



Gender Dysphoria

By Rick Thomas and Peter Saunders

Changing views of transsexuality are making waves in popular culture, politics and medicine. This File examines these developments from a Christian and scientific perspective and will be of interest to health professionals, pastors, churches, organisations and families relating to people with gender dysphoria (previously gender identity disorder). It updates a previous CMF File.¹

Bruce Jenner, American Olympic gold medal-winning decathlete, made headline news in 2015 when he publicly announced his transition to a female, Caitlyn Jenner. In 2016, nominations for BAFTA awards included *The Danish Girl*, a film loosely based on the life of Einar Wegener, a Dutch painter in the 1920s who transitioned to Lili Elbe and became one of the first to undergo reassignment surgery, from the complications of which she tragically died.

Transgender people – those who identify with a different gender to the one assigned to them at birth – were first given legal recognition in their new gender under the terms of the UK Gender Recognition Act 2004.² To acquire Gender Recognition Certificates they had to have been medically diagnosed with significant dysphoria (discomfort or distress as a result of a mismatch between their biological sex and gender identity³) and to have lived successfully for at least two years whilst presenting themselves in their acquired gender.

The Equality Act 2010⁴ made it unlawful to discriminate against transgender people and the Marriage (Same Sex Couples) Act

2013⁵ made it possible for an opposite-sex marriage to continue following one partner's gender transition, given the agreement of the other.

A recent parliamentary committee report called for a move away from viewing transgender identity as a disease or disorder of the mind, and replacement of the present medicalised process with a simplified administrative procedure based on self-declaration by the individual applicant, free of intrusion by medical and legal personnel. The same report proposed that 16- and 17-year-olds should be eligible to apply for gender recognition, that children should be able to use puberty-blockers and cross-sex hormones earlier, and that Government should move towards 'non-gendering' official records.⁶

Changes in the law reflect changes in public attitudes and culture and have their counterparts in professional guidelines. The US Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-4, 1994) referred to cross-gender identification as 'Gender Identity Disorder'.⁷ In the Fifth

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Edition (DSM-5, 2013)⁸ the same phenomenon is described as 'Gender Dysphoria', shifting the emphasis from gender incongruence as a disorder to the distress (dysphoria) associated with the experience of that incongruence: 'It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition'.⁹

This change appears to have been

ideologically driven, the aim being to de-pathologise gender incongruence. A minority of psychologists and psychiatrists dispute the reclassification, preferring to see gender identity disorder as a body image disorder whereby a person may have an unshakeable conviction that they are one gender when in fact they are the other.

The General Medical Council (GMC) has produced guidance for doctors treating transgender patients¹⁰ and the Royal College of Psychiatrists published its 'UK Good Practice Guidelines' in 2013.¹¹

Sex and Gender

For almost 400 years Western societies have embraced a scientific understanding of the world, based on physical observations. Thus, at birth, a child's sex is determined by examining its external genitalia. Genetically males have XY sex chromosomes and females XX; morphologically males have testes and females have ovaries. Biochemically, sex hormones such as testosterone (male) and oestrogen (female) trigger the appearance of secondary sex characteristics (eg. voice, body hair distribution, menstruation).

This observed 'binary' system fits with the biblical description of created humanity as male and female.¹² Very rarely a person is born with an intersex condition,¹³ when it may be very difficult to determine the sex due to abnormalities in hormonal function or chromosomes. These conditions reflect disorders of sexual differentiation in the developing embryo and do not represent a 'third sex'. They should not be confused with transsexual people whose biological sex is not in doubt but who feel emotionally and psychologically as if they were born into the 'wrong' body. Most people experience congruence between their biological sex and their sense of gender identity, but for some people that congruence is lacking, sometimes from an early age, and they experience a degree of distress, or 'dysphoria', as a result.

Traditionally, the terms 'sex' and 'gender'

Terms¹⁶

- **Transgender** - an umbrella term for the many ways in which people might experience and/or live out their gender identities differently from people whose sense of gender identity is congruent with their biological sex
- **Intersex** - a term that describes conditions in which a person is born with ambiguous sex characteristics or anatomy - chromosomal, gonadal or genital
- **Gender Dysphoria** - the experience of distress associated with incongruence between one's biological sex and one's psychological and emotional gender identity. The degree of dysphoria and the effectiveness of coping strategies vary from person to person
- **Transsexual** - a person who has concluded that he/she was born in the 'wrong' body and wishes to transition (or already has transitioned) through hormone treatment and/or reassignment surgery
- **Genderfluid** - a term used by a person who wishes to convey that their experience of gender is not fixed as male or female, but may fluctuate along a continuum and/or encompass aspects of both gender identities
- **Gender bending** - intentionally crossing, or 'bending' gender roles
- **Cross-dressing** - dressing in the clothing, or adopting a presentation, of the other sex. Motivations vary
- **Transvestism** - dressing or adopting the presentation of the other sex, often for the purpose of sexual arousal. Not generally associated with gender dysphoria and may not identify as transgender

have been clearly distinguished, 'sex' referring to a person's biological make-up and 'gender' to those roles and behaviours typically associated with masculinity and femininity. Stereotypical gender roles may always have been in part generalisations, but in any case they have not survived recent changes in culture.

Increasingly, gender is being seen as a social construct, even a matter of choice.¹⁴ Gender identity is being portrayed as 'fluid' rather than fixed, a fluctuating point along a continuum of possible experience between male and female that may encompass aspects of both.¹⁵ 'Transgender' is the umbrella term used for the various ways in which people might live out their gender identities, outside of the simple categories of male and female (see box above).

Ways of viewing Gender Identity concerns

Mark Yarhouse, a clinical psychologist, describes three different lenses through which people may view gender identity concerns:¹⁷

1. **The integrity framework.** This view emphasises the sacred integrity of maleness and femaleness in creation, and the importance of their complementarity. One's biological sex is an immutable and essential aspect of one's personhood and to tamper with it is a denial of something sacred.
2. **The disability framework.** This view

recognises the fallen nature of our world and sees gender dysphoria as an example of things not being the way they were meant to be. It portrays dysphoria not as an immoral choice but as a non-moral, mental health disability in which sex and gender are not in alignment, to be addressed with compassion.

3. **The diversity framework.** In this view transgender issues are seen as something to be celebrated and honoured as part of normal human diversity. Its more strident proponents wish to blur the distinctions between sex and gender, recasting both as outdated social constructs.

In our Western cultural context, the diversity framework is emerging as most salient and is the view that increasingly drives public policy agendas. It is also becoming the prevailing source of guidance within the mental health professions. As a step towards the development of a nuanced Christian response to inform practice, pastoral care and public policy engagement, Yarhouse suggests an *integrated framework* for understanding gender incongruence that includes:

- respect for the integrity of sex differences
- empathy and compassion in the management of gender dysphoria
- identity, community and meaning for those navigating gender dysphoric lives

What are the causes of Gender Dysphoria?

Prevalence studies conclude that fewer than 1 in 10,000 adult natal males and 1 in 30,000 adult natal females meet the criteria for gender dysphoria, but such estimates vary widely.¹⁸ Gender dysphoria in adults is associated with an elevated prevalence of comorbid psychopathology, especially mood disorders, anxiety disorders, and suicidality.¹⁹ Mechanisms are incompletely understood, but genetic, neurodevelopmental, and psychosocial factors probably all contribute. Various theories exist and, as in the debate about homosexuality, their proponents tend to favour either nature or nurture explanations.

Most popular among those who believe nature is making the significant contribution is the brain-sex theory, referring to ways in which brain structure scripts towards male or female dispositions or behaviours.²⁰ But cohort sizes in cited studies are very small, post-mortem samples often come from transsexual persons who had used hormone treatments, and studies focus on brain morphology to the exclusion of other considerations like brain connectivity, load and efficiency. To the unbiased observer, results are highly inconclusive.²¹

Proponents of theories that suggest nurture makes the significant contribution give greater weight to the psychosocial environment in childhood.²² But cited studies tend to be correlational in design and although they may point to a relationship between gender identity struggles and psychosocial factors, they do not prove causation.

Given the breadth of the transgender umbrella, one unifying theory that would account for development seems unlikely. It may well be that aetiology is multifactorial and that contributions come from both nature and nurture. Good research, unbiased interpretation, open discussion and humility are all to be desired in seeking greater understanding. What does seem to emerge from clinical experience is that 'true' gender dysphoria is not 'chosen'.²³ It is isolating and distressing and sometimes the dysphoria may be compounded by hostility from others or by social stigma. With changing societal attitudes towards transgender people those with 'true' dysphoria may be being supplemented by others who are confused or experimental

but without more research, it is not possible to be sure.

Approaches to Treatment

Should greater weight be given to a person's gender identity so as to alter their body to conform to that identity (through hormones or transgender surgery), or should a person experiencing gender dysphoria receive psychological treatment or counselling aimed at altering their sense of gender identity to conform to their biology? Or should they simply be supported in their contradictory state?

As our culture moves towards a diversity framework, the notion of gender fluidity is increasingly accepted and the idea of trying to 'correct' a person's gender identity to conform to their biological sex is correspondingly less acceptable. Political correctness about the new orthodoxy can be strongly expressed and it is becoming increasingly difficult publicly to state alternative (and previously widely held) views.²⁴

a) Children

Questions about whether and how to treat children who present with gender dysphoria are particularly contentious. Some children seem naturally to go through a temporary phase of wanting to be the other sex and to dress in other clothes, but appear to 'grow out of it' just as naturally and go on to develop a congruent gender identity. According to the DSM-5, rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In biological males, persistence has ranged from 2 to 30 percent. In biological females, persistence has ranged from 12 to 50 percent.²⁵ It's clear that, for the majority of gender-confused boys and girls, gender dysphoria desists over time as they enter adolescence,²⁶ though a significant proportion of them go on to identify as bi-sexual or same-sex attracted (ranging from 63 to 100 percent for biological males, and 32 to 50 percent for biological females).²⁷

For those children whose dysphoria does not desist naturally, there are several treatment options that have been recommended by various therapists:

1. 'Watchful waiting' approach – in which cross-gender behaviour is permitted but not encouraged.²⁸ This approach allows a child to explore various gender

activities without the imposition of rigid gender stereotypes and allows the child to gravitate towards his or her own interests.

2. Intervention to decrease cross-gender identification, using behavioural therapy approaches – coaching parents to ignore cross-sex behaviour and to encourage gender-appropriate activities and play, and psychotherapeutic approaches – aimed at intervening more 'within' the child. In this way, the majority of children who are gender dysphoric experience resolution of their dysphoria before adolescence.²⁹ However, it is not known what proportion would have resolved 'naturally' and what proportion responded to intervention. The Portman Clinic³⁰ in London reported that 80 percent of children referred for gender dysphoria chose as adults to maintain a gender identity consistent with their birth sex.³¹ Further research is needed.
3. Facilitating social transition to the other gender by using affirmative approaches, for example the adoption of a new name, preferred gender hairstyle, clothing and play.³²

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4. Puberty Suppression. Children between the ages of 10 and 13 are given monthly injections of hypothalamic hormone blockers, thus preventing the gonads from making oestrogen and testosterone, in order to delay puberty and allow time for the gender-conflicted child to enter adolescence and make a more mature decision (at around the age of 16) whether to affirm either their birth sex or their cross-gender identity. If the latter, then they begin taking the hormones of the opposite sex.

Given that dysphoria will desist naturally without active intervention in the majority of children as puberty progresses, there should be no rush to facilitate early social transition or puberty suppression. There are additional concerns with puberty

suppression about brain development, bone growth and subfertility, as well as the possibility that the dysphoria might naturally have abated at the age of 12 or 13, but by which time treatment would have commenced.³³

b) Adults

The Standards of Care of the World Professional Association for Transgender Health (WPATH) note that the primary goal of therapy is 'to find ways to maximise a person's overall psychological well-being, quality of life and self-fulfilment'.³⁴ In general, the least invasive treatment option that enables the patient to live with, or find relief from, dysphoria is recommended by clinicians as the treatment of choice.

Treatment outcomes in adults point to a high attrition rate with as many as 50 percent of those who seek services dropping out due to personal ambivalence or frustration with the length, complexity or cost of the process.³⁵ It is not clear what happens to these people, but it seems likely that they find a way to compartmentalise their dysphoria, sufficiently to be able to function in life, or come to accept their biological sex and gender role.³⁶

Of those who undergo psychological treatment towards resolution in favour of their birth sex, a majority do not report resolution.³⁷ Instead, the most frequent outcome is to engage in cross-gender behaviours intermittently, often privately or in distant locales, as a coping strategy to reduce the felt tension within.³⁸

Finally, there are those who adopt full-time the gender role of the opposite sex. This may or may not involve having hormone treatment and/or reassignment surgery³⁹ following a psychological assessment and a period living full-time in the acquired gender.

Research on the outcome of gender reassignment surgery indicates that, for the majority (about 75 per cent) of those who undergo this process, the outcome is positive.⁴⁰ Predictors of a good outcome include good pre-reassignment psychological adjustment, family support, at least one year of living in the desired role, consistent use of hormones and previous psychological treatment. The author points to implications of the research that include an appreciation of the diversity of transgendered experience, the need for

more research on non-reassignment resolutions to gender dysphoria, and the importance of assisting the transgendered individual to identify the resolution that best suits him or her.

A more recent review of over 300 people who completed sex-reassignment surgery in Sweden over a fifty year period reported high levels of satisfaction and low levels (2.2 per cent) of regret,⁴¹ but also considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population.⁴² The long term study reveals only that there is an association between reassignment surgery and increased suicide risk in later life; it does not prove causation.

Commenting on the review, former Johns Hopkins chief psychiatrist Paul McHugh noted that the suicide mortality amongst those who had had sex reassignment surgery rose almost 20-fold above the comparable non-transgender population – a disturbing result that he felt might reflect the growing sense of isolation reported by aging transgendered people after surgery.⁴³ He suggests that psychiatry has caved in to individual preferences and cultural pressures, and likens sex-reassignment surgery to ‘liposuction on anorexics’.⁴⁴ In the US, suicide attempts among trans men (46%) and trans women (42%) are roughly ten times the rate found in the overall population, according to the findings of the US National Transgender Discrimination Survey.⁴⁵ Researchers found a number of factors that influenced whether a person was more likely to attempt suicide – in short, the more forms of discrimination, harrasment and victimisation that transgender people experienced, the more likely they were to attempt suicide. A recent study from Ontario confirms this effect. There, the suicide attempt rate for transgender people was about 18 times higher than the general population, but the study also found that some factors greatly reduced the attempt rate. In particular, the closer they were to having a body and outward identity that matched their internal gender identity – the less likely they were to attempt suicide.⁴⁶

Studies investigating the prevalence of psychiatric disorders among transgender people have identified elevated rates of psychopathology. A recent review⁴⁷ identified 38 cross-sectional and longitudinal studies describing prevalence

rates of psychiatric disorders and psychiatric outcomes, pre- and post-gender-confirming medical interventions, for people with gender dysphoria. It indicated that, although the levels of psychopathology and psychiatric disorders (mainly depression and anxiety) in transgender people attending services at the time of assessment are higher than in the non-trans population, they do improve following gender-confirming medical intervention, in many cases reaching normative values. However, there was conflicting evidence regarding gender differences and many studies were methodologically weak. For example, those who progress as far as medical intervention are, (because of screening), the most psychologically stable. Perhaps this indicates the difficulty of scientific objectivity in an area where there are so many vested interests.

The Fall distorts ‘both the physical experiences and the cultural expressions of gender’

Current GMC guidance permits a doctor ‘not to provide or refer any patients (including patients proposing to undergo gender reassignment) for particular services to which he or she may hold a conscientious objection’.^{48 49}

There are some very practical concerns that result from legislation that recognises gender-reassignment. Changing legal identity does not change biological identity. In aspects of health care, it is important to know a person’s biological sex. Some people prefer to see a woman doctor and may feel intimidated or uncomfortable if that doctor were to be transsexual. Sports organisations want to be sure that those competing in women’s events do so ‘on a level playing field’. Which changing rooms and toilets should transsexual people use? The situation is more complex still if they have changed legal gender but had no hormonal and/or surgical intervention.

Gender dysphoria represents a mismatch between a person’s perception of their gender and their actual biological sex. The danger is that in giving so much attention to changing a person’s body to bring the two in line, not enough effort will be given

to helping the person alter their gender perception to fit their biological sex, which will remain unaltered by surgery.

The status given by Western society to self-designation and individual choice, and the belief that technology can enable us to transform or escape what in the past was a given but may be experienced as a negative even destructive limitation, combine to empower the view that gender identity should take priority over biological sex.

The Bible and Sexuality

The Bible teaches that God made human beings in his image and of two sexes – ‘male and female he created them’.⁵⁰ They are different by design, but equal in value and, as St Paul makes clear (Galatians 3:28), enjoy equal access to God’s grace. God gave human beings a ‘stewardship’ mandate to multiply and fill the earth⁵¹ and equipped them with complementary bodies in order to fulfil that plan. In uniting as man and wife they would become ‘one flesh’⁵² and the Apostle Paul teaches us that this exclusive and loving union would be an ‘icon’, or sign of the love and union of Jesus and his bride, the Church.⁵³

In a discussion with his disciples about marriage and divorce, Jesus refers to three kinds of ‘eunuchs’ – those able to live contentedly as single persons.⁵⁴ He includes those ‘born as eunuchs’ – those who have no natural inclination to heterosexual marriage. Jesus appears not only to recognise that there are such, but to celebrate their freedom to serve his Kingdom, a theme picked up by Paul when writing to the church in Corinth.⁵⁵

Whilst Christians may have a range of views about gender role stereotypes, they do hold to a binary view of gender as God’s created pattern and must resist the redefinition of gender as fluid.

The Bible makes no specific mention of transsexuality; but the warning against ‘cross-dressing’⁵⁶ could perhaps best be understood in context as a comment upon actions aimed at blurring or confusing the clear gender distinctions within created design. The reference to the ritual uncleanness of those with testicular injury⁵⁷ may also have relevance for surgical procedures aimed at altering normal external genitalia.

Christians acknowledge that as a result of the Fall, things are no longer as they were

meant to be. The knowledge of God is scarce, and his pattern for human flourishing is unknown or ignored by many. The Fall distorts 'both the physical experiences and the cultural expressions of gender'.⁵⁸ But the good news at the heart of the Christian message is that God is a redeemer, graciously restoring something of his marred image in those who turn to him, and working through them lovingly to restore something of the brokenness in society. Ultimately, his promise is that all of creation will be fully restored in the new heaven and new earth,⁵⁹ but for now we are individual 'works in progress' as the Holy Spirit continues to make us more and more like Jesus Christ.

Christians should be careful not to adopt a legalistic and simplistic stance, representing the choice faced by the gender dysphoric person in terms of a simple yes/no decision of the will, for or against obedience to God's law. We do better to recognise the confusing complexity of the conflict being experienced, offering acceptance, community and compassion in working with the person to find the least invasive ways to manage the dysphoria, all the time pointing them to the One in whose image they are made and in whom wholeness is found.

To those wrestling with gender confliction and incongruence, as with all disorders, the gospel brings hope that the God who made us male and female can realign distorted identity and bring increasing coherence between sex and gender, even if such healing may not always be fully realised in this life.

Toward a Christian response

Christians must ensure that marginalised minorities are protected. Therefore they will strongly endorse the human rights of transgender people, affirming their dignity and guarding them from discrimination. Many transsexual people experience profound loneliness, sometimes aggravated by the shame and rejection they often feel projected towards them by religious people. By offering true friendship and acceptance Christians can help transform the experience of those isolated by their dysphoria.

True gender dysphoria is not a wilful choice, not deliberate sin. Very few transgender people are intent on

deconstructing meaningful categories of sex and gender. Compassion and empathy should characterise a pastoral response. Whilst clearly teaching the truth to all age groups, that God made mankind in his own image, male and female, Christians must

Our identity as Christians is not in our felt gender but in Christ, whether male, female, intersex or gender conflicted

find ways of helping gender-conflicted people experience welcome, identity and community amongst them, discovering for themselves a relationship with God, the transforming power of his loving fatherhood and the wisdom of his ways. The presence in churches of such transgender people, seeking to navigate their way as disciples of Jesus with integrity amidst complexity, is surely to be welcomed. It is an approach that chimes with Yarhouse's suggestion of an 'integrated framework' described above.

Beyond that, it may become possible to encourage a dysphoric person to consider strategies to resolve their dysphoria in keeping with their birth sex. However those coping strategies may prove unsuccessful and some people may then wish to seek relief from their dysphoria through cross-gender identity behaviour, hormone treatment and even reassignment surgery. Where possible, less radical and permanent strategies – for example, changes in name or mode of dress rather than pharmacological or surgical intervention – will be less damaging and therefore preferable.

A merciful, compassionate Christian response will involve continuing to care for people whatever choices they make, even when they resort to the more drastic strategies in an attempt to cope with their dysphoria. However, continuing to provide care should not imply endorsement of such choices as morally right or clinically appropriate and some clinicians will refuse to refer patients for gender reassignment surgery on conscience grounds believing that it cannot be in their patients' best interests to embark on strategies that disregard God's pattern in creation.

Conforming to the Lordship of Christ means seeking God's grace and strength neither to surrender to our felt passions and

inclinations if they cause us to act contrary to divinely ordained patterns, nor to encourage or assist others to do so. 'Wholeness' is found in relationship with God, and in following his ways and wisdom. Each of us is called to walk in obedience as a disciple of Christ, regardless of the cost to us personally, just as when a Christian who experiences strong feelings of same sex erotic attraction chooses not to express them but rather to live a life of faithfulness and celibacy.

Our identity as Christians is not in our felt gender but in Christ, whether male, female, intersex or gender conflicted. In the words of John Wyatt, we are 'flawed masterpieces'⁶⁰ undergoing restoration in the present and with a glorious future to come.

Rick Thomas is CMF Senior Researcher.

Peter Saunders is CMF Chief Executive

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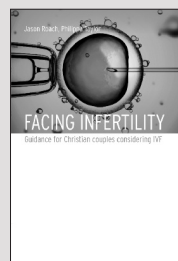
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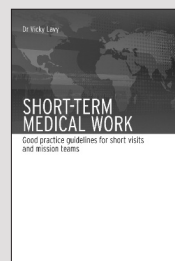
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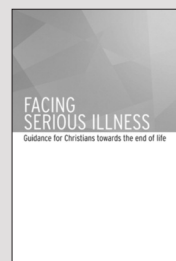
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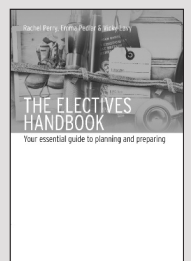
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