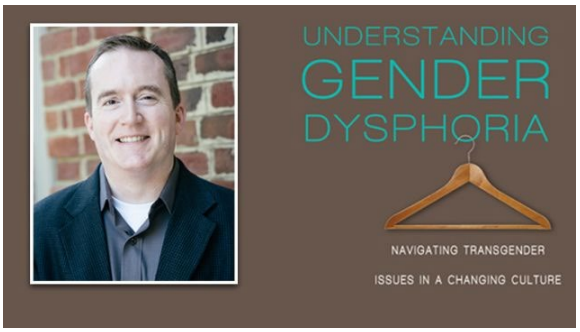
Gender Dysphoria

Main Idea: Gender Dysphoria involves an incongruence between one's biological sex and gender that causes intense distress. It is understood through three frameworks: integrity, disability and diversity. The best framework integrates all three. Christians need to do a better job of not shaming those who are transgendered. Treatment usually involves decreasing cross gender identification, watching and waiting, facilitating preferred gender identification or sex reassignment/puberty blockers. Most mental health professionals facilitate preferred gender identification.

Key Terms



Biological sex: As male or female (typically with reference to chromosomes, gonads, sex hormones, and internal reproductive anatomy and external genitalia).
Primary sex characteristics: Features that are directly part of the reproductive system, such as testes, penis and scrotum in males, and ovaries, uterus and vagina in females.
Secondary sex characteristics: Have no direct reproductive function, for example, facial hair in males and enlarged breasts in females.
Gender: The psychological, social and cultural aspects of being male or female.
Gender identity: How you experience yourself (or think of yourself) as male or female, including how masculine or feminine a person feels.
Gender role: Adoptions of cultural expectations for maleness or femaleness.

Biological sex Male or Female
Gender identity Man or Woman
Gender role Masculine or Feminine

Biological sex: Male→ Intersex ←Female
Gender identity Man→ Androgyny ← Woman
Gender role Masculine--> Outside cultural norms ←Feminine

Gender dysphoria: The experience of distress associated with the incongruence wherein one's psychological and emotional gender identity does not match one's biological sex.
Transgender: An umbrella term for the many ways in which people might experience and/or present and express (or live out) their gender identities differently from people whose sense of gender identity is congruent with their biological sex.
Cisgender: A word to contrast with transgender and to signify that one's psychological and emotional experience of gender identity is congruent with one's biological sex.
Gender bending: Intentionally crossing or "bending" gender roles.
Cross-dressing: Dressing in the clothing or adopting the presentation of the other sex. Motivations for cross-dressing vary significantly.

Third sex or **third gender**: A term used to describe persons who are neither man nor woman, which could reference an intermediate state or another sex or gender or having qualities of both man/woman in oneself.
Transsexual: A person who believes he or she was born in the "wrong" body (of the other sex) and wishes to transition (or has transitioned) through hormonal treatment and sex reassignment surgery.
Genderfluid: A term used when a person wants to convey that their experience of gender is not fixed as either male/ female but may either fluctuate along a continuum or encompass qualities of both gender identities.
Genderqueer: An umbrella term for ways in which people experience their gender identity outside of or in between a male-female binary (e.g., no gender, genderfluid). Some people prefer a gender-neutral pronoun (e.g., "one").
Drag queen: A biological male who dresses as a female (typically flamboyant dress and appearance) for the purposes of entertaining others. Such a person may not experience gender dysphoria and does not tend to identify as transgender.
Drag king: A biological female who dresses as a male (stereotypic dress and appearance) for the purposes of entertaining others. As with drag queens, such a person may not experience gender dysphoria and does not tend to identify as transgender.
Transvestism: Dressing or adopting the presentation of the other sex, typically for the purpose of sexual arousal (and may reflect a fetish quality). Such a person may not experience gender dysphoria and may not identify as transgender. Most transgender persons do not cross-dress for arousal and see transvestism as a different phenomenon than what they experience.

Intersex: A term to describe conditions (e.g., congenital adrenal hyperplasia) in which a person is born with sex characteristics or anatomy that does not allow clear identification as male or female. The causes of an intersex condition can be chromosomal, gonadal or genital.

Common Biblical Teachings

1. **The Effeminate:** "Neither the effeminate . . . shall inherit the kingdom of God." (1 Cor. 6:9-10)
2. **Emasculation:** "He that is wounded in the stones, or hath his privy member cut off, shall not enter into the congregation of the Lord. (Deut 23:1)
3. **Cross-Dressing:** "The woman shall not wear that which pertaineth unto a man, neither shall a man put on a woman's garment: for all that do so are abomination unto the Lord thy God." (Deuteronomy 22:5)
    - These passages likely were about preventing the Israelites from taking part in Canaanite rituals which involved swapping of sex roles and cross-dressing.
4. **Eunuchs:** "For there are some eunuchs, which were so born from their mother's womb: and there are some eunuchs, which were made eunuchs of men: and there be eunuchs, which have made themselves eunuchs for the kingdom of heaven's sake. He that is able to receive it, let him receive it." (Matt 19:12)
    - The eunuchs in these contexts were most frequently either court officials or slaves and not gender dysphorics.

The Four Acts of the Biblical Drama

Creation: Adam and Eve lived as different gendered person and this enabled the "one flesh" unity that God commanded.

- "All of the research on gender differences in various personality traits, cognitive abilities, and preferences consistently shows that, even when there are statistically significant differences between women and men, these differences pale in magnitude beside the variations among women and among men."
- **Ontological Sex**: Human beings are ontologically (and not merely in appearance) male and female. God deliberately separated into female and male in the creation of humankind as a way of structuring into creation a basic need for us to be in relationship.

Fall: We are all disordered before God so Gender Disorders can be seen as a natural consequence of the Fall.

a.) **Klinefelter Syndrome:** The person has an extra sex chromosome (XXY)

b.) **Androgen Insensitivity Syndrome**: The person has external female genitalia and an outward appearance as female but XY male chromosomes.

c.) **Congenital adrenal hyperplasia (CAH):** Can have many outcomes but could include a person with XX chromosomes but male external genitalia. CAH is "the result of an enzyme deficiency and "is inherited as an autosomal recessive disorder."

d.) **Essence vs Culture:** How much of what we think of as essential is acculturation as male or female? Sometimes rigid gender stereotypes are culturally based and not essential.

Exceptions: Recognizing that there are exceptions to binaries is not the same thing as saying the sex binary is arbitrary, socially constructed or oppressive.

The Culture War: The current culture war is between those who view sex and gender as arbitrary oppressive social constructs that need to be deconstructed and those who view sex and gender as essential aspects of being human.

Redemption: God doesn't want us to stay fallen and intends to redeem us through Jesus Christ. To glory in our fallen conditions is to reject redemption.

Frameworks of Gender Dysphoria

1. **Integrity Framework:** This lens views sex and gender in terms of "the sacred integrity of maleness or femaleness stamped on one's body." Cross-gender identification is a concern in large part because it threatens the integrity of male-female distinctions.
    - Same-sex sexual behavior is sin in part because it does not "merge or join two persons into an integrated sexual whole"; the "essential maleness" and "essential femaleness" is not brought together as intended from creation.

2. **Disability Framework:** Gender dysphoria is viewed as a result of living in a fallen world in which the condition is a nonmoral reality. The causal pathways and existing structures are viewed by proponents of the disability framework as not functioning as originally intended. It is compared to depression or schizophrenia and seen as nonmoral.
    - "While the fall into sin has created distortions in how femaleness and maleness are experienced and expressed, living in the time of grace means that we must seek to redeem gender and sexuality in harmony with God's intentions.

3. **Diversity Framework:** A third way to think about transgender issues is to see them as something to be celebrated, honored or revered. There are those who wish to recast sex as just as socially constructed as gender.
    - Those who advocate for the strong form tend to be academics who are proponents of the scholarship of Michel Foucault, Judith Butler and others.

4. **Integrated Framework:** Gender Dysphoria may result from a disability and is not just the result of wilful disobedience. We need to be sensitive to the integrity of fundamental doctrines of gender contained in scripture. We should help manage gender dysphoria in the least invasive way possible. The weak form of the diversity framework can validate a person's experience.

Dealing with Shame: Most people hear in the church that they are fundamentally flawed, and it is their fault which leads to shame. The diversity framework gets at **meaning, purpose, and sense of self, identity and community.** If people just get shame from the church they will turn to the diversity framework for meaning, purpose, sense of self, identity and community.

- Author says not to embrace the integrity paradigm at the risk of gender diversity being rendered meaningless—as merely an unfortunate form of suffering that will ultimately be erased in eternity.
- **My Own Notes:** Maybe etiology doesn't matter, as it is an expression of the fall. The only thing that matters is where one's heart is at in submitting to the revealed will of God. Offer a broken heart and a contrite spirit and work towards being "born again" and overcoming the fall, not rationalizing staying fallen. We have no guarantees about outcome, God may not take this away but he does expect humility, submission and effort in complying with His will.
- Christians can benefit from valuing and speaking into the sacredness found in the integrity framework, the compassion we witness in the disability framework, and the identity and community considerations we see in the diversity framework. No one framework in isolation will provide a sufficient response or a comprehensive Christian model of pastoral care or cultural engagement.
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What Causes Gender Dysphoria?

The most concise answer to the question of causation is this: we do not know what causes gender dysphoria. It's not the incongruence between sex and gender that is thought of a disorder but the dysphoria that results from that incongruence.

How vs Who Distinction: Some people will use transgender to describe how they are ("I am a person who is transgender, by which I mean I am a person who experiences gender dysphoria") while others will use transgender to describe who they are ("I am transgender, a member of the transgender community").

Brain-Sex Theory: The idea is that there are areas of the brain that are different between males and females (sexually dimorphic structures). "Brain sex" refers to ways in which the brain scripts toward male or female dispositions or behaviors. It is certainly true that the brain is the most used sexual organ of the body.

- **Two distinct sexual development processes**: the presence of testosterone in utero leads to the development of external male genitalia and to a male differentiated brain. But these are two distinct processes; they do not occur at the same point in fetal development. Sex differentiation of the genitals occurs much earlier leaving a time period where disruption can occur. This means someone could theoretically experience male genital differentiation and then female brain differentiation later.

a.) Prenatal hormonal hypothesis: Gender dysphorics are more likely to be left handed than right-handed and left-handedness is known to relate to prenatal hormonal exposure. Finger-length ratio is a marker of prenatal hormonal exposure to testosterone and transsexual males show the same ratio as females do. The more the testosterone the more the ring finger grows.

- However, women born with Congenital Adrenal Hyperplasia who produce more testosterone on average and have somewhat deformed genitals do not experience more gender dysphoria.

b.) Neuroanatomic brain differences hypothesis: The stria terminalis (BSTc), an area of the hypothalamus, is similar in transsexual males as it is to biological females. This comes from the Jiang-Ning Zhou and colleagues' study. However, the males in the study had been acting in cross-gender roles for years and were all on feminizing hormone therapy so we don't know if nurture modified the brain structures.

- In another study by Wilson Chung and colleagues it was found that the area of the hypothalamus was indeed different among men and women but this difference didn't appear until later in life challenging the idea that the difference was apparent from birth. The brain structure did not become sexually dimorphic until adulthood.
- **Limitations:** Several limitations of this research should be noted. These limitations include (1) small sample sizes, (2) post-mortem samples in which transsexual persons frequently used hormone therapy, and (3) emphasis on morphology rather than a range of other considerations.
- Beyond morphology or structure, there are also issues with brain activity, connectivity, load (thickness) and efficiency (speed) that often go overlooked in a nearly exclusive focus on structure.
- Identity is known to exist within the frontal cortex and not the hypothalamus so it's unlikely this is the explanation.

c.) Biased Interaction Theory: We identify with role models that we think we are alike. Most males identify with boys because they act alike but for some males they identify more with feminine role models. This leads them to think they don't "fit in" with boys and that they therefore may be girls.

<u>Blanchard Typology</u>

1. **Male to female androphilic type:** Males who transition to females but are attracted to males and are therefore homosexuals. They tend to transition earlier in life, recall being more feminine and are unlikely to get married or be parents.
2. **Autogynephilic type**: The biological male finds the idea of himself as a female sexually arousing. They typically transition later in life, have sexual experiences with females are more likely to have married and to have become biological parents. They recall less childhood femininity but are more aroused by cross-dressing.
3. **Female to male:** They are female at birth but believe they are psychologically male. They tend not to be attracted to males and are more attracted to females but want those females to accept she is really a male.
4. **Bisexual Type:** This type has shown attraction to both males and females in the past.
5. **Asexual Types:** person has shown no arousal patterns.

The fact that there is an observable typology based upon sexual attraction/orientation suggests a more complicated pathway(s) for the etiology of gender identity concerns than is found in the brain-sex theory.

Meyer-Bahlburg Risk Factors: Prenatal hormone exposure, Feminine appearance, inhibited/shy temperament, separation anxiety, late in birth order, sensory reactivity and sexual abuse, insecure attachment in boys.

- **Parenting:** Associated risk factors related to parents include preference for a girl, parental indifference to cross-gender behavior, reinforcing cross-gender behavior, encouragement of "extreme physical closeness with boys," insufficient adult male role models and parental psychiatric issues. Gender dysphoria is not the result of a failure to identify with the same-sex parent.
- **Peer Group:** Boys show preferences for cross-dressing and cross-gender play. Fear of and avoidance of other boys which leads to rehearsal of female roles in play.

"If you know one transgender person, you know one trans-gender person!"

- **Equifinality** says that there could be multiple pathways to the same outcome which appears to be the case with transgenderism.
- **Multifinality** says that a group of people could have the same factors as part of their history but have different outcomes.

The experience of true gender dysphoria is not chosen, nor is it a sign of willful disobedience, personal sin or the sin of the parents. However, engaging in cross-gender behavior may be more volitional, and the motivations are different. Are those motivations about sexual arousal or about self-expression?

Phenomenology and Prevalence

DSM V Criteria in Children

- A strong desire to be of the other gender or an insistence that one is the other gender.
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for the playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

Ideology kills: The book "As Nature Made Him" documents the case of a baby boy who underwent a botched circumcision and who was raised as a girl at a time when some experts were quite confident that social learning could trump biology. The boy, John, was actually unable to sustain an identity as a female (Joan) and transitioned to male in adolescence. Tragically, as an adult he took his own life.

Rates of Persistence: According to the DSM-5, Gender Dysphoria persists from childhood to adolescence in only 2.2 to 30 percent of biological males and 12 to 50 percent of biological females.

DSM V Criteria in Adolescents and Adults

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex character-istics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The DSM-5 includes early and late onset as specifiers.

1. **Early Onset Male to Female:** There is often a history of social exclusion and harassment with high social anxiety and few social skills. They often hide their transition history if others aren't supportive and are more vulnerable to addictions and survival sex work. This is the more common presentation though it is likely to resolve itself in most people.
2. **Late Onset Male to Female:** They grew up with more traditional masculine childhoods and have "fit in" most of their lives. They often experience great losses of employment, community and family when they transition.

Prevalence Rates: The DSM-5 estimates that between 0.005 percent to 0.014 percent of adult males and 0.002 percent to 0.003 percent of adult females have Gender Dysphoria. Findings from other studies put the prevalence estimates in ranges from 1 in 10,000 to 1 in 13,000 males and 1 in 20,000 to 1 in 34,000 females.

Male vs Female: Gender Dysphoria as a diagnosis and the broader experience of gender dysphoria along a continuum appears to be more common among males than females, with a ratio of at least 3:1.

Transgender vs Gender Dysphoria: More people identify as transgender than experience Gender Dysphoria. In one study, between 1 in 215 and 1 in 300 people identified themselves as transgender but most would not meet the criteria for gender dysphoria. Certainly, gender dysphoria can exist without the desire for hormonal treatment or surgery.

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Cross-Dressing: A person could cross-dress but not experience gender dysphoria; they might cross-dress because the act of cross-dressing is itself sexually arousing.

Table 4.1. Facets of Cross-Dressing: Purpose, Extent, Locale

Purpose	Expression	Management	Arousal
Extent	Underwear	Outerwear	Outerwear/makeup/hair
Locale	At home/private	Public/out of the area	Public/local area

- Most cross-dressers either only wear underwear of the other's sex (about 68% of all who cross-dress) or only wear other sex clothing at home (21%). Essentially, Kinder's estimate is that only one out of three hundred persons who already cross-dresses would want to transition to the other sex.

Early Onset Male to Female: often a history of social exclusion and harassment with high social anxiety and few social skills. They often hide their transition history if others aren't supportive and are more vulnerable to addictions and survival sex work. This is the more common presentation though it is likely to resolve itself in most people.

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Prevention and Treatment

There are 4 major interventions: i.) Resolution through identifying with birth sex, ii.) watching and waiting, iii.) facilitating identifying with preferred sex and iv.) Puberty Suppression.

1. Resolution of gender dysphoria through intervention to decrease cross gender identification: Emphasis on resolution of Gender Dysphoria by decreasing cross gender behaviors and identification.

- The known emotional and social correlates of gender incongruence—issues like family and peer conflict and ostracism, as well as depression, anxiety, school aversion and school drop-out—provide a rationale for intervention. We expect that we can diminish these problems if we are able to speed up the fading of cross gender identity which will typically happen in any case.
- **Behavioral therapy** encourages the same-sex parent (or grandparent or mentor) to spend more time and share positive play experiences with their child while also avoiding criticism of the child. The parents are coached to essentially ignore cross-sex-typed behavior if possible and identify strategies to redirect the child to behaviors that reflect more that child's gender. In following an operant conditioning approach, parents praise the child for any gender-appropriate activities or play.
- **Psychodynamic approaches** (psychoanalysis, psychotherapy, psychoanalytic psychotherapy) based on object relations, self psychology and other conceptualizations take a developmental perspective, explore identification with the same and opposite sex, and intervene more "within" the child (than through the environment).
- **Hybrid or "third way" model:** They extend the treatment beyond simple behavioral reinforcement by providing therapy to address a child's gender incongruence and identity from the "inside out," while also setting limits and providing education to address gender identity from the "outside in." Parents are also provided assistance in identifying activities that facilitate a same-gender identification, and there is typically a significant increase in time spent with same-sex peers (milieu protocol) that has been shown in research to be associated with "more typical sex-differentiated behavior."

Meyer-Bahlburg Protocol: This is a protocol for intervention to facilitate the resolution of gender dysphoria among biological males. That protocol focuses on the following:

- Fostering positive relationship with one's father or male caregiver or role model
- Fostering positive relationships with one's male peers
- Fostering gender-typical habits and skills

- Facilitating male peer group interactions
- Facilitating positive feelings about being male
- To reduce stigmatization, the protocol focuses on services to the parents who work with the child rather than work directly with the child.
- For example, a National Public Radio report on the topic cited the Portman Clinic's treatment of 124 children since 1989. The approach taken at the Portman Clinic is to have children live in a way that is consistent with their birth sex. It was reported that 80 percent of the children chose later as adults to maintain a gender identity consistent with their birth sex.
- **However, most children whose dysphoria resolves report that they have a homosexual or bisexual orientation as they enter their teen years.** Among those children whose gender dysphoria desisted, a range from 63 percent to 100 percent of biological males and 32 percent to 50 percent of biological females identify as gay, lesbian or bisexual in adulthood.

2. Watchful waiting: Take a neutral approach that allows for cross-gender dress and role adaption while avoiding reinforcement. There is not an a priori assumption in place that functions as a goal for the child's gender identity.

3. Facilitation of the gender identity of the preferred sex in anticipation of an adult identification. Psychosocial facilitation is considered "affirming" insofar as it practices out of several assumptions, including that "being transgender is not a mental illness." According to Olson et al., "Affirmative approaches actively promote exploration of gender identity and assist adolescents and their families in learning about and engaging in appropriate gender transitioning interventions."

- The elements involved in psychosocial facilitation could include "adoption of preferred gender hairstyles, clothing, and play, perhaps adopting a new name."

4.Puberty Suppression: Intervention to block hormones until a child (now a teen) can decide about gender identity in later adolescence.

- Children between the ages of ten and thirteen are prevented from entering puberty by receiving injections of hormone blockers that keep the gonads from making estrogen or testosterone. This, in turn, prevents the expected changes at puberty, such as girls developing breasts, starting their menstrual cycle, and so on. Boys will not grow body and facial hair, nor will their voice deepen. The idea is to then allow time for the child to enter into adolescence and for the teen (at around age sixteen) to eventually decide whether to develop a gender identity in accord with their birth sex or with their preferred/psychological/phenomenal sex.
- At 16 the children are then given the option to take the opposite sex hormones or they can transition back into their biological sex.
- It is also important to explore whether the dysphoria is a negative response to homosexuality/ same-sex sexuality rather than an actual desire to change one's sex.

Reversibility of Interventions

1. **Reversible Interventions**: The reversible steps include adopting cross-gender hairstyles, clothing and interests, as well as perhaps use of a preferred name.
2. **Partially Reversible** Interventions would be cross-gender hormone therapy (testosterone or estrogen depending on the direction of preferred gender identity).
3. **Irreversible Interventions** are surgical, of which there are a range, and I will discuss these under treatment of adults. Currently, most surgeons in the United States will not provide surgery until the adolescent turns eighteen.

Outcomes in Adulthood

When we look at outcomes for adult experiences of Gender Dysphoria, Carroll notes four typical outcomes:

1. **Unresolved outcomes**: Unresolved outcomes simply reflect that there is a high attrition rate—estimated at up to half of clients who seek service.
2. **Biological sex and gender role acceptance:** Others come to accept their biological sex and gender role (path 2). They may feel gender dysphoric, but they live as their birth sex and adopt a lifestyle that reflects that. Psychological resolution appears to be more likely among "a subgroup of cross-dressers with gender dysphoria" who view the problem as a fetish or paraphilia and treat it with CBT interventions.
3. **Engage in cross-gender behavior intermittently:** This is the most frequent outcome. According to Carroll, "the majority of these men are heterosexual, often married, usually vocationally stable or successful."

4. **Adopt cross-gender role through sex reassignment**: It is strongly recommended (but not currently required) that a person then undergo a period of psychotherapy. If a person were to reach a point at which they were a candidate for surgery, it is recommended in the Standards of Care that they live for a year in the real-life experience of living full time as the desired gender.

Decision Making Strategies Around Sex Reassignment

1. **Awareness:** Characterized by distress related to Gender Dysphoria
2. **Disclosure**: Sharing with significant others one's diagnosis and experience of Gender Dysphoria.
3. **Exploration**: Initial exploration of options for one's identity and identity label along a continuum.
4. **Transition**: Further exploration of body modification.
5. **Integration**: Synthesis of identity in light of transition.

Sex Reassignment Surgery

1. **Biological Male**: Vaginoplasty or the creation of a neovagina (with a penectomy or the removal of the penis and orchiectomy or the re-moval of the testes). Male hair can also be removed, and corrective surgery can be performed on the larynx. Surgery to enhance the breasts (breast aug-mentation) can also be performed.
2. **Biological Female:** The breasts, uterus and ovaries can be removed. Some patients will also request phalloplasty or the creation of a neophallus. If the patient has an enlarged clitoris (sometimes as a result of taking male hormones), it may be cut loose in a way that it can be experienced more like a penis (metaidioplasty).

Low Rates of Regret: A recent study that examined outcomes over a fifty-year period in Sweden (1960–2010) indicated a 2.2 percent rate of regret for both MtF and FtM transsexual persons.

- **Gender:** What we know at this point is that those with a female-to-male conversion report adjusting better, on average, than those whose conversion is male-to-female, although again there is great variability.
- **Age:** Older persons pursuing reassignment do not report having as favorable outcomes as younger persons.
- **Autogynephilic** cases appear to be at greater risk for regretting the decision to pursue sex reassignment.
- However, most people who experience gender incongruence in adulthood do not undergo surgery. Most cross-dress intermittently either as an expression of their sense of gender identity or they use cross-dressing as a way to manage their dysphoria, among other possible motivations.

Increased Suicide Risk: Although previous research on follow-up of transsexual persons tended to be rather favorable, researchers tended not to follow the person over a long period of time. A more recent study that provided data on long-term follow-up reported increased risks for suicide attempts, death from suicide, and psychiatric inpatient care that are "considerably higher risks" than the general population.

- This study found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalizations in sex-reassigned transsexual individuals compared to a healthy control population. Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons.

Sex Reassignment as delusional beliefs: It is not obvious how this patient's feeling that he is a woman trapped in a man's body differs from the feeling of a patient with anorexia nervosa that she is obese despite her emaciated state. We don't do liposuction on anorexics. Why amputate the genitals of these poor men? Surely, the fault is in the mind not the member.

- The transgendered suffer a **disorder of "assumption"** like those in other disorders familiar to psychiatrists. With the transgendered, the disordered assumption is that the individual differs from what seems given in nature—namely one's maleness or femaleness. Other kinds of disordered assumptions are held by those who suffer from anorexia and bulimia nervosa, where the assumption that departs from physical reality is the belief by the dangerously thin that they are overweight.

Toward a Christian Response

Narrative Therapy: Narrative approaches are often used with marginalized groups whose "story" has been written by a dominant culture: "On a larger level, entire groups of people could have their story about themselves completely overtaken by a more dominant group story about them."

- **Mainstream Narrative:** Most mainstream, secular narrative approaches to gender dysphoria would posit that it is the sex and gender binary that is oppressive to the person who is gender dysphoric.
- **Scripts:** A script is a cultural expectation for behavior and meaning making.

The Transgender Script

- Gender dysphoria reflects a naturally occurring difference among types of people (transgender rather than cisgender).
- Your gender dysphoria as gender incongruence suggests who you are ("who I am") rather than how you are ("how I am").
- Gender dysphoria points to a community of others who experience a similar phenomenon ("I am part of the transgender community").
- Your gender incongruence points to something at the core of who you are, something that is central to your identity. A person often receives the message that they are born this way.
- The dysphoria may signal who the person "is"—that is, "I was born in the wrong body; the person I am is inside of me, and I need to express that." The person has a sense of identity (who I am; I am transgender) and a sense of community: "I am part of the transgender community," which could mean different things to different people.

The Christian Script

- This is a spiritual matter; this is sinful.
- Fulfillment comes from adopting a traditional gender role that corresponds with your biological sex.
- The failure to find worth and purpose and meaning in traditional gender roles and expressions is a mark of willful disobedience.
- Cross-gender behaviors and roles are unacceptable as they undermine the truth about who you have been made to be.
- gender dysphoria itself were a sign of willful disobedience.
- Ultimately, these messages **communicate shame** to the person navigating gender identity concerns. Shame is the psychological and emotional experience of believing yourself to be inadequate in ways that lead you to reject yourself. It hides itself from others on the assumption that if others knew this about the person, they too would reject them.

Integrated Script

- Experiences of gender dysphoria are part of my reality (that is, "how I am").
- I did not choose to experience gender dysphoria or gender incongruence, and I honestly do not know the cause.
- Perhaps being transgender is part of my identity; however, I am a complex person and am more than gender dysphoric.
- I do not know how I came to experience gender dysphoria, but I can consider what it means to me today and where I go from here.
- There are probably a dozen different directions for any experience of gender dysphoria, and I plan to consider many of them, and may select some of them, considering the least invasive steps when possible.

Table 6.1. A Multi-Tier Distinction in Language and Meaning

	Language	Meaning
Tier 1	"I am a person who experiences gender dysphoria."	The most descriptive way to convey part of your experience.
Tier 2	"I am someone who is transgender" or "I am a transgender person."	Use of *transgender* as an adjective; describing how you are.
Tier 3	"I am transgender."	Use of *transgender* as identity. This is who you are.
Tier 4	"I am transgender, which I define as . . ."	Use of *transgender* and a personal definition to more accurately define who and how you are at the same time.

Mapping Gender Identity

1. **How does the person experience his or her gender identity concerns**? This involves gauging a person's experience of gender incongruence, as well as a person's sense for how they are managing that incongruence.
    - The gender identity concerns, while important, may not be the greatest concern in this person's life.

- A person can identify ways in which gender dysphoria has influenced him or her, as well as how the person has influenced gender identity concerns. Probe for ways the person has managed the dysphoria and ways that the person is exacerbating it.
- On a scale from 1-10 ask the person how gender incongruent he feels and his current ability to manage it.

2. **Join the Person on an Attributional Search:** How does the person make sense of his or her gender incongruence? From an integrity point of view the incongruence reflects the fallen world we live in, from a disability point of view it is a non-moral reality of the fall and from a diversity point of view it is something natural to be celebrated.

Telling Others: I try to assure them that they are not alone in the sense that I know and will not leave them, and I will work with them on finding others who can provide support.

1.) **Proscriptive constraints** regarding gender identity communicate the following: "Discussions about gender identity are not welcome here." This message comes from individuals and communities for whom the topic is so threatening that there is no discussion to be had.
2.) **Prescriptive Constraints** communicate the following: "Discussions about gender identity can and should be discussed, but we only discuss it in this certain way." This can make discussing gender identity concerns difficult because the person who is struggling initially feels welcome to disclose but then is quickly told that there is only one way for them to actually think about their gender identity.

- Sometimes distinguishing "how you are" from "who you are" may be helpful when sharing experiences of gender dysphoria with another person.
- **Not your fault:** I also tell those who experience gender dysphoria that if the person they tell reacts with anger, disbelief, rejection or hurt after they tell them about their experiences, it is not their fault. I usually reiterate that they did not choose to experience gender dysphoria; they found themselves experiencing gender dysphoria, and this is not an issue of blaming but of realizing there may be negative reactions for different reasons.

Critiquing the Christian Response

Correct the Sinner: Many are simply overwhelmed by something they do not understand or do not wish to investigate outside their religious doctrines. That is, "if you don't correct the sinner, you're complicit in the sin."

Traditional Church model: It has been observed that a traditional evangelical church focuses on behavior first, followed by belief in Christ and a sense of Christian community. It essentially looks like this: Behave→Believe →Belong

Missional Church Model: instead belonging comes first and then faith in Christ and then we don't know what you become. Belong→Believe →Become.

a.) **Inwardly missional Church:** Focuses on clear teachings for those who are within the community. This kind of church places greater emphasis on the integrity framework. It is a church that sees as its mission the communication of a faithful, biblical witness about sexuality and gender to those who reside within. Such a church may risk not being as hospitable to those on the outside.
b.) **Outwardly Missional Church:** Focuses on being missional to the local, broader community in the area surrounding the church itself. The emphasis is on reaching out, inviting in and creating a sense of belonging,

Criteria for Inclusion: The terms of inclusion from the local church are that a person fit into the male-female binary and experience congruence between biological or birth sex and psychological and emotional experience of gender identity.

- Are Christians prepared to support transgenders without the condition that the person manages that dysphoria in a way the Christian community would support?
- One impulse is to convey the integrity framework to the exclusion of the potential benefits seen in the disability or diversity frameworks.

Prevailing Treatment: The prevailing view within the mental health field is to address the dysphoria through cross-gender identification and expression, supported in the context of therapy, and with the possibility of additional steps to facilitate a transition.