

Transsexual and Transgender Persons: A White Paper Reflection

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There are some individuals who experience conflict between their embodied anatomic gender and their psychological experience of gender. They may speak of being a woman trapped in a man's body, or vice versa. They sometimes express the desire to change their bodies, particularly their physical sexual characteristics, so as to take on the bodily sexual characteristics of the sex that is opposite from their biological sexual identity. People speak of "sex-change operations" or "sexual reassignment surgery," in which the external sexual characteristics of the opposite sex are fashioned by surgical means, supported by hormonal treatments.

The psychological community describes this condition as "gender dysphoria" (formerly "gender identity disorder"). It must be distinguished from other states or conditions, such as homosexuality, transvestitism, or hermaphroditism.

For a variety of reasons in our contemporary culture, the desire to change sexual identity by surgical and other medical interventions seems to be more common than in past years. Even the terms used to describe the phenomenon are fluid. The once-accepted term "transsexual" is often replaced by "transgender," reflecting the belief that while sex is biologically-based, gender is psychologically and socially constructed, and thus not bound by or necessarily linked to one's biological sex.

The purpose of this white paper is to provide some background on the issues related to transsexual and transgender persons and to suggest some lines of pastoral response from the Catholic theological tradition. It is intended as a working document, subject to revision as more information becomes available on this complex topic.

Distinctions

The fifth edition of the American Psychological Association's Diagnostic and Statistical Manual (DSM-5 [2013]) has chosen the term "gender dysphoria" to replace "gender identity disorder" in DSM -4. The APA comments:

For a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.

[see www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf]

Studies suggest that genuine transsexualism is more common among men; occurrence is about 1 in 30,000 male births and 1 in about 100,000 female births. This condition can cause extreme anxiety and distress; it is estimated that about half of these persons die before the age of 30, often by suicide.

Transsexualism is distinguished clinically from transvestism, in which a person is more comfortable sexually by wearing clothing symbolic of the opposite sex (sometimes called “cross-dressing”). Transvestites do not desire to change their actual gender, they simply adopt dress and ornaments of the opposite sex. Genetically and anatomically, transvestite persons are unambiguously male or female; their adoption of clothing is an external and generalized sexual expression, rather than an internal tension with their own sexual identity.

Some children are born with ambiguous genitalia, with both male and female characteristics in various combinations. A person may have one testicle and one ovary, often with both a uterus and partially-developed external organs of both sexes, or may have one side of the body predominantly male and the other, predominantly female. Once known as hermaphrodites (from the names of two Greek gods, the Hermes and the female Aphrodite), the term “intersexuality” or “intersexed” may be used, or diagnosed as Klinefelter syndrome. Genetically, such persons have an XXY chromosomal formula, containing both the male (XY) and female (XX) combination. Traditionally, such children have been raised in the sexual identity that seems to predominate (usually as girls). Even if surgical interventions take place to adjust the body to the predominant gender identity, the genetic complement remains ambivalent.

Transsexualism also differs from homosexuality. The homosexual person belongs to a determinate sex, experiences himself or herself as belonging to that sex, and does not want to change his or her sex. Rather, he or she is sexually attracted not to persons of the opposite sex but to those of the same sex. Thus, unlike transsexuality, homosexuality does not involve internal conflict between one’s anatomic sex and one’s perceived psychological sex. Rather, homosexuality involves the type of sexual attraction to others.

Sexuality and Gender: A Theological View

In a culture in which social media such as Facebook give menus of 70 different gender options, confusion and controversy continue to surround sexual issues. One of the defining debates of our time is whether sexuality is completely fluid, a social construct that can be changed or ignored at will, or whether human sexuality is a received fact with inherent sacred value and moral limits on its meaning and expression.

The Catholic theological tradition, rooted in Scriptural teaching and natural law, expresses the virtually universal consensus across times and cultures that the human community is composed of two complementary sexes, male and female. Both are created in the image of God, with equal

dignity, value, and personhood. While physiological and psychological variations of sexuality do exist within the human family, they do not alter the essential reality that humanity is composed of men and women. As Genesis states: “God created man in his image; in the divine image he created him; male and female he created them” (Genesis 1:27). The second account of creation in Genesis 2 reflects the same complementarity of the sexes with the creation of woman from the side of man. Jesus confirms this teaching clearly in Matthew 19:4.

In this vision, the human person is a composite of body and soul, an incarnate spirit, an embodied person with reason and will. The soul does not merely inhabit the body indifferent to its physical composition, nor is the body merely an appendage of the soul. Human sexuality transcends the mere division of the sexes as seen in animals and even in some plants; rather, sexuality touches all the aspects of the person: body, mind, will, and spirit. Therefore, in the Church’s understanding, aspects of both the physical and the psychological orders combine to determine sexuality.

That said, it is true that the determination of sex proceeds through different stages as the person comes into being. Genetically, a person’s sex depends on the genetic complement (XX for females, XY for males). After about five weeks of embryonic development, the testes or ovaries differentiate; by the time of birth, the external sex organs are clearly distinct, which becomes the common way to distinguish boys and girls. These external manifestations of sex develop further during puberty with the “secondary sex characteristics”; and accompanying psychological changes take place in personal and psychosexual maturation in relation to self and others. Given the long, gradual, and progressive development of both physical and psychic elements of sexuality, it is understandable that variations and disturbances can occur at any of these levels and stages.

For the transsexual person, there is a dissociation between the fully determinate physical, genetic, and biological sex and the psychological perception of sexual identity. In simple but still accurate terms, there is a conflict between body and mind relative to one’s sexuality.

This conflict is often intense and profound, bringing anxiety, tension, confusion, and suffering. Often, this internal struggle reaches the point of seeking surgical and hormonal interventions that will change the body’s sexual characteristics to match the psychic perception of sexuality. Such surgeries are not life-threatening and recovery for a healthy person is relatively quick and uncomplicated. However, it should be made clear that the replication of the opposite sex’s external organs does not in fact produce the sexual function of such organs. While certain features of the body have been changed, the genetic and biological fact of the person’s sex are not changed. Thus, it is not true that the person has changed his or her sex; it is simply that bodily characteristics have been artificially altered to correspond to the psychological perception of sex.

Pastoral Responses

Given the transsexual person's conflict between body and mind, the fundamental choice for those who want to address the person's stress and suffering seems to fall between changing the body to match the mind, or changing the mind to match the body. While this is somewhat oversimplified, it highlights the two major approaches that have been taken. It should be noted that there is a consensus that the conflict in the transsexual person is primarily psychological: the body the person is born with, male or female, has an intact, complete, and functional sexual identity. The body is changed, though not repaired or healed, by surgical and hormonal means. There is no current evidence that the cause of gender ambiguity is biological or neurological; rather, it remains probable that it is the mind that is the source of the conflict.

Thus the long-standing forms of intervention for transsexual persons has involved treating the mind: restoring and strengthening the person's sense of self-worth, broadening the perception of self beyond the sexual sphere, and growing in their ability to relate to self and others in constructive and healthy ways. Even those who desire surgical treatments are required to go through counseling and psychological screenings, and because sexuality is more than merely physical, often require ongoing psychological support and help even after their operations. While bodily changes and the lifestyle changes that follow may help to relieve the person's dissociation and stress, they do not constitute a genuine change and an entry into the fully integrated self of the man or the woman they wish to be. As Ashley and O'Rourke state succinctly: "surgery does not really solve these persons' life problems because ... their problem is not primarily sexual satisfaction but the relief of the burden of anxiety, which can usually be lightened by psychotherapy." it does not enable them to achieve sexual normality or to enter into marriage and have children."

Conclusion

The disharmony between mind and body experienced by transsexual persons is real and can be severe. It calls for compassion, respect, understanding, and appropriate support. Surgical and hormonal treatments that focus on changing the body to heal the internal rift with the mind seem to fail to address the deeper roots of the disharmony and bring about the healing of the whole person.

Regardless of the origin of the disharmonies, tensions, or struggles we face, God loves each person. We cannot always change what happens to us or how we exist in our minds and bodies in an imperfect world. However, appropriate care for body, mind and spirit can help us accept our limitations and develop our potentials in harmony with human dignity and respect for God's will.