps evil?" What about our ability to ascertain ethical practices in our day? Are we able to perceive mistreatment? In other words, can we discern and refute a theory or an intervention when it goes against what is fashionable or even recommended by the authorities of our day?



Arguably, we are at a time that requires a thoughtful examination of how we ethically care for and protect our children. Right now, in the United States, there are an estimated 13,000 people who started a pharmaceutical treatment as minors to block the natural

maturation process of their biological sex.³ To date, there have been 11,000 gender reassignment surgeries performed in the United States, according to the American Society of Plastic Surgeons.⁴ The surgical market is predicted to grow from the year 2020 value of \$304.8 million to a forecasted \$781.8 million in 2027.⁵ That is roughly a 14 percent growth rate over the next seven years. As demands are placed on this market, we can expect minors to be increasingly targeted for these lucrative interventions. We should be greatly alarmed by the fact that minors can access medical interventions to radically alter their physiology in an effort to “fix” gender dysphoria. This disturbing fact should garner our full attention and prompt us to act.

Currently, there are reported instances of minors seeking counseling for a set of distressing psychological symptoms (*e.g.*, anxiety, suicidal ideation, substance abuse) that are often found in tandem with gender confusion. In many cases, the focal point of treatment will be the gender dysphoria diagnosis. Part of the subsequent treatment recommendations will be for the clinician to affirm the minor’s desired gender identity. According to the DSM-5, the clinician is supposed to wait six months before diagnosing gender dysphoria.⁶

There are several problems with this diagnosis. For now, there is no clear and sound understanding into the etiology of gender dysphoria. In fact, one large-scale study found elevated reports of depression and anxiety that were two and three times higher in gender minorities or transgendered persons.⁷ Based on these findings from 2016, the authors called for more studies to investigate the cause of depression and anxiety among those identifying as transgender.

At this time, there is still no clear reason given by researchers that fully explains the elevated rates of psychological distress in the transgender community. Rather, the argument is often made that discrimination is one of the primary sources of psychological distress in the community. We can recognize that the effects of discrimination or bullying may account for distress in some people, but is this true in every case? Can we really say that discrimination is the primary reason why studies like the 2020 report from the Trevor Project continue to find that 52 percent of transgender and nonbinary youth surveyed considered suicide in the last year?⁸

There is also mounting evidence that other psychological symptoms, like substance abuse, are also associated with gender dysphoria and experienced at higher rates when compared to those who do not identify as transgender.⁹ Shouldn’t this give us pause before sending minors on a path that involves medical intervention?



Protecting the Vulnerable Must Be Central to the Helping Profession

Aside from a lack of solid evidence to support the medical approach to gender dysphoria, we cannot forget that gender-affirming practices are in grave opposition to the ethical standard of causing *no harm*. When a minor is offered a risky intervention like puberty blockers or gender reassignment surgery, which lacks solid empirical evidence, this should

be deemed an ethical violation. Again, these treatments are given without a clear understanding into the etiology of gender dysphoria or the long-term effects these procedures have on minors.

Historically, children have been viewed as a vulnerable population and are owed greater protection by our current ethical standards. Yet, we are seeing states like Oregon redefine these basic ethical principles, as evidenced by permitting 15-year-olds to make permanent alterations to their physiology.¹⁰ Minors who are expressing psychological distress and are not yet old enough to vote in elections have been deemed capable of giving consent to make structural changes to their bodies that may alter the rest of their lives.

At the very least, decisions to undergo radical treatments—including puberty blockers, initiating a lifelong supply of hormone treatments, and surgical procedures aimed at removing healthy organs and body parts—should not be done in haste and not until development has ceased. Likewise, these decisions should be made with true informed consent that respects an appropriate age to self-determination. To further support genuine consent, gender clinics should be mandated to discuss the full range of medical and surgical outcomes, including a possible desire to de-transition sometime in the future.

Much like Freud's day, we stand at an exceptional point in history. We are faced with a decision about how we will ethically and responsibly care for the distressed children of our day. Freud and his colleagues showed us that true scientific advancement can be contaminated when the helping profession is unduly influenced by politics. Freud yielded to the political class, and the experiences of trauma victims were mostly sidelined for many decades to come. What will our response be? Will we see beyond the current in-vogue theories and interventions of a constructed idea like gender dysphoria? Will we protect vulnerable children from being physiologically and psychologically marred by these harmful and unethical practices? Importantly, can we commit to searching for real answers to address the true source of our children's pain?

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Endnotes

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ABOUT THE AUTHOR



Dr. Jennifer Bauwens serves as Director of the Center for Family Studies at Family Research Council. In her role, she researches and advocates for policies that will best serve the health and well-being of families and communities.

Jennifer has a Ph.D. from New York University, where she was bestowed the Robert Moore Memorial Award and granted valedictorian for her dissertation on Hurricane Katrina.

Dr. Bauwens has worked extensively as a clinician providing trauma-focused treatment to children in foster-care and behavioral health settings and to adults who've experienced interpersonal traumas, such as sexual abuse and assault. She created programs to mitigate the effects of traumatic events for survivors of domestic violence and abuse, and she's trained on violence prevention for youth and adults in both national and international contexts.

Her scholarship has focused on the effects of psychological trauma, including man-made and natural disasters. She's worked on projects to investigate the long-term psychological sequelae of witnesses and survivors from September 11, 2001, and other acts of community violence. Additionally, Jennifer has taught on psychological trauma and research methods in several graduate programs, including Rutgers University and Princeton Seminary. She has also served as an editorial consultant for, and published in, peer-reviewed journals focused on clinical practice and traumatic stress.