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Treatment of Children with Gender Dysphoria

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Currently in Canada there is zealous promotion of all LGBT matters. There is, however, often a lack of scientific evidence for some claims that are made. Nor is critique welcome in some quarters, as many speakers have found, and sometimes it is even made clear that the expression of any contrary views will not be allowed. This is unrealistic, since there are always positive and negative dimensions of human behaviour: we are complicated, multi-faceted and not always predictable. Political correctness has limits, and it is high time to pay closer attention to factual correctness.

In our society, capable adults make their own conscience decisions about their actions in moral matters, and, to protect freedom of conscience, this extends across the board, whether or not there are times when we think other people are wrong and that what they do is neither in their own nor society's best interests. This freedom, like all freedoms, is not without limits, e.g., if it can be shown that some decisions are likely to harm oneself or others directly, then some actions are prohibited.

Children are different. They do not have the capacity to make serious life-changing decisions. They cannot envisage the many possible implications of their behaviour in the way that adults do. They need a different approach, which is why most legal systems use the designation "minor," recognizing that young people, usually up until the age of sixteen, need help and protection in making such decisions.

If one of my grandchildren were to confide at a young age, as some children are already doing in kindergarten or first grade, that he or she were identifying as opposite gender, I would be concerned. First, this is clearly a serious matter, and how much can a four or five-year-old know about anything so serious after such a short time in the world?

Looking down the road, an adult can foresee all sorts of implications. Not so a child. The percentage of children self-identifying as cross gender is very small, and society is still working out how to respond in order to best help the child. The child states he/she "feels" like a member of the opposite gender, wants to act and dress like the opposite gender, and is most often unsettled and questioning.

Clearly something needs to be done. All such children need counselling from someone who understands the "big picture" and who can accompany them on a journey which will be quite different from that of their peers. Young children do not know that's what they face, but adults do, just as they understand the long-term implications of other circumstances in children's lives.

This counselling is not "conversion therapy," currently decried as a discriminatory and dangerous practice. Perhaps it is dangerous, perhaps not, but certainly the terminology is deficient. No one can "convert" anyone, unless by coercion or by brainwashing.

Even in the religious use of the term, the individual is the one who converts or changes. It is not achieved by the practitioner of any religion or by any evangelizer. The individual is the one who decides to turn to God (in religious conversion), or away from alcohol or drugs (through AA or other such counselling), or to alter behaviour (e.g., through marriage counselling), and so on. Such counselling or therapy entails the art of listening, explaining possibilities and outcomes where necessary, assuaging fears and evaluating desires, and also trying to determine the reasons for such fears and desires.

The same type of therapy is used for children, corresponding to the needs of the child. Where a child has gender dysphoria, a counsellor or behaviour therapist will try to establish if there are other concerns that could be affecting the child psychologically. Since such dysphoria happens infrequently, it is not accurate to explain gender dysphoria as normal or age-appropriate behaviour. Experientially and statistically that is not the case. On the contrary, parents usually become concerned for the child; teachers become concerned about how to handle the matter; school boards and other institutions establish policies to deal with questions raised by the child's situation.

At the same time, opinion in the psychological and psychiatric literature is clearly divided. We look to research and statistics to help explain matters with which we are not familiar, and it is not enough to rely only on claims made by advocates.

From any angle, those tend to be biased in favour of the stance they represent, whereas scientific and long-term studies try to achieve some measure of objectivity. Some long-term studies state that, as long as no hormone treatment is administered to a child around puberty, 80% of children reclaim their gender identity as male or female. This is an extremely high percentage, and decision makers need to be aware of this information before hormone treatment is provided, remembering they are dealing with minor children who do not fully see the long-term implications of starting the development of permanent characteristics of the opposite gender.

One implication is that being provided with hormone treatment will start the child on a course where this re-acceptance of his/her gender will not even have a chance to happen. Hormone therapy, not without its own long-term problems for some users, takes away the child's freedom to make an adult decision when that stage is reached. Surely this raises serious questions about informed consent, considered one of Canada's most important legal principles?

Another major point that decision makers should take into account in treating gender dysphoria in children is the notion of gender fluidity. Recent studies do not endorse the notion of "born this way," which some advocates use to justify the stance that the child's felt experience of being the other gender is simply to be affirmed and

encouraged as innate, therefore recommending treatment that moves them in that direction. Perhaps we should not be so hasty.

Dr Lisa Diamond heads a writing section of the *Handbook on Sexuality and Psychology* of the American Psychological Association (the largest scientific, professional organization in the US). She has given numerous TED talks on gender fluidity, and not only states that "the vast majority of gender dysphoric minors will eventually accept their chromosomal sex," but also that "therapy that is open to change is more beneficial than gay-affirmative or transgender-affirmative therapy." Writing from a lesbian perspective, Dr. Lisa Diamond is insistent that facts obtained through scientific studies are necessary for any grounded position on how we help people with gender dysphoria, especially minors.

The conclusions of the Association are telling. Its *Handbook* says there are three approaches to treatment of children self-identifying as transgender. They are: "…attempts to lessen the dysphoria and non-conformity; attempts to get the environment—family, school and community—to fully accept the child's variant gender identity; the wait and see approach." Further, it says that the "full acceptance" approach "runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist."

The first approach is open to discussion of what is involved in lessening the dysphoria, but may involve puberty blockers and so on: it is not clear what is meant. If one is concerned about accurate facts, full disclosure and the need for informed consent, it would appear that the third approach is of greatest benefit to children.

It is important to be clear that the recommended "wait and see" approach does *not* mean that nothing should be done while the child struggles with confused and confusing feelings about how to "be" in the world. Naturally the child needs counselling and support, and parents, medical and psychological professionals, teachers and any other professionals in the child's life can and should give that. There are psychologists, psychiatrists and counsellors who have spent years supporting such children, with the result that their long-term studies, findings and advice would be of great assistance to those of us who are in the learning process about what is involved in being supportive of the child with gender dysphoria as well as learning about how to discern what is in the child's best interests, especially over the long run.

There are, after all, many theories about gender identity, and it is important to remember that theories can only be shown to be accurate once long-term studies are available. Many voices advocate total freedom of gender expression these days, but such an approach has not yet been validly tested for its capacity to help people to be psychologically grounded and secure in their identity over their whole life.

Until more is known about such freedom and its effects, it would seem more prudent to support and monitor children's psychological

states rather than encouraging them in directions where the implications are not yet understood. We need to become more aware and less dismissive of existing long-term studies that, unfortunately, are not sanguine about the psychological and psychiatric state of transgendered people in adulthood, and which show that the suicidal ideation often found in youth is still a reality in mid-life and beyond.

Such studies give us vital information about supporting people with gender dysphoria. The need for support, counselling and accompaniment might well be lifelong for some people, as it frequently is for people with other types of psychological or psychiatric condition.

From an official Catholic teaching position, it is important to note what Pope Francis states in *Amoris Laetitia*, 56, concerning gender identity questions:

> Yet another challenge is posed by the various forms of an ideology of gender that "denies the difference and reciprocity in nature of a man and a woman and envisages a society without sexual differences, thereby eliminating the anthropological basis of the family. This ideology leads to educational programmes and legislative enactments that promote a personal identity and emotional intimacy radically separated from the biological difference between male and female. Consequently, human identity becomes the choice of the individual, one which can also change over time". It is a source of concern that some ideologies of this sort, which seek to respond to what are at times understandable aspirations, manage to assert themselves as absolute and unquestionable, even dictating how children should be raised. It needs to be emphasized that "biological sex and the socio-cultural role of sex (gender) can be distinguished but not separated".

CONCLUSION

Advocacy in any field must not be mistaken for evidence-based treatment decisions based on reliable and reputable scientific research. To ignore such research is to misinform and potentially endanger children with gender dysphoria, to whom we owe the best therapy available. ■

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