This is a pre-copyedited, author-produced version of an article accepted for publication in Christian Bioethics *(Volume 26, Issue 3, December 2020, Pages 243–268*) following peer review. The version of record is available online at: <https://academic.oup.com/cb/article-abstract/26/3/243/5906706?redirectedFrom=fulltext> , <https://doi.org/10.1093/cb/cbaa015>

**Social and Medical Gender Transition**

**and Acceptance of Biological Sex**

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1. INTRODUCTION

“Everyone, man and woman, should acknowledge and accept his sexual identity” (Catechism of the Catholic Church, 1992). In this paper, I will explore this comment: one of few in the Catechism closely related to gender transition whether medical (hormones, surgery) or social (dress, names, pronouns). The ethics of gender transition is a developing area for Catholic Church teaching, though intersecting with developed areas; my focus in this paper is also more philosophical than theological or confessional. Gender transition is unlikely to have been the focus, or the main focus, of the Catechism statement, written as it was in 1992 when transgender issues were much less to the fore. That said, the statement may be as good place as any to start the discussion, expressing as it does an approach to biological sex with fairly broad appeal, extending also to some, including some Christians, who identify as transgender and/or experience dysphoria.

How should we understand the phrase, though?[[1]](#endnote-1) Note that it refers not to *gender* identity, one’s subjective sense of maleness or femaleness, but to *sexual* identity i.e. *biological sex* as something to ‘acknowledge’ and ‘accept’. Given the range of personal situations in which one can find oneself, from intersex to gender dysphoria to same sex attraction, such acceptance of biological sex is surely compatible with various forms of unchosen experience and atypical physiological features. It is hardly a secret, after all, that human beings have widely divergent thoughts and feelings in these areas, and presumably the Catechism is not asking people to assume a mental state that is – whether currently, or perhaps indefinitely – a psychological impossibility for them.

II. ACCEPTING OR ACKNOWLEDGING?

To the extent that acknowledging and accepting might be seen as different things, acknowledging seems the easier of the two. Trans-identified people may well acknowledge factually (Yardley, 2015; Hayton, 2020) that their biological sex is what it is, irrespective of the gender with which they identify. “My biological sex is male, but my gender is female”, the person may say. Transitioned people may willingly, if wryly, note that transition does not change their or anyone’s birth sex: transwomen, for example, may be ‘socially’ women, but are in no way biological women. There are, in fact, different self-understandings among those identifying as transgender/transsexual. Even those who regard their own experience of dysphoria as the result of a biological intersex condition (the ‘brain sex’ model of dysphoria) may still acknowledge that at least their predominant[[2]](#endnote-2) biological sex is as it was recorded correctly at birth i.e. either male or female.

What stronger sense can be given to ‘acceptance’ beyond mere ‘acknowledgement’ of the fact that one is biologically male or female, and will always remain so? Of course, there is one obvious dimension where biological sex and its implications might be ‘accepted’: that of sexual ethics ‘proper’ – which seems in fact to be the focus of the Catechism statement, as the context makes clear. Minimally, acceptance means accepting the moral implications of one’s biological sex for any romantic, marital, and sexual choices one may make. This rich and challenging subject will be the focus of this paper only insofar as these choices intersect with choices concerning gender transition. I will not argue for, but will simply assume in the paper the truth and importance for human flourishing[[3]](#endnote-3) of the approach to sexual ethics taken by the Catechism and other likeminded sources of moral teaching. I will also assume the truth of the not unrelated position that human persons are *bodily* beings, not series of experiences or purely spiritual substances that merely ‘use’ their physical bodies.[[4]](#endnote-4) In the context of trans-identification, it should be noted that while self-descriptions in this area often have a somewhat dualistic ring to them,[[5]](#endnote-5) this need not be the case, and some explicitly disavow any dualistic self-understanding (Patti, 2016).

III. MEDICAL TREATMENT AND ACCEPTING ONE’S BIOLOGICAL NATURE

It might be said that *any* form of gender transition, medical or social, must preclude the value-focused ‘acceptance’ of – if not the factual ‘acknowledgement’ of – one’s biological sex. However, to ‘accept’ that one’s sexed nature and the body parts and functions associated with it are objectively good and ordered in some sense to one’s fulfilment as a human being only takes us so far. After all, one can accept that one is a biped kind of being, and that having two legs is right and proper for bipeds, while also accepting amputation as a medical necessity in the case of (at least) a physical pathology. The patient may ‘reject’ his leg qua unhealthy itself and/or as causing or threatening ill-health in some other part of the body without seeing it as unsuitable qua body-part for the kind of being he is, i.e. a biped kind of being. Castration to treat a physical health problem such as cancer, whether in the testes themselves or in some other, affected part of the body, is another case in point. Even if the healthy functioning of the parts removed is precisely what is being attacked, as it exacerbates cancer elsewhere, such an attack in the interests of the organism as a whole can still be morally quite appropriate. Of course, it does not follow that the post- castration/amputation state should be seen as entirely on a par with bodily wholeness, much less celebrated or embraced as constituting or confirming one’s identity in some profound and positive sense.[[6]](#endnote-6) One can celebrate the protection from severe ill health and even the social or psychological or spiritual opportunities one’s new condition may present without denying one has lost an ordered part of the human body that was in some sense good – albeit in no way essential to one’s characterisation as a male human being (or a human being more generally).

IV. HEALTHY FUNCTIONS THAT TRIGGER PSYCHOLOGICAL DYSFUNCTION

What about procedures aimed at avoiding *psychological* harm in relation to a body-part or function? One thinks of e.g. amputations for Body Integrity Identity Disorder (BIID)[[7]](#endnote-7) where a person may be chronically and painfully disturbed by the presence of a healthy but alien-feeling limb. If such operations can ever be seen as potentially acceptable for anyone, with whatever serious doubts and caveats (Song, 2013), it would need to be by appeal to some significant, sufficiently likely health benefit for the patient of a kind that could outweigh the significant damage caused.

Certainly when it comes to other, much less drastic procedures from which a patient will recover to some extent, albeit with some persisting damage, we may indeed be willing to accept such procedures in the interests of the patient’s overall health. An example might be a caesarean for a woman with a severe phobia concerning childbirth and/or a mental illness triggered by childbirth – both of which may be compatible with the patient herself accepting that vaginal birth is normal for human beings and not pathological in itself. At least in the case of such relatively though not entirely benign procedures (caesarians do impact negatively on reproductive health) we allow psychological and overall health to be sought despite lasting unintended damage caused.

To say this is not to say that *social,* as opposed to medical, goals can similarly justify interventions that cause the same level of damage – whether intended or unintended – to a particular part and function. On the contrary, we should be careful not to run together health interests and social interests when weighing what procedures are ‘best’ for ourselves or another person. There is more of an onus, most of us think, against causing than allowing harm, not least where the harm in question results from an intended bodily procedure. Often it is not possible or reasonable to prevent all harm and suffering, but bodily respect can still be shown: health deserves its own respect as a distinct ‘human good’ or aspect of human well-being. Few of us would defend, say, the castration of a young person to promote some spiritual or artistic goal, any more than we would defend limb amputation to enhance his overall social well-being (for example, enabling a scholarship that would lift him out of a poor and miserable life).

That said, the ‘principle of totality’(Pius XII, 1952, Pius XII, 1953) according to which surgical interventions must be in the overall health interests of the patient (or at least not cause serious permanent damage overall) can certainly be seen as incorporating psychological health (Jones, 2018). Indeed, mental health is a very important aspect of overall health. Even where a mental health condition has an identifiable organic cause or co-cause, we identify it as a mental health condition in the first place precisely by identifying (albeit not infallibly) pathological feelings and perceptions in the person concerned. Such feelings and perceptions are the problem itself*,* not mere co-existing symptoms of a problem otherwise defined. Thus the very fact that the person may be triggered by something in itself benign, as in the case of a phobia, is a feature of adverse mental health, even if we do not know the cause or co-cause.

It is true that, as David Jones has noted in this context (2018, 330-31), there is a difference between being distressed ‘by’ something, where that something is the *cause* of our distress, and being distressed ‘about’ something – bearing in mind that we can be distressed ‘about’ either real or imagined external threats, as well as aspects of ourselves like functional or dysfunctional bodily features. The point is well taken, though in practice, as Jones also notes, being distressed ‘by’ and ‘about’ something can certainly co-occur. In any event, it is not immediately clear that pathological feelings, simply as an aspect of mental health, cannot justify at least some function-impairing or even function-destroying procedures, for the sake of the overall health of which mental health is a part.

Physical as opposed to mental pain may be caused in fairly straightforward ways involving physical causes and effects culminating in the perception of pain. However, even physical pain requires, of course, the eventual transition of stimuli into their perception – which perception can, indeed, relate to things that do not physically exist, such as an amputated limb. The phantom limb is clearly what one is distressed *about* rather than *by,* since the limb no longer exists – though other physical causes produce the pain that seems to come from it. Indeed, even with normal physical pain, one is often distressed *about,* not just *by,* the painful part. Certainly, the causal pathway to the pain is often not one’s main concern as a sufferer, even if that pathway is thoroughly physical (and indeed, teleological, in that it warns of physical injury).

Both physical and mental health conditions vary in the extent to which *idiosyncratic* perceptions of the sufferer may be involved. In any case, as regards mental health, while it is certainly better to address the root causes of triggering where we can, it can at least be right to respond (as in the childbirth case) by *circumventing,* even ifdamaging however inadvertently, the healthy albeit triggering function.

Mental health treatments quite generally are concerned with distress, and are at least sometimes palliative rather than curative; for example, a patient very distressed by PTSD might have sedation, which addresses neither the harm done by trauma to the brain nor the social/psychological dimensions of PTSD. Similarly with gender dysphoria, the relative parts played by neurological and psychological and social contributions[[8]](#endnote-8) do not necessarily dictate the appropriate treatment for the person. That said, here as elsewhere, curative as opposed to palliative methods are certainly preferable in principle, not least because they are more respectful of human structural teleology (which comprises health) and its exercise (which comprises some degree of healthy functioning).

V. LIMITS TO PROMOTION OF PSYCHOLOGICAL HEALTH VIA DISABLING PROCEDURES

It would seem there must be *some* limits – certainly when it comes to permanently disabling procedures – to what we are prepared to do to alleviate distress by harmfully impacting on healthy body-parts, even for the health of the whole organism as we see it. Sex and reproduction is one particularly important area of health and healthy functioning, affecting the body as a whole and involving a rich dimension of social roles and meanings. However, the sexual/procreative is not the only area where special moral restrictions seem to apply: there are other morally sensitive functions such as those involved in interpersonal communication, and particular perceptual, aesthetic and cognitive functions that seem to call for special respect.

A person distressed by his ability to speak, an extremely important biological-social capacity, might need to be treated differently, should he want that function thwarted, from a person merely distressed by his ability to smell: a more ‘local’ and less multi-layered capacity. These are both functions that ideally should be ‘accepted’, but rejection of one is far more significant than rejection of the other: rational communication is the basis for so much of what lifts human beings above non-rational animals. Similarly, if a person with very severe OCD is traumatised by his ability to make moral choices, so crucial is this function to the moral life that it seems to call for a more ‘hands off’ approach than many other functions. Temporary sedation in this situation aimed at thwarting the choice-making function, if only by inducing sleep, would be one thing; depriving the person of the power to make any choices, ever again, for the rest of his life – especially if this was the aim, not a side-effect – would be something very different. We might also consider parts of the brain associated with empathy, or with remorse, or spirituality: to attempt a life-time obstruction of these functions seems abhorrent, even if our aim were that of promoting overall health. Certainly, health – the tendency to integrated functioning as the human kind of living whole we are (Watt, 2015) – should be promoted where we can, as a ‘human good’ that makes up our very self. That notwithstanding, other human goods and indeed, especially important aspects of health itself must be respected in the process.

VI. SEXUAL/REPRODUCTIVE FUNCTION AS SPECIAL

To return to the sexual realm: the capacity for sexual desire might be reduced on an ongoing basis for the benefit of a patient who was psychiatrically distressed by sexual desire; however, permanently removing this capacity, even for psychiatric reasons, seems harder to justify – and arguably more so than permanently removing the power to experience hunger or thirst. To make another comparison: it could be argued that a hysterectomy and removal of ovaries, even if intended to promote psychological and overall functioning, is morally even more serious than amputation of a leg for BIID, though the latter surgery will impact on motor functioning throughout the day. After all, life-giving, life-nurturing reproductive potential is a ‘transcendent’ aspect of human nature: something strongly ‘vertical’[[9]](#endnote-9) and not only ‘horizontal’ in the references it makes, both ‘downwards’ to the coming generation and also ‘upwards’, as believers see it, to the mysterious *fons et origo* of every life. Our reproductive powers, which point to participation in the very act of creating a new member of our rational kind, call for respect over and above powers to carry out acts more on our current plane.

In any case, it is morally relevant in this context that the mind and brain have their own telos, no less than the reproductive organs. It is a large part of the telos of the mind and brain to ‘take in’ reality, including the reality of one’s own bodily, sexed being. Ideally at least, the mind and brain should be helped to appreciate, rather than to escape from, such realities. As Melissa Moschella (2019, 196) notes in the context of gender dysphoria, “It seems relatively noncontroversial to claim that a primary function of our psychological capacities is to enable us to accurately know and thus appropriately respond to the extra-psychological world.”

What if a fully healthy response to one’s biological sex as an aspect of that extra-psychological world seems unfeasible psychologically though – even after thorough exploration of potential means to that end? It must be admitted that the question may be somewhat moot in some contemporary environments where exploration, or at least, extensive and systematic exploration of alternatives to gender transition may in practice be unlikely. This is not least owing to the increasing politicisation of health care: increasingly, mental health and other professionals are being prevented[[10]](#endnote-10) from offering, or even considering the offer of help to patients or clients to accept their bodies, in this though not in other areas. The person may be experiencing intense stress and anxiety and overwhelmingly focused on transition as a solution: both therapists (Ayad, 2018; Marchiano, 2019; Withers, 2019; D’Angelo, 2019) and detransitioned and desisted people (Callahan, 2018; Horváth, 2018; Sam, 2018; Pique Resilience Project, 2019; Patrick, 2019; Anon Contributors, 2019) have noted the ‘tunnel vision’ that can prevent consideration of alternatives to transition, not least where there are co-existing psychological features such as autism.

But what if – however rarely this occurs – such alternative approaches have indeed been thoroughly explored by an adult patient, who is now convinced, together with duly resistant medical gatekeepers, that transition is the only hope of his achieving peace of mind? Before exploring some distinctions between different levels of intervention, it is worth looking at a fundamental kind of objection sometimes raised: one that would seem to apply equally to crossdressing, use of hormones, and surgery of a major or minor kind. This is the objection that all such measures involve deception of some kind, whether of others or of oneself.

VII. DECEPTION OF OTHERS

I have written elsewhere (Watt, 2019) on the issue of deception, which is certainly a disvalue, but surely not one producing moral absolutes across the board, even in the important area of communicating one’s sex. In other, more trivial areas, we routinely deceive or try to deceive each other in ways (not involving lying) which seem not only morally permitted but often morally required. Feigning more interest in a conversation than we feel, or less alarm and perplexity, are just two examples of such potentially justified deception. Certainly, our sex is a more serious matter than many if not all things on which we might communicate non-verbally, and the reason for deception, at least of a prolonged or widespread kind,[[11]](#endnote-11) must be correspondingly serious. A closer analogy would be a case where one deliberately gives the impression that one is a biological parent when one is not (or vice-versa) such as by simulating pregnancy and childbirth in the case of a child one wants to adopt (Watt, 2019). Here there is a serious moral onus against deception but not, it seems, an absolute prohibition, applying whatever else may be at stake.

Similarly, the area of biological sex itself is important, in virtue of the goods of marriage and family life to which it refers, even for those with no wish, intention or perhaps ability to marry or have children. Marriage and shared, committed parenting is not just a good for those immediately involved, but a social good that all should recognise; there is a real moral onus against deception in this area and arguably in the closely related area of biological sex which grounds both family and associated roles. All that said, serious psychological concerns, no less than external pressures, can legitimate deception in both areas, though one should not be too quick to assume such deception is justified, especially in choices of one’s own.

VIII. SELF-DECEPTION

What should we say about the issue of *self-*deception, though, in relation to gender transition? Melissa Moschella – who also objects to deception of others – has the following comment on this issue:

Since hormonal and surgical treatments do not actually change one’s sexual identity to bring it in line with one’s gender identity, their success in reducing psychological distress must ultimately be based on self-deception (even if subconscious). Such self-deception is inherently bad and also bodes ill for the ability of such interventions to alleviate psychological distress in the long run (Moschella, 2019, 202).

“Subconscious” in these comments could refer to a degree of subconscious illusion following the transition, or it could refer also to a subconscious wish to deceive oneself in making the transition. And if being in a deceived state is always “inherently bad” simply in the sense of being suboptimal or unfortunate in itself, this would not necessarily mean that any conscious choice to deceive oneself in the future – much less a subconscious motive for transitioning[[12]](#endnote-12) – was bad in a *moral* sense.

Again, it may be helpful to find parallels in other, perhaps less contentious areas where we very consciously choose to deceive ourselves at a later point in time.[[13]](#endnote-13) While this sounds serious, and it certainly *can* be serious, sometimes it seems benign. Take the case of someone from a warm country struggling to get through a Northern winter who uses a daylight-simulating automatic lamp so that she will wake up happy rather than depressed, with a vague feeling she is back at home. Or we might think of someone with acute anxiety who finds it comforting to sleep with the security blanket she had as a child. She is not a child, and knows she is not a child, but feeling somewhat *like* a child may be the only thing that helps her get through the night and escape the painful associations her adulthood may have for her. Perhaps this strategy is not ideal, and could degenerate into unhelpful fantasy: my point is simply that it does not seem immoral in itself.

Admittedly, the kind of complete deception we see as potentially appropriate sometimes to aim at in others we would normally see as inappropriate to aim at in ourselves. Moreover, the bar is higher when it comes to self-deception concerning *oneself*, as opposed to the outside world. Knowing ourselves seems, after all, particularly important for us in making our plans and living our lives – though this would apply more to a higher level of self-deception during our fully-wakeful hours. There also seems a particular bar against bodily self-alteration, as opposed to using external aids, to produce some level of self-deception, not least as this may impact functions of intrinsic value (about which more below). Even so, these may not be impossible bars to surmount, depending how serious the self-alteration and also the degree of psychological pressure one is currently experiencing. We might think here of a Jewish person who is so traumatised by his memories of the Holocaust that, although he does not deny he is Jewish – something currently visible from his appearance – he wishes to forget this as much as possible in his new life (we can imagine he has no surviving Jewish family or friends or religious affiliation). Having facial surgery to make himself ‘feel’ more Gentile, though in full awareness that he is Jewish and always will be, may be a suboptimal and even distasteful measure, but is it absolutely morally excluded?

IX. ERASING HISTORY

One thing that might raise particular alarm bells is any attempt to rewrite history in one’s own mind – going beyond the avoidance of painful memories to their attempted overlay with pseudo-memories, accompanied perhaps by explicit inner or external denials (for example, that one was born in, and remains a member of, one’s actual ethnic group). Such self-deception might indeed extend to the point at which the initial ‘distancing’ intervention is sought. Again, a birth mother who relinquishes her child to adoption might deny then or later that she is a biological mother and want so hard to believe this that she even tries to destroy any trace in her body that she has carried a child. She might say either “I never had a baby – I'm not a birth mother or a mother of *any* kind”, or alternatively, “I’m not *really* a birth mother: look, my body contains no trace of any pregnancy”.

Biological sex is more fundamental than biological parenthood in the sense that it is what *underwrites* biological parenthood – though biological parenthood in turn makes sense of biological sex. True, being a biological parent is an existing family connection with another human being, and as such seems to demand some level of acknowledgement, whether or not one is bringing up the child. But with gender transition, there is likely to be at least an identification with a different *kind* of family relationship to one or more family members than one’s biological sex would indicate. One wants to be a son not a daughter, a brother not a sister, a father not a mother and so on – even if family members still see the relationship in biological-social terms continuous with the roles played in family history. Even if one has given birth to a child, one may want to recast one’s parenthood in non-maternal terms, evading as best one can the biological reality that is, however, archetypal for maternity. As with the ‘simple’ evasion of biological motherhood described above in the case of the relinquishing mother, the degree of self-deception here, however understandable, seems morally quite concerning. This is not least because particular family relationships carry particular responsibilities: children need not just generic ‘parents’ but recognised fathers and mothers who can guide them into adulthood and, particularly in the case of a same-sex parent, act as role models for them. The child of a transitioning parent will be left with no mother, or no father, unless the parent specifically recognises the continuing role relationship – leaving, however, the transition only partial and the role-modelling inevitably impaired.[[14]](#endnote-14)

X. CALM OR ELATION?

Another relevant question that may arise in regard to bodily or other self-deceptive measures is whether the effect sought or produced is a state of calm, perhaps at the absence of some stressor, or rather, pleasure and elation. The more vivid the positive feeling associated with the measure, the greater the self-deception and the more pathological it would appear to be. If the person with her security blanket has intensely pleasurable feelings of being back in her childhood, or the Holocaust survivor is elated by his new WASP[[15]](#endnote-15) appearance, then it seems we may be moving into an area of fantasy best avoided, no less than similar fantasies produced by mind-altering drugs. Just as drugs like morphine are appropriately titrated against pain, to produce as normal a mental state as possible, we should be similarly concerned about evasive/deceptive measures in relation to identity whose effects cross over from the calming to the worryingly blissful and indeed addictive, drawing one ever further away from the reality one wants to escape. It is one thing to avoid thinking about one’s adulthood or ethnicity as too distressing; something else entirely to revel in illusory, even if consciously illusory, escape. If this is the case for the adult who wants to be a child, or for the Jewish person who wants to be Gentile (or vice-versa), how much more does it apply when the intervention involves not just a change to one’s body (rather than something external like a security blanket) but a change creating, and often intended to create, the permanent disabling of healthy reproductive features. We will return to this later on.

XI. LIMITS TO PERMISSIBLE SELF-DECEPTION

In contrast, the person with dysphoria wanting to amend his or her body and/or use external opposite-gender aids such as clothes may be aiming simply at feeling calmer and escaping crippling anxiety and depression. Real as autogynephilia is for those who experience it (Lawrence, 2017; Withers, 2019; Hayton, 2020 (a) and (b); Anon, 2014) many of whom will be in heterosexual marriages, for others there may be no sexual motivation for the transition, or at least, no *immediate* sexual motivation, as opposed to likely longer-term plans. (Note that for all levels of transition, there are likely to be plans concerning sexual relationships which raise ethical issues of their own – for example, as involving morally unavailable sexual partners, or fantasies or acts morally excluded even in relation to lawful spouses.[[16]](#endnote-16) An example might be the desire of a biological male, married to a woman, for a lesbian relationship with her following transition; it was as a husband[[17]](#endnote-17) she accepted his vows, and their bond cannot be thus recast.)

So where does this leave us? If self-deception is *sometimes* morally permissible, depending on its extent, motivation and likely accompanying feelings, should we say that *all* sex change procedures, right up to function-destroying procedures, can be similarly permissible? Or should we draw distinctions – and if so, are these distinctions simply between a greater and a lesser onus against the procedure, or are they at least sometimes between the potentially permissible and the absolutely impermissible?

Even if deliberate deception of others, and *some* level of deception of oneself, may be permissible in this area to remedy significant mental distress, the bar is at very least higher if certain means rather than others are employed. As all levels of psychophysical function by definition have value in themselves – functions are defined as helping to compose the well-being of an organism (Watt, 2015) – it is better in itself if as many functions as possible are left undisturbed. Thus an external barrier to communicating one’s birth sex (in terms of clothes and makeup) has less of an onus against than coopting the body itself via hormones and/or surgery to make a false communication, where not only the final ‘outward’ social function of the body is blocked, as clothes or makeup might block it, but ‘inner’ social and reproductive function is blocked as well. To the extent to which this blockage is intended to be – or even only foreseen to be – permanent, this is correspondingly more serious, and moral absolutes may again come into play.

XII. SECONDARY REPRODUCTIVE FEATURES

What other moral distinctions should we make in regard to gender transition? For example, should we distinguish between changing primary and changing secondary sexual features? Leaving aside the effects of hormones, sex reassignment surgery (SRS) ranges from facial feminisation or masculinisation surgeries through mastectomies or breast augmentation surgeries to what many find most troubling: sterilising procedures involving genitals and other reproductive organs. While a recent study using high-quality Swedish data (Pachankis, 2019) has shown benefits of SRS that on closer inspection (Regnerus, 2019) seem rather unimpressive, the in-principle permissibility of such interventions still needs to be explored. At least for the sake of argument, we should assume that SRS and hormones are, or may be, of overall therapeutic value – not least as some other research, if perhaps of lower quality, has been more positive in its findings.

Both primary and secondary sexual features follow from one’s orientation from conception to male or female fertility: an orientation potentially but in practice not normally reversed by embryological accidents such as chimerism i.e. the fusing together of an embryo with his/her twin. Accepting biological sex might be understood as accepting complementarity, although this should not be taken to mean that one must embody as much complementarity as one can. Some aspects of complementarity are of lesser importance and/or a matter of convention (such as long hair for women), while at the other end of the spectrum, complementarity is not so much wrong to eradicate as *impossible* to eradicate: one will always be (at least after early embryonic life) a member of a certain biological sex. That said, some aspects of complementarity can, of course, be eradicated without eradicating one’s sex – hence the question which of these aspects are morally wrong to eradicate and perhaps seek to replace.

Interestingly, some research (Ainsworth and Spiegel, 2010) has found that facial surgery has comparable results to (other) SRS in terms of quality of life[[18]](#endnote-18) – though presumably, those with very severe dysphoria would not respond similarly to facial intervention only. Unlike the genitals, which are really about just one thing or at most two (the sexual/reproductive and the urinary functions) the face expresses many things, and even to the extent to which it communicates a *gendered* message, this cannot be reduced to the sexual/reproductive in any narrow sense. This is also true of secondary sexual characteristics such as the male chest or female breasts which are part of the person’s gendered presentation normally in a ‘background’ and not very sexualised way. Note, however, that such general communication is not without any reproductive *reference*: for example, unrelated role models or protectors may be identified as such precisely because they look ‘motherly’ and supportive in the case of a woman, or ‘fatherly’ and protective in the case of a man.

Of course, facial features and either breasts for a woman or a flat chest for a man also have a direct reproductive function in helping potential sexual partners identify the person as male or female, and perhaps eliciting some level of attraction. However, this social-reproductive function is ancillary to the core social-reproductive function of the male and female reproductive systems: the latter explains the former, not the other way around. And the wider social function of the visibly male or female chest is to communicate one’s sex to others generally, not *just* to a potential sexual partner or the child one may conceive.

When it comes to medical transition, there is an important difference between female breasts and the male chest in terms of thwarting of function whether temporary or permanent. In the case of the male chest, the social function, but *only* the social function of the chest is (deliberately) thwarted in causing the male hormonally to grow breasts, or doing breast augmentation surgery. This social function is not without importance, but among functions is comparatively minor, not least because there are other readily available ways, such as clothing, in which people can signal their biological masculinity or femininity should they choose. In contrast, the biological female who has an SRS mastectomy undergoes in addition significant albeit perhaps not intended damage to the lactating function of her breasts: damage that even her dysphoria arguably cannot outweigh. (Note that the ‘principle of totality’ does not permit interventions already identified as morally excluded – otherwise health-promoting contraceptive sterilisations and even some abortifacient acts might be approved.)

Are the female breasts when it comes to SRS more like the face or like the womb in moral terms? As regards the nurturing function, breastfeeding is important but not normally essentialto children’s welfare, bonding with their mothers or social identification as their biological children. Nurturing a baby this way normally but corrigibly identifies one as a mother: far more corrigibly than pregnancy and birth which identify one as a mother in all cases (again, these are archetypally maternal activities) and a genetic mother too in most cases. That said, the ability to breastfeed normally follows physiologically from birth, which in turn follows from conception: in that respect, breastfeeding, like the support of the womb, is ‘vertical’ and not just ‘horizontal’ in the references it makes. It seems that the female breasts are therefore more like the womb in that it is wrong to remove them for reasons of psychological distress: this shows a lack of valuing – in fact, a very active destruction –

of an important, sexually-activated function (in addition to destroying their communicative function whether sexual or more general). Even if the destruction of the lactation function itself is not intended, the removal of the organ whose basic function this is, because the organ is psychologically repugnant, still resembles the removal of the womb, ovaries and fallopian tubes for psychological reasons without the additional intention to prevent pregnancy. Unlike the use of hormones which may also impact on fertility without this impact necessarily being intended,[[19]](#endnote-19) here there is a clear negative focus on the organ itself, if not its reproductive function. A central part of one’s sexual complementarity is being definitively rejected.

XIII ‘BOTTOM SURGERY’: STERILISING MOTIVATIONS AND/OR EFFECTS

Here we turn to a focus on so-called ‘bottom surgery’ very directly affecting reproductive and/or sexual function: removal of the womb and fallopian tubes and also the gonads, and alteration of the genitals to resemble those of the opposite sex. We might begin by recalling that sexual organs, while rightly called ‘private parts’, are private only in a qualified sense. For example, the acts genitals are oriented towards are certainly private to the couple, but the relationship that makes sense of those acts, as the kind of relationship that could in theory nurture a child coming from them, is important for children and society: marriages are rightly not often celebrated in strict privacy, not least because of their implications for any resulting child. More generally, the unseen genitals, as a mark of one’s sex, have a social reference that goes beyond a real or potential social-sexual partnership. Biological sex quite generally is a communal and not just a personal matter: it is oriented not just to sexual partnership and biological maternity or paternity, but more generally towards ways of living out other relationships that evoke the familial: the brotherly or sisterly, say, or the paternal or maternal.

Unlike surgery to make oneself look younger or of a different ethnic group, there is not just dysfunction but serious dysfunction caused by ‘bottom surgery’ in particular. The sterilisation aspect of such surgery and indeed, puberty blockers and hormones given to children[[20]](#endnote-20) is a cause of concern even to many who do not object to sterilisation of adults in a contraceptive context. In the context of SRS, sterilisation may not, in fact, be contraceptively motivated i.e. made in anticipation of sexual choices on one’s own part that might lead to pregnancy. To say that is not, however, to defend SRS sterilisation; on the contrary, sterilisation out of horror at the mere fact of natural fertility seems a more radical rejection of the good of fertility than sterilisation because one feels one has ‘completed one’s family’ – ethically problematic as the latter remains. If ‘conventional’ sterilisation, however regretful, is wrongly ‘anti-fertility’ – that is, anti- a transcendent aspect of human nature – how much more is sterilisation not even geared towards avoiding the outcome of one’s sexual choices, but rather towards escaping natural fertility even in the abstract – since one is intending to eschew the relevant sexual choices. After all, in the more usual case of sterilisation the person may at least *regret* the loss of his or her fertility which may be seen as something good not just in the abstract, but as an aspect of the person him/herself.

In addition to horror at *reproductive* functioning, there may be more immediately a horror of functioning *sexually* as, for example, a woman: even if the person in question is attracted to men this may be understood in terms of being a gay man, while the idea of being attractive to men as a woman is a matter of utter aversion. More generally, the wish for SRS may be very much tied to the kind of relationships, whether these are seen as gay or straight, that the person may wish to form. The (or a) motive for genital surgery is often an approximation to opposite-sex-type sexual functioning, with all the ethical problems this raises, given that the neo-vagina and neo-phallus, having no physiological orientation to fertility, have no true sexual-reproductive role.

To return to ‘accepting’ biological sex: it is difficult to see how one’s sex is truly ‘accepted’ if one seeks a body resembling as far as possible the sexually-functional body of a member of the opposite sex while at the same time seeking to erase one’s own genuine sexual-reproductive functionality: a key expression of the ultimately inescapable physiological complementarity found in a body naturally and inevitably oriented to a certain kind of fertility.

To repeat: a sex change no more affects or calls into question biological sex than do natural states of impotence or infertility. To ‘reverse’ genitals or remove gonads or the womb is, however, to remove the very centre and explanation of one’s physiological complementarity with the other sex, if not one’s complementarity itself, which ultimately cannot be removed.

XIV. MALE-TO-EUNUCH

It is worth recalling here a phenomenon perhaps not sufficiently addressed in the literature: that of males who identify as male-to-eunuchs and desire castration (removal of the testicles) due to an intense disgust at their own genitals. This desire has some things in common with the desire for male-to-female transition, but stops short of an identification with the opposite gender or wish for opposite-sex genitals. Indeed, the person is arguably in a better, more realistic state of mind than the MTF person: his disgust at his genitals does not lead him to seek something impossible i.e. female sexual/reproductive functionality or functioning – or even the *appearance* of such functionality or functioning. In contrast, SRS aims not only to *erase* as much as possible the sex with which one was born but to *replace* it – or at least *appear* to have replaced it. While the sheer desire for castration might be seen as more ‘negative’ than a desire for sex organs of the opposite sex, it is nonetheless a desire it is *possible* to fulfil and in that respect more like the desire for amputation of a non-reproductive part in the context of BIID.[[21]](#endnote-21) To repeat, this is not to deny that male-to-eunuch surgery is seriously objectionable morally, given the special importance of core reproductive functions which means that the principle of totality arguably cannot be invoked to justify such surgery. As with SRS, one can empathise respectfully with the suffering that prompts such a drastic response without endorsing either the surgery itself or the identity it is meant to confirm or express.

XV. ‘BOTTOM SURGERY’, FANTASY AND ACCEPTING BIOLOGICAL SEX

To return to SRS ‘bottom surgery’: in addition to the intrinsic objections concerning reproductive/sexual function, so serious are these operations that – even remembering the distress they are intended to alleviate[[22]](#endnote-22) – one suspects a worrying degree of fantasy on the part of those requesting them: perhaps the feeling that one will *really* change sex, or at least, that the surgery will make one’s body *be,* as opposed to *feel,* ‘correct’.[[23]](#endnote-23)Even if, in theory, one may accept that no amount of surgery will change one’s biological sex, the potential for an unacceptable level of self-deception, reaching not just the subconscious but, to some extent, one’s fully conscious thoughts, is very real. Those wanting to transition are hardly alone in the modern world in failing sufficiently to respect their own sexual/reproductive teleology; nevertheless, full medical transition certainly distances the person from that teleology to a remarkable degree.[[24]](#endnote-24) If *this* counts as accepting one’s biological sex, it is hard to make a case for much else counting against it. Nor can we even say that such radical procedures are clearly beneficial to health overall, factoring in the infertility which would need to be given due weight, even if reproductive health were an aspect like any other.

XVI. ACCEPTING GENDER

But, it might be objected, there is more to human beings than our bodies – even leaving aside any deep-seated bodily basis there may be for cross-sex identification. So why should only our physical side, or certain aspects of it, be ‘accepted’ and not our thoughts and feelings? Should we not accept our inner gender identity which may be at odds both with some parts of our bodies and with the social gender in which we were raised? After all, many transitioned people will testify that they felt ‘fake’ while they were living in their birth gender (Chappell, 2017) while in contrast following their transition, they are now living and presenting themselves in a more authentic way.[[25]](#endnote-25)

As regards self-presentation, this is a complicated subject: crossdressing obviously needs to be considered separately from verbal disclosure of dysphoria, for example. Self-disclosure of dysphoria – to family and friends and chosen others – can certainly serve authenticity and be otherwise indicated. This remains the case even if dysphoria is neither a healthy part of the psyche nor thought by the person to be so – any more than common human phobias or anxieties or feelings of self-loathing, which should also sometimes be disclosed.

However, as with other psychological issues, to *acknowledge* is not to *accept* either dysphoria or cross-sex identification as a healthy expression of diversity[[26]](#endnote-26) or even to conclude that an outward expression of either is necessarily the best way forward. Trans-racialism is again a case in point: while it may be good for family and friends to know how one *feels* in this area, a desired social presentation as a Black American (for example) would need to be thought through very carefully indeed. It should not be assumed that this will work well for oneself any more than for the community into which one hopes to be accepted: a degree of authenticity in self-expression may go hand in hand here with an ample measure of deception and self-deception.

With crossdressing for dysphoria we are in fact constantly faced with the twin albeit non-contemporaneous challenges of social disruption[[27]](#endnote-27) and indeed possible social contagion (Littman, 2018) on the one hand, where the transition is visible or disclosed, and on the other hand, often deliberate deception of strangers and acquaintances, if not close friends and family, where the person passes well and does not self-disclose. This is one reason why even cross-dressing that does not lead to medical transition needs careful thought and sufficient justification in terms of psychological health, as well as self-scrutiny as to one’s motives, which will clearly vary from person to person.

Social and hormonally produced cross-sex presentation, and perhaps minor facial surgery, may be the best options available to a particular person given current psychological realities, and the person may be quite honest about accepting his or her biological sex and some or all of its moral implications. However, it should not be too readily concluded that even social transition, let alone hormones or minor surgery, is the answer; moreover, whether or not this is the case, the situation is certainly not something to celebrate. After all, if the mere existence of some deep-seated feeling gives a person reason, not only to acknowledge but to accept and celebrate that feeling, psychological and indeed moral self-improvement loses any anchor it might have. “Do what you feel” is often not very helpful guidance: *admit* what you feel is surely a better general guide to mental health and moral well-being.

To return to ‘accepting’ feelings: there is a difference between ‘accepting’ biological sex and ‘accepting’ one’s dysphoria and/or cross sex identification. Whereas in the case of biological sex, sexual/reproductive teleology is in fact a *good* thing, however one feelsabout it – and therefore something to ‘accept’ as well as to ‘acknowledge’ – in the case of cross-sex identification, the psyche’s being in some sense at war with one’s reproductive biology is a psychological or psychophysical *problem,* *not* a problem with the reproductive biology itself. Feelings of rejection of that biology therefore demand not ‘acceptance’ in any positive sense but at most ‘acknowledgement’, as part of an honest assessment of one’s inner life.

XVII. IDENTITY AND IDENTIFICATION

Transition is often presented as an issue of expressing one’s identity; however, a distinction drawn recently by one detransitioned man (cited later in this paper) between *identity* and *identification* is worth pondering. Identity has connotations of ‘essence’ or at least, something especially deep-seated and often important and valuable about us. In contrast, identification is a much more neutral word, referring simply to what we think and feel in respect of ourselves, whether currently or in the longer term.

Biological sex, like family membership, seems a suitable candidate for our basic identity in the sense of what anchors us objectively in the world: something with which we *should* identify, difficult as this will sometimes be. Biological sex and biological family ties concern not feelings, but our earliest history and indeed pre-history, in regard to our parents’ meeting and helping to form us, by means of two very particular gametes. Feelings are real and should be given their due, but they do not change our earliest history or that history’s irrevocable marks on our body’s directedness towards this or that form of fertility. Nor, of course, do our current feelings and perceptions affect our past, perhaps forgotten feelings and perceptions,[[28]](#endnote-28) though they may provide crucial clues to interpreting our conscious or subconscious history, as gender-critical therapists have urged (Marchiano, 2019; D’Angelo, 2019).

Dysphoria is no exception to the rule that our mental lives are greatly influenced by our social environment. This can work in various ways: a vulnerable gender-atypical child who grows up in a local or wider culture (including a playground or family culture) which is rigid about expectations for girls and boys may be pushed towards dysphoria and/or trans-identification by the child’s perception of demands that seem impossible to meet. That said, in many parts of the world, there is now an external ‘pull’ as well as an external ‘push’ towards dysphoria and possible transition: trans-identification is widely presented and celebrated in social media and increasingly in school environments. ­

Even leaving aside those cases of gender dysphoria which were hidden in the past, it is difficult to see the exponential rise in trans-identification among young people in some parts of the world as simply unearthing already-existing feelings. Lisa Marchiano (2019) comments on this point:

Children who were unhappy with their gender were the concern of a tiny minority of specialists until a medical pathway opened up to treat them with the advent of the use of puberty blockers for gender dysphoria. The availability of the treatment appears to have essentially created the demand, and the edges of the category have creeped ever outward. What was once an extraordinary measure for someone suffering greatly from a rare condition has become commonplace.

Describing a “feedback loop that is encouraging thousands of young people to seek body altering treatments”, Marchiano (2019, 69) candidly observes that “The medical and mental health fields must guard against becoming entranced by exotic new conditions, such that, in our excitement, we unconsciously reinforce maladaptive behaviours.” More generally, she reflects:

At its core, gender dysphoria speaks to a profound loss of connection with our embodied, instinctual selves... The hyptertrophied mind, cut off from its own instinctual, embodied base, disavows its connection to nature, instinct – and the unconscious. The living body has become mere clay which must be surgically and chemically altered to bring it into line with its master, the mind. Paradoxically, the symptoms of gender dysphoria may in part be an attempt of the unconscious to reassert itself and signal that something is amiss and needs our attention (Marchiano 2019, 60).

XVIII. CONCLUSION

Whatever the part played by social environments in the emergence, and not just the visibility, of gender dysphoria, no-one can deny the intense unhappiness of so many experiencing dysphoria today. Many who transition will not proceed to ‘bottom’ surgery or mastectomies – i.e. surgery on parts closely linked to fertility which I have argued is intrinsically excluded even on the questionable assumption that overall long-term health will be improved. However, there is, I am also claiming, a non-tri­­vial onus against even more minor and external measures such as facial surgery and cross-dressing, even leaving aside the issues of sexual ethics in the usual sense with which gender issues are very much entwined. And while hormones may not be excluded in all cases, their long-term effects including impotence and/or infertility can be very serious, and the motive in taking them needs examination too.

In regard to young people, early social transition and puberty-blockers with little attempt to deal otherwise with dysphoria are of very serious concern as is the proactive raising of gender identity questions even to children still at primary school. To use the BIID analogy once again, it is rather as if schoolchildren were asked how they felt about having ears – with perhaps the background suggestion that ears can always be hidden with tape if need be or even surgically removed. Even those of us who would accept removal of ears as a last-ditch response to crippling (and fertility-unrelated) BIID in an adult would baulk at such an open invitation to body dysmorphia in a population that might well otherwise escape it.

I have argued in this paper that certain forms of transition, such as those involving deliberate causation of sexual/reproductive dysfunction, should in no case be pursued, due above all to the particular significance of sexual/reproductive functions (and the causally downstream function of lactation). I would not want to claim that no form of transition should be pursued by anyone, nor that subsequent to transition of any kind, detransition is necessarily the answer. In either case, this very much depends on the state of health and personal circumstances of the individual concerned.[[29]](#endnote-29)

That said, the voices of detransitioners and desisters are very valuable in providing a bridge from the experience of trans-identification and medical and/or social transition to the insight that these are stopgap and/or harmful responses to issues that need to be otherwise addressed. Detransitioners and desisters, looking at the experiences of those still identifying as transgender, recognise much of what they see. They may not regard transition as the wrong choice for everyone, but see it as potentially avoidable for those they perceive as like their former selves. They give much-needed encouragement to people with dysphoria – including other transitioned people with regrets[[30]](#endnote-30)– that they may be able to accept their own sexed bodies too, even if some dysphoria may remain. They testify to the fact that self-acceptance in the form of accepting one’s sexed body is a goal worth seeking,[[31]](#endnote-31) both as an aspect of health and well-being and as something that more generally promotes this.

Perhaps it may be fitting, then, to end this paper with the recent words of one detransitioned man: words which eloquently express his recovery of both the ‘acknowledgment’ and the ‘acceptance’ of reproductive teleology whose importance this paper has sought to defend. ‘Patrick’ (2019, 177) comments as follows in a book chapter entitled *Detransition was a beautiful process:*

I realised I was only suppressing the man that I am *de facto* and trying to become something that I could not be. Sex, I had come to know, is biological and cannot be changed. I might have carried with me a cross-sex identification potential throughout my life, a potential that unfolded under very difficult circumstances and in the context of a personal crisis, but one cannot conflate identity and identification. Medical transition is just a palliative treatment, and a very poor one.

And later, commenting on his detransition:

It was a relief to be able to emancipate myself from a psychological constraint and accept myself as what I am. I even started to appreciate my male body, since it is the only one I have… I could root myself again in nature, in a return to some sort of immanence, and overcome this need to transcend a natural given which had locked me in a self-referential modality of existence. Psychologically, it was vital. It was about life. I had to embrace my natural condition (Patrick, 2019, 178-9).

ACKNOWLEDGEMENTS

I am grateful to Anthony McCarthy, David Jones, Andrew Sodergren, Ted Watt and two anonymous reviewers of *Christian Bioethics* for their helpful comments on this paper.

NOTES

1. One immediate question is whether the Catechism is describing a positive obligation, or an absolute negative obligation (as the sexual ethics context might seem to suggest) or a mixture of the two. Absolute obligations are normally negative, not positive in content. [↑](#endnote-ref-1)
2. In fact, even intersex as normally understood is arguably not a matter of ‘predominant’ sex at all: the person has a sex which is often not even difficult to determine and which has a clear claim to be respected (for example, if the parents of an intersex child, or an intersex adult, are considering surgery that will damage reproductive function). In the words of Andrew Sodergren (personal communication), “we should ponder what sex the body as a whole is trying to communicate… If the body reveals the person, what is this body naturally trying to say?”

   Bryan Cross (2019) notes: “Although sex ordinarily corresponds to the presence or absence of a Y chromosome, ontologically the distinction between male and female is not grounded in genetics but in the two natural orders of the body with respect to sex, toward the production of one gamete type or the other. In this way, sex is not at root private and subjective but objective and public. It is something that ordinarily can be directly recognized by others, because sex is manifested in the teleological order of the body.” He observes that “Just as being male in sex and acting in accord with the male gender do not depend on the presence of sexual desire, fertility, or even the presence of the male genitalia, so they do not depend on the presence or absence of a particular brain structure or genetic factors.” [↑](#endnote-ref-2)
3. For philosophical explorations of this subject, see e.g. Pruss (2012); McCarthy (2016). [↑](#endnote-ref-3)
4. Melissa Moschella (2019, 195) comments: “If I am my mental states (or the cerebrum that underlies those mental states), then my gender identity is determined solely by how I feel (or by the brain states underlying those feelings), and I, strictly speaking, do not actually have a sexual identity, since sexual identity is a characteristic of my body, not of me.” [↑](#endnote-ref-4)
5. See, for example, the following self-description: “Instead of existing in a body that distorted my truth, I decided to embrace who I was and make that self visible to myself and to others… my chest interferes with making my true self and my gender visible. What I see on the outside doesn’t align with what I feel on the inside, and it creates a lot of chaos and discomfort…**My dysphoria is caused by a body that erases who I know myself to be – and who I love being**”(Finch, 2015).

   In contrast, one detransitioned man relates, looking back on his transitioned state: “I didn’t owe my identity to a natural fact of biology shared by other women. I was shutting myself up in a bubble of self-identification. And this turned out to be very dangerous; since my identity had no physical basis, psychologically I regularly collapsed. Suicide attempts ensued. It is awful to live with the obsession of being something without the material basis to support it. I was disconnecting myself from reality and floating between the sexes, with a body that I was only damaging” (Patrick, 2019, 176). [↑](#endnote-ref-5)
6. For example, some authors (Wassersug, McKenna and Lieberman, 2012) suggest that men who have had to be castrated for medical reasons might embrace a ‘positive’ identity as eunuchs rather than seeing themselves as mutilated men. On male genital self-mutilation, whether psychotic or as a form of attempted self-treatment e.g. for gender dysphoria, see Veeder and Leo, 2017. [↑](#endnote-ref-6)
7. BIID has been described as a heterogeneous phenomenon with a significant percentage of those affected reporting a sexual motivation – see Blom et al., 2017. [↑](#endnote-ref-7)
8. In the words of Lisa Marchiano (2019, 58):

   “While I find it plausible that acute gender dysphoria – unexplained, mysterious, and extremely painful – has always been with humanity, I suspect the number of genuine sufferers has been very small. Like other disturbances in the mind-body relationship such as anorexia or body dysmorphia, gender dysphoria appears to have a significant genetic component. Shorter has theorized that some people may be ‘genetically predisposed to acquire some kind of disturbance of the mind-body relationship’ (1993, p.193). That such a predisposition might be a common root of the three conditions is an intriguing possibility supported by the co-occurrence of eating disorders and gender dysphoria (Feder et al, 2017). Yet, while there is likely a biological component to gender dysphoria, the cultural narrative surrounding it will in large part determine how it is experienced by sufferers.” [↑](#endnote-ref-8)
9. Note that it is this ‘vertical’ dimension, even with infertile couples, that makes the unitive act so special: this is not *just* about the couple but is the *kind* of act by which children are conceived. [↑](#endnote-ref-9)
10. Moore and Brunskell-Evans, 2019. For further examples, see the GenderHQ website pages on ‘harassment’ at <https://www.genderhq.org/trans-activism-identity-politics-harassment-censorship> and on ‘Conversion therapy laws’ at <https://www.genderhq.org/conversion-therapy-laws-gay-lesbian-transgender> [↑](#endnote-ref-10)
11. A woman’s failing to correct the misapprehension that she is a man in an exchange of business emails with a contact from a very misogynistic society would be an example of limited, potentially permissible deception for reasons of only moderate importance. [↑](#endnote-ref-11)
12. Such a motive might emerge into consciousness with time, and there is also a question whether we have a duty to scrutinise especially our more contentious plans to see if they involve, perhaps as an integral part, subconscious motives of a kind it would be wrong to intend. Such motives can make our overall plan unchoiceworthy, on a ‘causal’ interpretation of the ‘means’ condition in double effect reasoning. [↑](#endnote-ref-12)
13. Another very common example of choosing to deceive oneself at a later time, perhaps with complete success, is setting one’s watch a little ahead to reduce the risk of being late. [↑](#endnote-ref-13)
14. For more on the relational responsibilities of those experiencing dysphoria and their family members and others around them, see Watt, 2019; Watt, 2020. [↑](#endnote-ref-14)
15. ‘White Anglo-Saxon Protestant’. [↑](#endnote-ref-15)
16. It is hard to see how genuinely marital sex can occur if the husband either cannot or will not now act on the basis that – dysphoria notwithstanding – he is indeed the husband in any sexual relations between them. Otherwise the options become either marital celibacy (this is indeed chosen by some couples who stay together following transition) or a form of sex that unfortunately cannot constitute the one-flesh, ‘reproductive-type’ union which is the unique mark of the marriage the couple once entered into (assuming they are indeed validly married – those who believe they are not, due perhaps to strong albeit concealed dysphoria at the time of the marriage can again choose to stay together on a companionate, non-sexual basis). [↑](#endnote-ref-16)
17. In the words of Hayton (2020, b), “although [transition] may be a palliative solution, it’s hardly a satisfactory solution. My wife was left without a husband – she was attracted to my body as it was when we met, not as it is now – and my children worried desperately about the reaction from their friends. It was a huge mess.” [↑](#endnote-ref-17)
18. It is worth remembering here that facial feminisation surgery may be undertaken partly, at least, as a means to entering into relationships which may be non-heterosexual in the context of the person’s biological sex. [↑](#endnote-ref-18)
19. It may well be the case that infertility is intended by the individual and/or by the doctor (for example, because the patient finds fertility itself distressing) but this is a matter of personal psychology that is likely to vary. [↑](#endnote-ref-19)
20. One gender clinician comments on this point:

    “I feel there’s something really dishonest about the effort going in to getting children to preserve their fertility. What are we setting them up for? It’s not enough to talk about fertility preservation. We are playing down the reality way too much; for example, we can’t not think properly about the process of getting a child to go and masturbate in an IVF clinic. Should we gloss over questions about whether children with massively traumatic histories will really be able to adopt? We aren’t talking enough the reality of any blocker or hormone treatment massively reducing the chances of them being able to preserve sperm or eggs. It would be a more honest conversation to say ‘you are almost certainly sacrificing having children’ but the demands being placed on us are for not thinking” (Moore, 2019, 249-50). [↑](#endnote-ref-20)
21. Nor need there be much in the way of social deception involved: while we normally expect to know if we are interacting with, or even just seeing, a biological male, there is no similar expectation as regards the male we see having working genitals. There may be a subconscious assumption to this effect, but one that plays a practical role only in particular contexts such as dating/considering for dates; certainly this is not something most people would see as an appropriate subject on which to seek information. [↑](#endnote-ref-21)
22. Those who deny regretting their own transition may still acknowledge its burdens and limitations. One commentator (Carollo, 2016) describes transition as “... one of the hardest, most overwhelming experiences someone can go through. It's the kind of gamble you make when your back is against the wall and everything seems at stake... I needed gender-affirming surgery to alleviate gender dysphoria and feel as comfortable in my body as possible, but there is no cure for gender dysphoria — you can only treat the symptoms, and our ability to treat the symptoms is limited.” [↑](#endnote-ref-22)
23. See, for example, this comment from a male-to-female transitioned person: “Having my correct genitals is a very comforting and “right” feeling —I rarely think about what is, and isn’t, down there, except by contrast with the junk that used to be there.  I can cross my legs without pinching anything, I can pee sitting down with my legs pressed together, I never need to adjust and hide dangly bits...” (Wiens, 2014).

    The new genital area is however ‘correct’ in no intrinsic sense but only in the subjective sense that a wig is ‘correct’ for a man who wants to look like a long-haired woman. In terms of reproductive health at least, the patient has clearly been moved *further away* from what is correct. [↑](#endnote-ref-23)
24. Paul Hruz (2019, 103) referring to sex change procedures for adolescents, comments:

    “...it can be reasonably hypothetised that procedures that distort or destroy an individual’s ability to see both ontology and teleology in human sexuality will be unable to produce long-term benefit.” [↑](#endnote-ref-24)
25. Note that while truthful *communication* of feelings, including non-verbal communication, can certainly sometimesbe morally appropriate, any such communication via (say) crossdressing will not be complete unless those who see one are also aware of one’s biological sex. Such ‘full disclosure’ is to some degree socially disruptive; it is also often precisely what the transitioned person is seeking to avoid. The point (or an important point) of crossdressing and any medical transition may precisely be to ‘pass’. [↑](#endnote-ref-25)
26. To use an admittedly over-worked but helpful analogy in this area, it is one thing to admit one has an eating disorder; something else to celebrate that same disorder and define one’s life around it. Body-shape and indeed shrinking from food may ‘authentically’ announce one’s anorexia, but this kind of authenticity is of very limited value. [↑](#endnote-ref-26)
27. This would also apply to a person who identifies as gender-fluid and wants to present in a sexually ambiguous manner: this is less deceptive than wanting to pass as a member of the opposite sex, but may have a greater potential for disruption than discreet passing. Of course, some individuals will naturally look androgynous, or even very much like a member of the opposite sex, such that presenting unequivocally as the sex they are may take positive action on their part. For example, a naturally very masculine-looking biological woman may look male unless she grows her hair, plucks her eyebrows etc: things she may or may not wish to do or be obliged to do – this will depend on her personal situation and sensibilities. [↑](#endnote-ref-27)
28. “Detransition rapidly turned out to be a beautiful process. I was finding again the boy that I was and the man that I grew to be. Old feelings and memories came back up to the surface. I was reconciling myself with the past, a bit like when one comes across old pictures of oneself, filled with a slight melancholy and a sense of indulgence. There had been a great deal of self-loathing” (Patrick, 2019, 178). [↑](#endnote-ref-28)
29. An analogy might be the reversal of a sterilisation performed for contraceptive reasons: even those who believe the sterilisation was morally wrong can recognise that the personal and medical cost of trying to reverse it may be too high. [↑](#endnote-ref-29)
30. In describing the effects of medical transition, it is often claimed that regret is rare – though it should of course be remembered that lack of regret and improved overall health and well-being are not one and the same. Others have noted that in many studies, many transitioned people are lost to follow-up: these are perhaps more likely to be regretters and/or those doing badly. There are a number of anecdotes of those who have detransitioned, for example, without contacting the clinic that originally treated them or otherwise entering the statistics (see e.g. Hacsi, 2018; Moore, 2019; <https://www.genderhq.org/trans-youth-regret-rates-long-term-mental-health>). [↑](#endnote-ref-30)
31. Just as it is appropriate for a person with dysphoria to aim at some degree of bodily self-acceptance, it is appropriate for a doctor or therapist to share that aim, and perhaps indeed proactively and respectfully to raise this issue as something ‘on the table’. Here as elsewhere, it would be asking too much to require complete concordance between the aims and values of the patient/client and the aims and values of the doctor/therapist for any agreed therapy to proceed. After all, with physical illness, a patient with atypical views about bodily causation can still participate in a ‘therapeutic alliance’, sharing with the doctor at least the intention the doctor alleviate his suffering and/or promote long-term health, by means perhaps only partially visualised by him. Note, however, that while doctors should refuse to provide any treatment they see as (overall) medically harmful, they may sometimes need to provide a suboptimal, though potentially acceptable, treatment – which could include continued hormones for a hormonally transitioned adult even if the doctor believes the person could benefit more from an (unwanted) therapeutic approach. Quite generally, with therapy as with physical interventions, sufficient consent must be obtained in what should be a relationship of respect. For an account of her practice by one therapist working with gender-questioning adolescents, see Ayad, 2018.

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