The Problem with Distress :
Why Patients Deserve Diagnosis Before Intervention

By Tracy C. Coyle

"When we are no longer able to change a situation, we are challenged to change ourselves."
— Viktor Frankl

“Attention is the rarest and purest form of generosity.”
—Simone Weil

Introduction

The Problem We Think We Solved

There is a quiet satisfaction that comes with believing a problem has been resolved. In medicine, that satisfaction is often hard-won. It follows decades of debate, accumulated evidence, and the slow convergence of practice around something that finally feels humane, workable, and defensible. When a field reaches that point, it is natural—perhaps inevitable—for vigilance to relax. The category is named. The pathway is defined. Care becomes routinized. What once required judgment becomes protocol.

In recent years, gender-related distress has come to occupy this kind of settled space. What was once treated as rare, confusing, and difficult to classify is now widely understood, publicly discussed, and clinically approachable. The shift has been framed—correctly in many respects—as a moral advance. People who once suffered in isolation can now speak. Those who seek help are more likely to be believed. Barriers to care have been lowered. A vocabulary exists where none did before.

From the outside, it appears that a problem has been solved.

Yet beneath this surface resolution lies an unresolved clinical question—one that has been quietly displaced rather than answered. We have learned to respond to distress. We have become adept at naming it. We have even organized systems of care around it. What we have not done, with the same care or insistence, is ask what that distress *is*.

Gender dysphoria, as it is currently understood, is not a diagnosis in the classical medical sense. It does not specify a mechanism. It does not distinguish among causes. It names a state of suffering along a particular axis and treats that state as sufficient. This has been defensible as a pragmatic accommodation: a way to ensure access to care without pathologizing identity. But accommodation is not diagnosis. And a symptom, however morally compelling, is not an etiology.

In every other domain of medicine, this distinction is fundamental. Fever is not a disease. Pain is not a pathology. Shortness of breath is not a diagnosis. These are signals—important, often urgent—but they do not tell us *why* something is wrong. They demand inquiry, not conclusion. To stop at the symptom is to abandon the central task of clinical practice.

In the domain of gender-related care, that abandonment has been subtle and well-intentioned. It has occurred under social pressure, political urgency, and genuine concern for suffering patients. The field has been asked to resolve moral conflict as much as clinical uncertainty. In that environment, clarity can feel like cruelty, and differentiation like exclusion. It is easier—ethically and institutionally—to treat all distress as the same kind of thing.

But systems, like organisms, behave under pressure. They optimize for stability. They compress complexity. They trade precision for legibility. This is not malice; it is function. When a category becomes socially charged, a system narrows the range of permissible distinctions. It learns which questions calm conflict and which provoke it. Over time, the system stops asking certain kinds of "why."

What emerges is not bad faith. It is equilibrium.

The result is a single explanatory frame that now absorbs heterogeneous human experiences: childhood nonconformity, adolescent identity formation, trauma-mediated alienation, body image disturbance, social rejection, and—within a much smaller cohort—a persistent internal perception of bodily incongruence. These mechanisms are developmentally distinct. They imply different trajectories, different risks, and different forms of care. Yet they are increasingly treated as variations of the same condition.

For adults, this flattening may be survivable. For children and adolescents, it is not benign.

Development is not an event; it is a process. Children do not discover who they are in a single moment. They construct themselves across time, through play, failure, imitation, resistance, and revision. Distress during this process is common. It is often intense. It is not, by itself, diagnostic. To interpret that distress as evidence of a fixed internal truth is to convert a developmental signal into an ontological claim.

The danger is not that some children truly experience incongruence between self and body. They do. The danger is that *all* gender-related distress is increasingly read through that lens. When this happens, a system designed to relieve suffering begins to shape identity. The category no longer merely describes; it directs. A response state becomes a narrative. A narrative becomes a trajectory.

This book is not an argument against care. It is an argument for diagnosis.

It does not deny suffering. It insists that suffering deserves understanding. It does not question the reality of internal incongruence in some individuals. It asks only whether we have preserved the conceptual space to recognize it as distinct. It does not propose restriction. It proposes discrimination in the clinical sense: the careful separation of unlike things.

The problem we think we solved is distress. The problem we have not yet faced is what that distress *means*.

Why This Is Important to Address

Medicine exists for one purpose: to understand what is happening in a patient well enough to act in a way that improves that patient's life. Everything else—classification, standards of care, professional language, institutional authority—exists in service of that end. When those instruments drift away from understanding, they do not merely become inefficient. They become dangerous.

The reason this book is necessary is not that clinicians have become careless. It is that the field has been asked to carry moral, cultural, and political weight that medicine is not designed to bear. In that environment, diagnostic rigor begins to look like indifference. Differentiation begins to look like exclusion. And inquiry begins to look like resistance.

The pressure is subtle. It does not arrive as a directive to abandon science. It arrives as a request to reduce harm, to avoid stigma, to affirm dignity. These are legitimate aims. They are aims medicine should share. But when the effort to protect patients from harm replaces the effort to understand what is happening to them, care becomes symbolic rather than clinical.

Distress is morally compelling. A suffering person is difficult to deny. When that suffering is visible, public, and framed as urgent, the system responds. It must. Yet distress is not self-interpreting. It does not tell us what has gone wrong. It tells us only that something has.

In most areas of practice, this is obvious. A patient with chest pain may be anxious, ischemic, musculoskeletal, or gastrointestinal in origin. We do not treat "chest pain" as a disease. We treat it as a signal. We slow down. We differentiate. We test. We ask what mechanism could plausibly produce this experience in this person at this time.

In gender-related care, that step has increasingly been skipped.

The field has learned to respond to distress with immediacy and affirmation. This has been framed as progress—and in many respects it is. But immediacy is not diagnosis, and affirmation is not understanding. When the same interpretive frame is applied to every presentation along a broad spectrum of human experience, the system ceases to distinguish among causes. It begins to treat the outcome as the explanation.

This matters because different mechanisms require different forms of care.

A child struggling against rigid gender norms does not need the same response as a child who experiences a persistent internal mismatch between self and body. An adolescent navigating trauma or social alienation does not present the same clinical picture as one whose distress is centered on emerging secondary sex characteristics. An adult in midlife crisis is not developmentally equivalent to a preschooler with stable cross-sex self-reference.

Yet when distress itself becomes the diagnostic endpoint, these differences are flattened. The clinical question shifts from *what is happening?* to *how quickly can we relieve this?* Relief becomes the organizing principle. Etiology becomes optional.

For adults, this may result in misalignment. For children and adolescents, it can result in trajectory.

Development is path-dependent. Early interpretations shape later possibilities. When a system offers a single story to explain distress, that story does not merely describe—it directs. The child does not simply receive care; they receive an identity, a narrative, a future.

This is not coercion. It is structure.

Children are exquisitely sensitive to adult framing. They borrow language before they possess it. They inhabit stories before they can evaluate them. When distress is interpreted for them—by parents, clinicians, institutions—it becomes part of how they understand themselves. The distinction between "I feel wrong" and "I am wrong in this specific way" is not trivial. It is formative.

None of this requires bad intent. It arises naturally in any system under moral pressure. Institutions, like organisms, adapt to survive. They simplify. They standardize. They converge on stable patterns. When complexity becomes costly, it is reduced. When uncertainty becomes threatening, it is resolved.

The result is a field that now moves quickly, confidently, and uniformly in response to presentations that are anything but uniform.

This book is not an attempt to reverse progress. It is an attempt to restore medicine's most basic commitment: to understand before it acts.

The claim is simple:

Distress is real.
Distress is urgent.
Distress deserves care.

But distress is not diagnosis.

Patients—of any age—deserve more than relief. They deserve to be understood.