

Gender Dysphoria and Mystery Syndromes of the 1990's

Until recently, medicine had nothing to offer that was of any earthly use except insofar as it satisfied our love of ritual and mobilized the placebo effect. By some quirk of interpretation, the noxious taste and emetic effects of medicinal compounds passed as virtues, and when we recovered from illness (as we usually do) we ascribed our good fortune to the ministrations of healers, not our capacity for recovery. That such an inveterate fallacy vanished without a trace with the advent of scientific medicine in the 20th century is not to be believed.

In [a classic study published in 1978](#), both patients and their doctors tend to attribute recovery from a minor illness to medication even when the same patients would have fared just as well if they had never taken medication (and maybe if they hadn't seen the doctor at all). However, the practice of misattribution has branched out, and just as some credit medication with recovery from an illness that didn't require it, others blame illness on fictitious causes in the act of diagnosing themselves. So it was in the case of a cluster of intractable illnesses that confronted medicine in the 1990's. Arguably, misattribution is at work too in the burgeoning, and also self-diagnosed, disorder of gender dysphoria (GD). In both instances doctors encounter patients convinced that they suffer from a given condition regardless of a lack of objective signs; only recently, however, did it

become the doctor's bounden duty to accept a diagnosis without question on the patient's word.

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Among the syndromes fueled by misattribution is chronic whiplash, wherein patients blame whiplash for symptoms that would ordinarily cause little concern, and in the process make them concerning. [Write Robert Ferrari and Harald Schrader:](#)

In North America . . . there is overwhelming information on the potential for chronic pain outcomes after whiplash injury, with widespread knowledge of the expected symptoms even among people with no personal experience of having a collision. This expectation will in turn lead the person to become hypervigilant for symptoms, to register normal bodily sensations as abnormal, and to . . . make them more alarming, ominous, and disturbing—symptom amplification.

In other words, under the influence of loaded expectations, the whiplash victim attributes ordinary distresses (such as headache or back pain) to a folkloric construct, thereby intensifying the distress signals themselves. By withdrawing from normal activity, the patient further feeds the cycle. If someone in the throes of this syndrome were to seek treatment, the doctor would be ill advised to endorse the patient's self-conferred diagnosis of chronic whiplash, which after all has inflamed the problem.

As it happens, chronic whiplash is but one of a group of disorders that entered the ecosystem in the latter 20th century and were taken up by patients who diagnosed themselves and invested their health in their findings. That medicine could identify no cause for their distress only persuaded these patients that lived experience was more valid than conventional medical knowledge.

As if they somehow captured the imagination of the moment, the 1990's saw a proliferation of these self-diagnosed disorders. The conditions in question included silicone-breast-implant syndrome, fibromyalgia, sick-building syndrome and Gulf War syndrome, in all of which the patient reports distress which no lab test can clarify and for which no cause can be found. What makes the outbreak of all these syndromes around the same time a precursor to the explosion of GD in recent years is not only that they were self-diagnosed, but that they acquired constituencies and even belief-systems. In some cases an illness like these becomes more than an illness; it becomes an identity and a cause. [The best survey of these challenges to medicine](#) aggregates them under the rubric of “functional somatic syndromes,” with “functional” meaning that the disorder in question can't be traced to any laboratory finding or identifiable abnormality. Like a twin of the patient who misattributes improvement to treatment, the FSS patient misattributes an illness that resists treatment to a cause that eludes detection.

Write Arthur Barsky and Jonathan Borus:

Patients with these syndromes often have very explicit disease attributions for their symptoms, and they resist information that contradicts these attributions. These

patients often have a strong sense of assertiveness and embattled advocacy with respect to their etiologic suppositions, and they may devalue and dismiss medical authority and epidemiologic evidence that conflicts with their beliefs.

It is the stance of “embattled advocacy” that marks such patients as forerunners of the patients today for whom GD is all at once a self-diagnosis, a banner and a world-view.

Much like GD but without benefit of the internet, the mystery syndromes of the 1990’s had their own interest groups, all seeking “to mobilize public opinion, influence scientific debate, and shape public policy.” Barsky and Borus do not lend their support to these campaigns. Quite the contrary, their concern is how best to extricate patients from the unhappy syndromes in which they have invested, for some reason. Clinicians are advised to explain how symptoms grow louder and to avoid ratifying the patient’s fixed ideas and errors of attribution.

According to Barsky and Borus, the patients caught up in FSS’s do not spin something out of nothing and then get stuck in their own web; they spin the syndrome out of real ills, but ills which for others are simply part of life, such as fatigue, weakness and headaches. (Here, then, is a fore-glimpse of the “symptom pool” mentioned by today’s critics of gender ideology and its excesses.) By ascribing these ills to a pathological cause which varies by syndrome, the patients aggravate their distress and render it more difficult to treat. In other words, in the case of all these syndromes, from sick building to chronic whiplash, the disease is the conviction that one has a disease; the patient risks inhabiting a misattribution.

The non-somatic disorder of GD whose efflorescence we are now witnessing resembles the functional somatic disorders of the 1990's, with all their combined "assertiveness" bundled into a single hyperbolic crusade. "Gender dysphoria" becomes the ultimate explanation of the patient's problems, by analogy with the theorized cause responsible for the ills of the patient with an FSS. In that one's gender identity is supposedly entirely inward, with no physical trace or marker, it corresponds all too well with the mysterious undetectable something that lies at the heart of an FSS. Where the embattled patient of the 1990's constructs a controversial disorder out of common symptoms, adolescents now configure their crises into the cause célèbre known as GD. For some, having GD is like waging an argument with a dimorphic world. However, while Barsky and Borus seek to nudge the combative patient out of his or her belief-system, the practice of gender-affirming care (as it is called) validates and entrenches it.

In DSM-5 and its recent revision, GD calls for at least two symptoms on a list of six, five of which are either a desire (e.g., "A strong desire to be of the other gender" or "A strong desire to be treated as the other gender") or a belief ("A strong conviction that one has the typical feelings and reactions of the other gender"). To profess feelings seems more like a rite of identity politics than an actual diagnostic procedure. The patient affirms his or her feelings, the clinician affirms the patient, and the circuit is complete. It is under this sort of permissive diagnostic regime, and with clinician and patient acting in concert, that GD has reached its current prevalence. According to the [Cass Review](#) commissioned by England's National Health Service, "Recorded prevalence of gender dysphoria in people aged 18 and under increased over 100-fold between 2009 and 2021"—a surreal, belief-defying figure.

To a gender ideologue, the astronomical increase in a formerly rare condition means, of course, only one thing. It means that once the traditional intolerance of gender nonconformity is contested—once those oppressed by a sense of being in the wrong body have the freedom to make themselves known—then a condition judged rare turns out to be far, far less so than the judges were ever prepared to acknowledge. The Cass Review deems this explanation improbable, noting that “The exponential change in referrals over a particularly short five-year timeframe is very much faster than would be expected for normal evolution of acceptance of a minority group.” A more plausible explanation of the GD epidemic is that the numbers are highly inflated, and that generic troubles of adolescence have been branded as the disorder of the hour, first by the parties themselves, then by the clinicians who certify their self-diagnoses.

Just as whiplash occurs far less often in countries that lack the concept and lore of whiplash, epidemics of GD do not break out in the absence of a great deal of exaggerated buzz (corresponding to Ferrari and Schrader’s “overwhelming information”) about GD. Like the reputed cause of an FSS, the reputed origin of the distress of someone self-diagnosed with GD—that is, incongruence with one’s own body—circulates like folklore and locks in like ideology. As with an FSS itself but to an even greater degree, GD is for many a polemical act. Certainly it is more credible that young patients have misattributed their problems to a highly charged cause than that the number of gender-dysphoric adolescents has actually risen by two orders of magnitude over a few years.

The elevation of the formerly rare disorder of GD to its current charismatic status has encouraged the notion that it explains all things. But if there is no such magic key to the problems of adolescence, then it seems misguided for clinicians to focus single-mindedly on medical treatment of GD, somewhat like clinicians who enforce the medical model by endlessly testing for the cause that isn't there. In Abigail Shrier's *Irreversible Damage* we meet, among others, "Maddie," whose GD "seemed to intensify" in the course of treatment at the hands of a therapist fixated on gender identity to the exclusion of all else. Perhaps Maddie worsens because the disorder for which she is being treated is not the source and sum of her problems. A pattern of deterioration after self-diagnosis is documented in Lisa Littman's unjustly reviled [study of rapid-onset GD](#), with the adolescents in this case having convinced themselves that they suffer from GD even though they gave no sign of it beforehand. Patients like Maddie on the one hand and the population of Littman's study on the other risk making their woes worse by convincing themselves that they all stem from a single toxic cause.

Says a counselor in Helen Joyce's *Trans*, "With enough time and rumination, anyone can end up thinking that they're trans." To ruminate yourself into believing you are something you aren't, because a certain favored disorder explains everything you are, is to devote yourself body and soul to the fallacy of misattribution. (In Barsky and Borus rumination is "self-scrutiny"; in Ferrari and Schrader, "hypervigilance.") If the patients in *Trans* all actually suffered from GD, the author would not be able to make a good case that

their distress would probably resolve if allowed to, and that medical treatment imposes permanent and costly consequences on an episodic condition.

One can see why distressed young patients might slip into the belief that they belong to the other sex. In an era of identity politics GD offers an identity of honor to adolescents, a group proverbially searching for who they are. It is less easy to excuse medical doctors who abet patients' confusions by buying into the facile belief that they suffer from this curiously popular disorder. Ferrari and Schrader, employing a "biopsychosocial" model one would have thought congenial to postmodern medicine, wisely advise the treating doctor not to affirm the whiplash patient's misconceptions but to unweave them patiently, without becoming argumentative. In a similar spirit, Barsky and Borus caution doctors against endorsing the patient's adversarial belief-system. As patients continue to dig themselves into syndromes diagnosed by themselves, such advice continues to make sense. We do not want medical doctors joining in a folie à deux with their patients. We do not normally call on them to adopt the thinking of adolescents, people navigating the most notoriously volatile and mixed-up period of human life. We justly expect them to be able to distinguish an ideological mania from a profound disorder, folklore from causation, advocacy from evidence. Too often, gender medicine now fails these expectations.

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