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Catholic Teaching on Transgender (Gender Dysphoria)

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Recently there seems to be an increase in numbers of children and adults presenting themselves as wishing to be members of the opposite sex. These people are said to be experiencing “gender dysphoria,” and society mostly uses the word “transgender” to refer to them. This means they are experiencing a strong desire to be a person of the opposite gender, and they act as if they already are, or express the desire to do so: they wear the clothing of the opposite gender, they want to be called by a chosen name and to be part of the activities of the opposite gender, at least as far as possible. It is important to note that some children express these desires in an ongoing way as young as four or five.

If they are not allowed to act as they desire, it can cause anxiety and an overall sense of “not fitting in,” from their youngest days. It would perhaps be more accurate to say that they could experience heightened anxiety and insecurity, since it seems to be statistically evident that anxiety and other serious psychological conditions persist, unfortunately, throughout their lives.

Gender dysphoria, formerly known as Gender Identity Disorder, differs from intersex questions since there are no physiological abnormalities or anomalies, yet the person is convinced that he/she is, despite bodily evidence, a member of the opposite sex. It is crucial to remember that

the cause of this condition is as yet unknown: that it is psychological or psychiatric in origin and not physiological. Discussions and questions about possible treatments or managing the condition are at best theoretical. We must be prudent in our assessments as how best to handle these situations, recognizing that what adults may think is the best way, may over the long term be wrong. Yet something has to be done where children are concerned, and school boards, for example, are wrestling with this.

Gender dysphoria raises many questions for the child, the family, the school and wider society. The public has become more aware of the condition through many incidents involving the use of washrooms and change rooms, in schools, restaurants and public places. This may not be an issue when a child is young, but adolescence brings other considerations in its wake, of course for the child, but also for others. As is usual in moral issues, there is more than the individual to be considered: there is also the issue of the common good.

The response of school boards has been on the whole one of empathy with the child presenting, and they have shown concern for the child’s wellbeing as the foremost consideration, notwithstanding the need to be mindful of other students and the school and home communities involved. These days, school boards also have to navigate directives from provincial human rights commissions, and these directives tend to be liberal, with a strong secular leaning. There is no doubt these directives influence the response of school boards and others, and this raises another

raft of serious problems or questions for schools that are trying to maintain their Catholic ethos.

CATHOLIC TEACHING

Catholic teaching on gender identity follows its established teaching on sexuality and marriage.

- a) Briefly stated:
- each of us is made in God's image as man or woman;
 - gender identity is determined at conception, genetically, anatomically and chromosomally;
 - a person must accept that objective identity.

- b) *The Catechism of the Catholic Church* (September 1997 edition), Section 2333, states:

Everyone, man and woman, should acknowledge and accept his or her sexual *identity*. Physical, moral, and spiritual *difference* and *complementarity* are oriented toward the goods of marriage and the flourishing of family life. The harmony of the couple and of society depends in part on the way in which the complementarity, needs, and mutual support between the sexes are lived out

- c) *The Compendium of the Social Doctrine of the Church* (2004), Section 224, states:

Everyone, man and woman, should acknowledge and accept his or her sexual identity. Physical, moral and spiritual *difference* and *complementarities* are oriented towards the goods of marriage and the flourishing of family life. The harmony of the couple and of society depends in part on the way in which the complementarities, needs and mutual support between the sexes are lived out. According to this perspective, it is obligatory that positive law be conformed to the natural law, according to which sexual

identity is indispensable, because it is the objective condition for forming a couple in marriage.

- d) Address by Pope Benedict XVI to the Curia, Thursday December 12, 2012:

The profound falsehood of this (gender identity) theory and of the anthropological revolution contained within it is obvious. People dispute the idea that they have a nature, given by their bodily identity, which serves as a defining element of the human being. They deny their nature and decide that it is not something previously given to them, but that they make it for themselves. According to the biblical creation account, being created by God as male and female pertains to the essence of the human creature. This duality is an essential aspect of what being human is all about, as ordained by God.

There is no doubt that the Church, while sympathetic to those who have this condition, does not condone any move that would attempt to alter the person's body to represent the opposite gender, although it would recognize counselling therapies that try to alleviate the dysphoria or distress.

MEDICAL APPROACHES TO GENDER DYSPHORIA

The DSM (American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, DSM V, 2013) re-classified this condition from Gender Identity Disorder to gender dysphoria. Although the condition has been moved to a lower level, its very classification indicates its psychiatric nature. It is a condition where people with the condition are genetically and chromosomally male or female.

TREATMENT OF GENDER DYSPHORIA

The medical response remains divided as to how best to treat people with this condition, especially

children: is (a) psychotherapy the best treatment or (b) should there be cooperation in altering the body through hormones (for children and adults) and/or surgery (for adults)?

A. PSYCHOTHERAPY

Those who advocate therapy do so because they say gender dysphoria is more probably a psychological disorder.¹ The condition apparently affects 1 in 30 000 males and 1 in 100 000 females. Some statistics say that 50 per cent of people with Gender Dysphoria die before age 30, often from suicide after severe anxiety. The success rate of psychotherapy is difficult to establish because of the possible presence of other underlying psychological problems.²

B. HORMONE TREATMENTS

Young children entering puberty are sometimes prescribed reversible hormone blockers to prevent the normal development of sexual characteristics such as breasts, and there is discussion in the literature about the long term effects of these. Adults who undergo sex-reassignment surgery need hormone replacement therapy to bring about secondary sexual characteristics, although some characteristics will never be eliminated. Repeat hormone therapy may be necessary to bring about desired change in tone of voice, facial hair, etc. Differing opinions are voiced in the medical literature, indicating that this type of therapy is not without its drawbacks, specifically long term effects on hormonal balance, especially should the child decide against its use once the new regime is established. The question of the capacity for consent to such treatment in pubescent children must also be considered.

Even more important are statistics that indicate that perhaps up to eighty per cent of children “revert” to their given gender during or after adolescence. This is a key predictor to outcomes of treatment, and should be a further warning against hormone blockers.

C. SURGERY

Some adults with gender dysphoria eventually choose sex re-assignment surgery. This consists of castration of the male and construction of a (non-functioning) vagina, mastectomy and hysterectomy for the female, sometimes with the construction of a (non-functioning) penis and testes. As noted above, ongoing hormone therapy is necessary, with possibly serious side effects.

Some studies show that successful outcomes are experienced at a rate of 2 to 1, while other studies claim a much higher success rate.³ Others claim that “the paucity of control groups or this type of survey makes attribution of either improvement or deterioration to the surgical intervention scientifically questionable.”⁴ The question remains open.

Several reputable hospitals stopped doing surgery of this kind after evidence-based studies concluded that surgery held no advantage over psychotherapy in these cases.⁵ They further decided that cooperation in this type of surgery was not justifiable since it was not needed for physical health, and that physicians should not cooperate with a disordered desire. Surgeons were concerned about being requested to remove body parts and to construct others, not because the parts were unhealthy or endangered the person’s life, but because of the person’s desire to be, or at least resemble, a member of the opposite sex.

CATHOLIC TEACHING ON SURGERY FOR GENDER DYSPHORIA

The principle of totality means that the bodily integrity of the person is to be respected and maintained at all times, and the only reason for interfering with that integrity would be to prevent a more serious harm. For example, one would allow amputation of a leg to prevent whole-body poisoning by gangrene. No one would reasonably choose surgical amputation or removal of a physically sound limb or organ in a physically

sound body. That constitutes mutilation, and is inherently wrong.

Sex reassignment surgery is not necessary surgery in the usual sense, i.e., to remove or repair a diseased part of the body to enable healing of that part or the whole body. Nor is it elective surgery, where people have to calculate whether a particular surgery will improve their health or is perhaps not worth the risks involved. In the case of gender dysphoria, the destruction of physically sound organs, including their reproductive capacity, for a non-physical condition, is at least disproportionate. If there is a request for surgery based on a possibility of suicide, the person should be treated directly by psychiatric means and not by indirect means of radical surgery in an attempt to relieve the person's severe mental strain.

In any event, such surgery does not return people with gender dysphoria to sexual normalcy, nor does it enable them to have children. It appears that after surgery, ongoing psychotherapy is often needed. People with the condition may have difficulties in forming personal relationships, making follow-up difficult, which in turn is not helpful for acquiring sound statistical evidence of outcomes.⁶

CONCLUSION

Given the unknowns that surround the causes of gender dysphoria, and also given statistics on unfavourable outcomes of hormonal and surgical procedures that try to 'change' gender, we would do well to take the least interventional approach of counselling therapy and support for those who have this condition. More information and education is needed for the community to protect children who identify with gender dysphoria, with interventions such as the use of pre-puberty hormone blockers being rejected.

Catholic teaching is clear on the need to accept the objective truth of the reality of our bodies in this condition, and therapy should have that aim as its goal. ■

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In 2015 Pope Francis appointed Dr McQueen as an Auditor at the Synod of Bishops on the Family (October 4-25), and in September 2014, he appointed her as a new member to the International Theological Commission for a five-year term.

¹ Sugar, M. "A Clinical Approach to Child Gender Identity Disorder," *American Journal of Psychotherapy*, 49 (Spring 1995): 260-81. Oldham, L.H. "Attitude Change in Response to Information that Male Homosexuality has a Biological Cause." *Journal of Sex and Marital Therapy* 2 (2) (1999): 12-124.

² Bodlung, O. et al. "Personality Traits and Disorders among Transsexuals." *Acta Psychiatrica Scandinavia* 88 (November 1993): 322-27.

³ Lawrence, Anne A. "Factors associated with Satisfaction or Regret following Male to Female Sex Reassignment Surgery." *Archive of Sexual Research* 32 (August 2003): 299-315.

⁴ Ashley, B.M., De Blois, J., and O'Rourke, K.D. *Health Care Ethics: A Catholic Theological Analysis*. Washington DC: Georgetown University Press, (2006): 110

⁵ McHugh, P. "Surgical Sex." *First Things* 147 (November 2004): 34-38.

⁶ Ashley, De Blois and O'Rourke, *supra*. p.111.