The Science and Politics of Gender Dysphoria (Transgenderism) in Children

The Ethical and Religious Implications of Sex Altering Treatment

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Introduction

Within the past ten years, there has been an unusual rise in children as young as two years old being identified as transgender. However, many Christians do not have adequate tools to decipher between LGBTQ propaganda and medical science or articulate the appropriate biblical ethic regarding the diagnosis and treatment of children suffering from Gender Dysphoria (GD) with Puberty Suppression Hormone Therapy (SP) and Sex Reassignment Surgeries (SRS). In this paper, I plan to offer some clarifications that will separate true scientific facts from social propaganda. This subject is complex and understandably socially volatile but the Christian needs to be well informed with medical, social, and biblical truth. Hence, in Section One, I will define Gender Dysphoria (GD) from medical, social, and biblical perspectives. In Section Two, I will foray into the medical classification and treatment of GD. In Section Three, I will discuss ongoing ethical issues with the current social trends.

Section One: Definition of GD

Definition

Gender Dysphoria refers to the experience of conflict or incongruence in gender identity when a person's perceived gender differs from the biological sex at birth. Biological sex is a natural phenomenon and 99% of all children conform to their biological sex. Less than 1% of all children experience GD as part of their developmental process.[1] Children as young as two years old have expressed discomfort with their gender or the expected roles that match their biological sex. Most children outgrow this feeling at puberty.[2] The result from follow-up research among

[1] Michelle Cretella, "Gender Dysphoria in Children," *American College of Pediatricians,* (November 2018), https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. Accessed December 12, 2018.
[2] Madeleine S.C.Wallien, Peggy T.Cohen-Kettenis, "Psychosexual Outcome of Gender-Dysphoric Children," *Journal of the American Academy of Child & Adolescent Psychiatry,* Volume 47, Issue 12, (December 2008), https://www.sciencedirect.com/science/article/abs/pii/S0890856708601422. Accessed December 12, 2018

children with GD shows that 80 – 95% of children and 75-90% of adolescents[3] who express incongruence as children outgrow those desires after puberty or as adults.[4]

However, due to recent socio-political developments, the definition of gender dysphoria has become both ambiguous and controversial. New nuances have been introduced in the scientific literature to accommodate social activism, political correctness, and suitability for insurance claims. The redefinition and reclassification from Gender Identity Disorder (GID) to Gender Dysphoria offered in the Diagnostic and Statistical Manual fifth edition (DSM-V) is an example of this trend.

The DSM-5-TR defines gender dysphoria in children as a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least 6 months, as manifested by at least six strong preferences, desires, likes and dislikes. …The condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.[5] Also, according to the American Psychiatric Association (APA), *"Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify."*[6] It is important to note that in both definitions, the incongruence is no longer between one's biological sex and the feeling of being of the opposite sex. The shift to incongruence between assigned gender and experienced gender is a ploy to shift

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[3] Ibid.
[4] Thomas D. Steensma et al, "Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study," *US National Library of Medicine National Institutes of Health* (June 2013), https://www.ncbi.nlm.nih.gov/pubmed/23702447, https://www.ncbi.nlm.nih.gov/pubmed/18194003. Accessed December 12, 2018.
[5] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* (Fifth Edition, Text Revision (DSM-5-TR 2022).
https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.
[6] Ranna Parekh, "What Is Gender Dysphoria?" American Psychiatric Association, (February 2016), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria. Accessed December 12, 2018.

the fundamental cause of GD from an internal mental state that precedes the GD to an externally induced distress that is in response to social pressure, prejudice and bullying.

The current verbiage and description used for GD seem to vilify biological sex but favor the child's desired gender. The natural sex that matches the scientifically determined chromosomal make-up of the child (XY for male or XX for female) is portrayed as assigned gender—implying forced on the child by doctors and parents against the child's wishes. Whereas the child's desired gender—the product of the disorder/incongruence—is treated as normal, socially correct, and favorably referred to as the preferred gender.

Nonetheless, the American College of Pediatricians rightly asserts: *"Human sexuality is binary by design with the purpose being the reproduction of our species. This principle is self-evident. Barring one of the rare disorders of sex development (DSD), no infant is "assigned" a sex or a gender at birth. Sex declares itself anatomically in utero and is clearly evident and acknowledged at birth."*[7] GD is not an external battle with those who assign the correct gender at birth, but an internal battle within a person that requires a compassionate response of proper care until the person's mind aligns with his/her body. GD is a disparity between self-cognition of one's gender and biological sex. It is a mental dissonance between physiological make-up and mental awareness.

Medical Classification of Gender Dysphoria

The ethical implications of the treatment of GD correlate directly with the ethical implications surrounding the redefinition and reclassification of gender dysphoria in scientific manuals. Although gender disorders had been identified by German clinicians more than 150

[7] Cretella, https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. Accessed December 12, 2018.

years ago,[8] it was the publication in 1980 of The Diagnostic and Statistical Manual (DSM III) by the American Psychiatric Association that created the first formal diagnostic classification for Gender Identity Disorder (GID). Since then there have been revisions in terminology and classification of GID. GID was first classified under the category on psychosexual disorders and later in the 1987 revised DSM-III-R, classified under *"Disorders Usually First Evident in Infancy, Childhood, or Adolescence."*[9] Subsequently, by 1994 DSM-IV more revisions were made to create a stand-alone category for GID, which included transsexuals for various reasons including more access to SP/SRS treatment and insurance coverage.

In May 2013, the APA released the DSM-V, changing the diagnosis of gender identity disorder (GID) to gender dysphoria (GD). This move was in direct response to social pressure and gender identity activism. The goal was to de-pathologize GID and reduce the perceived stigmatization of gender dysphoric persons as psychiatric patients by focusing on the distress caused by GID. Kenneth J. Zucker, the chair of the DSM-V work group on GD, emphasized that the change from GID to GD better describes the distress that some gender dysphoric people experience because of the incongruity of their gender identity.[10] Hence, the new classification focuses on the distress as the clinical problem and not the gender identity disorder or incongruence.

This change in focus from identity incongruence/disorder to distress is regrettable because it does not capture the entire experience of gender dysphoric persons. Further, many GD

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[8] Ira B. Pauly, "Terminology and Classification of Gender Identity Disorders," in *Gender Dysphoria: Interdisciplinary Approaches in Clinical Management,* eds. Walter Bockting, Eli Coleman, (Binghamton, New York: Haworth press Inc, 1992), 1.
[9] Ibid., 3.
[10] Kenneth J. Zucker, et al, "Memo outlining evidence for change for gender identity disorder" in the *DSM-5, Archives of Sexual Behavior,* 2013;42:901–914, (June 2013), https://www.ncbi.nlm.nih.gov/pubmed/23868018. Assessed December 20, 2018.

persons do not experience clinically significant distress or desire for a sex change and therefore do not need distress intervention. A group of clinicians from a U.K. gender clinic objected to this distress-based classification. In protest they wrote: *"We have previously questioned the value of distress as a core criterion for diagnosis in DSM classification as it is a very general use of language, not specifically pathognomonic for any mental or physical illness, disorder or condition, and rather open to a wide range of interpretation as to what constitutes marked or clinically significant distress."*[11] Apart from the vagueness of a term as broad as distress, the question of who or what determines the standard for clinically significant distress is problematic given that prognosis is largely dependent on the report and behavior of the child.

The Push to De-Pathologize GD

Some advocacy groups have intensified this controversy by insisting that GID/GD should be deleted from DSM for socio-political reasons that are not science related. These activists argue that GD is not a mental disorder or sickness but a normal variant of human diversity. Classifying this condition as a psychiatric disorder, the activists contend, *"further alienates and stigmatizes gender dysphoric individuals by placing a psychiatric label on them*."[12] Many others who are mounting pressure for the eradication of gender conforming treatments and advocating gender affirming procedures are medical practitioners as well as interest groups who benefit from such treatments financially. These include some doctors, medical associations, medical journals, and other providers.[13]

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[11] Walter P. Bouman, C. Richards, "Diagnostic and treatment issues for people with gender dysphoria in the United Kingdom," *Sexual and Relationship Therapy* 28(3):165-171 (August 2013), https://www.researchgate.net/publication/259361679_Bouman_WP_Richards_C_2013_Diagnostic_and_Treatment_Issues_for_People_with_Gender_Dysphoria_in_the_United_Kingdom_Sexual_and_Relationship_Therapy_283_165-171, Accessed December 12, 2018.

[12] Pauly, 1.

[13] American Psychological Association, "About Transgender People, Gender Identity, and Gender Expression," https://www.apa.org/topics/lgbt/transgender.pdf. Accessed December 14, 2018.

Dr. Spack, one of the major advocates, is the director of one of the nation's first gender identity medical clinic at Children's Hospital Boston. In a 2012 medical article, he stated that the current APA "*position is aligned with our gender affirming approach to care which views gender variations as part of an expected diversity, and not pathology."*[14] *Mental health challenges may emerge related to cultural and social responses to a child or co-exist with gender non-conformity.*[15] With this assertion, he reduces a known mental incongruence of a distorted sense of self to variation and diversity and blames social response (acceptance or non-acceptance of the GD child) as the cause of mental disorder in GD children. By so doing GD, to him should not be viewed as a pathology but a natural evolutionary diversity.

The expressed hope of these activists is that GD will also be removed as a medical disorder one day, just as homosexuality was reclassified and removed from DSM in the 70s.[16] However, unlike homosexuality where the persons do not need a psychiatric evaluation before pursuing their lifestyle, gender dysphoric persons do. Also, GD individuals experience a remarkable occurrence of mood disorders warranting proper psychiatric evaluation before any recommendations are made. Therefore, it is against Christian ethic to support the removal of a medically proven anomaly from the DSM simply because advocacy groups do not like the stigma, or for the sake of income stream for medical practitioners. It is also unbiblical to accept gender fluidity as normal when the Bible and biological science make it clear that God created human beings in his image and likeness as male and female.

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[14] American Psychological Association, https://www.apa.org/topics/lgbt/transgender.pdf. Accessed December 14, 2018.
[15] Amy C. Tishelman et al., Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples, *US National Library of Medicine National Institutes of Health,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4719579/#R28. Accessed January 10, 2019.
[16] Jack Drescher, "Out of DSM: Depathologizing Homosexuality," *US National Library of Medicine National Institutes of Health,* Dec 4, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695779/. Accessed December 16, 2018.

The Biblical Position

It is important to emphasize here, that the Christian ethic is grounded in the authority and will of the Christian God as revealed in the Bible. Some activities might be ethically acceptable and work well for the culture or society but fail to pass the Biblical test. Christians believe that God created human beings not as isolated individuals but as a community, to develop societies where social interactions necessitate ethical considerations. The notion of what is right and what is wrong is grounded in God who is the ultimate Objective Morality. He has set rules and laws to govern not just the universe but human lives and relationships as recorded in the Bible.

The Bible makes it clear that maleness and femaleness are not artificial categories or cultural constructs.[17] God created humans to be male and female. Genesis 1:27 says: *"So God created man in His own image; in the image of God He created him; male and female He created them."* Christians believe that this is the norm and that the sin of Adam and Eve and the consequent Fall of humanity at the Garden of Eden resulted in a fallen world with the various anomalies we experience today. Christians do not deny the possibility of fallen humanity experiencing such things as gender dysphoria, homosexual attraction, heterosexual infidelity, and compulsive sinfulness. The redemption through the death and resurrection of Jesus Christ gives Christians temporal and eternal hope that any anomaly that is not rectified now would be rectified in the afterlife.[18] Therefore, Christians would rather cope with certain anomalies than accept resolutions that violate Biblical principles.

According to Scott Rae *"Accepting one's gender as one of life's givens seems most consistent with a Christian ethic, analogous to accepting one's race and traits that are*

[17] Andrew T. Walker, *God and the Transgender Debate: What does the Bible Actually Say About Gender Identity,* (North America: The Good Book Company, 2017), 53.
[18] Mark A. Yarhouse, *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture,* (Downers Grove, IL: InterVarsity Press, 2015), 46.

genetically given."[19] Gender and race are very integral to the personhood of any human being that God created in His own image and likeness, that changing any of them implies a violation of God's intent, despite any perceived anomaly. It seems appropriate to echo Romans 9:20 here, *"But indeed, O man, who are you to reply against God? Will the thing formed say to him who formed it, "Why have you made me like this?"* Therefore, the Christian position would be that Christians should apply medical treatment within Christian ethical limits. The availability of technology that could change a person's biological sex does not warrant that one's God-given gender should be changed. From this perspective, it is unethical for a Christian to seek suppression of puberty or sex reassignment surgery except for the cases of precocious puberty or hermaphroditism. This exception shows that Christians are not anti-science but allow science to function as it ought to. In other words, man is not made for science—science is made for man.

Precocious Puberty

Precocious puberty is the premature onset of puberty in children before age 8 in girls and before age 9 in boys. In this case, the use of puberty suppressing hormones is to slow down the process until an appropriate age is warranted. Hayes sums it up this way, *"treatment in these populations suppress puberty only until typical pubertal stages are expected, and in many cases, the child will go on to experience normal pubertal progression.*[20] Therefore, any anticipated long-term effects would either be non-existent or drastically reduced comparative to when puberty is completely suppressed. This treatment does not change the biological sex of the child or distort his/her gender identity.

[19] Scott B. Rae, *Moral Choices: An Introduction to Ethics*, (Grand Rapids, MI: Zondervan, 2009), 290.
[20] Hayes, http://dx.doi.org/10.18785/ojhe.1402.03. Accessed December 15, 2018.

Hermaphroditism (Intersexuality)

There are people born with ambiguous genitalia due to a genetic abnormality that is classified as true or pseudohermaphrodites. The treatment of physiologically ambiguous sex is usually with corrective surgery and hormone replacement therapy. This is usually done after appropriate tests have been done to determine the most accurate sex assignment based on biological indicators. One clinical report states that *"satisfactory effect can be achieved by surgical intervention with stable gender identity and minimal complications*."[21] This procedure is both medically and biblically ethical. In this case also, the biological sex determines the gender and there is no distortion of gender identity.

Treatment of Gender Dysphoria

What many people do not know is that Gender Dysphoria has always had a treatment that has a longstanding scientific success. There is one natural and one mediatory remedy for GD that has been successful 90-95% of the time when combined.

1. The role of physiological puberty in developing a gender identity

Extensive studies and literature show that there is 80-95% disistance among gender dysphoric children and 75-90% in adolescents.[22] In a June 2017 paper, the American College of Pediatricians stated: *"Experts on both sides of the pubertal suppression debate agree that within this context (non-treatment) 80 percent to 95 percent of children with GD accepted their biological sex by late adolescence. This worldview began to shift, however, as adult transgender activists increasingly promoted the 'feminine essence' narrative to secure social acceptance."*[23]

[21] Z. Jingde et al., *Surgical Treatment of Hermaphroditism: Experience with 25 Cases,* (November 2009). https://www.ncbi.nlm.nih.gov/pubmed/19806042. Accessed December 21, 2018.
[22] Steensma et al, https://www.ncbi.nlm.nih.gov/pubmed/23702447, https://www.ncbi.nlm.nih.gov/pubmed/18194003. Accessed December 12, 2018.
[23] Cretella, https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. Accessed December 12, 2018.

80-95% of children no longer experience GD because they outgrow GD at puberty naturally and do not need gender reassignment hormones or surgery. The implication is that physiological puberty plays a significant role in developing gender identity.

However, the early treatment and suspension of puberty terminates this natural process for children with GD and reduces the percentage of desistence to zero because research shows that 100% of the children treated early with SP end up becoming transgender adults.[24] A study was conducted with 70 pre-pubertal children that were treated with puberty suppression hormones. The results show that all subjects eventually embraced a transgender identity and requested sex reassignment.[25] It is, therefore, strikingly unethical that all these children who otherwise would have outgrown GD at puberty are not given a chance to desist due to early puberty suppression treatment.

2. Gender Conforming Psychotherapy

Gender-conforming psychotherapy was used for a long time to realign the child to his/her biological sex by helping the child's mind catch up with his/her body. The goal was to address any possible domestic issues, treat any psychosocial morbidities in the child, and guide the child into aligning gender identity with biological sex. This approach is an evidence-based risk-free medical practice which has produced 80-95% success results as shown earlier. However, the current guideline for diagnosis and treatment of GD focusses on affirming the child's desired gender. The shift in focus of treatment from the disorder to the distress impacted the use of psychotherapy in the treatment of children with GD. In a recent publication, Hayes observes:

[24] Annelou L.C. De Vries et al, "Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study," *The Journal of Sexual Medicine,* (August, 2011), https://www.sciencedirect.com/science/article/pii/S1743609515336171. Accessed December 20, 2018.
[25] Ibid.

> *In the past, medicine utilized psychological interventions focusing on aligning the mind with the body and addressing underlying ideologies or potential misconceptions treating GD as a psychological condition, not a physical one. In recent years, the paradigm has shifted, ideology now stating that the mind is correct, and the body is afflicted, and new interventions focus on aligning the body to what the mind believes by implementing pubertal suppression with GnRH agonists, cross-sex hormones, and sex reassignment surgeries. For children and adolescents with gender dysphoria, they may desire such interventions in order to establish an external appearance that more closely aligns with their gender identity.*[26]

This shift in ideology has led to an intense battle of medical classification and seems to have guided the revisions of the DSM-V.

The APA insists that *"Treatment may focus primarily on affirming psychological support, understanding feelings and coping with distress, and giving children a safe space to articulate their feelings. For many children, the feelings do not continue into adolescence and adulthood.*[27] The danger with this prognosis is that it is both antithetical and unethical to give affirming psychological support to many children whose gender dysphoric feelings will not continue into adolescence and adulthood. The recommendation of affirming all persons with incongruities as potential transgender adults implies a wrong presupposition that all children with GD are potential transgender adults.

Also, clinical management of similar disorders where a person's feeling of self-identity does not match reality does not involve the affirmation of the disorder. Examples of cases similar to GD are Anorexia Nervosa, Bulimia Nervosa and Body Integrity Identity Disorder (BIID). Anorexia Nervosa is an eating disorder in which people have an intense fear of gaining weight thereby starving themselves and can become dangerously thin. Bulimia Nervosa is a psychological eating disorder that is characterized by episodes of binge eating followed by

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[26] Kelsey Hayes, "Ethical Implications of Treatment for Gender Dysphoria in Youth," *Online Journal of Health Ethics 14(2),* (2018), http://dx.doi.org/10.18785/ojhe.1402.03. Accessed December 15, 2018.
[27] Parekh, https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria. Accessed December 12, 2018

inappropriate methods of weight control. A person who suffers from body integrity identity disorder claims to be a disabled person and feels trapped in a fully functional body. All these conditions are known to result in distress, depression and even suicide.

BIID persons feel so distressed that they sometimes seek surgical amputation of healthy limbs or the surgical severing of their spinal cord to match their inner feeling of disability.[28] That is why Dr. Anne Lawrence, who happens to be transgender, insists that BIID has many parallels with GD.[29] Children with GD have a perfectly healthy body in most cases, but they feel trapped in a wrong body. To suggest sex reassignment surgery, as a means of affirming this false assumption is like suggesting amputation or surgically induced paraplegia for BIID. The case of BIID shows how unethical and even inhumane this suggestion could be.

Suspension of Puberty Therapy and Sex Reassignment Surgery in Dysphoric Children

There is an ongoing debate addressing the ethical implications of administering suppression of puberty (SP) using continuous gonadotropin-releasing hormone (GnRH) agonists (whereby puberty is obstructed to avoid distress), as well as sex reassignment surgery (SRS) (whereby a person's genitals are changed to that of the opposite sex), in children and adolescents with gender dysphoria (GD). The debate is centered on the concerns raised by many medical practitioners and ethicists in the field about the risks and ethical implications of these treatments as the first line of action in the clinical management of children with GD.

This section will summarize some concerns with SP and SRS together because most people who undergo suppression of puberty would go on to request sex reassignment surgery.

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[28] Cretella, https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. Accessed December 12, 2018.
[29] Ibid.

Problems with the Use of SP and SRS in Treatment of Gender Dysphoria

It seems that adult transgender activism is driving the social and medical pressure to affirm all children who persistently indicate GD. Medical practitioners seem to be in a hurry to implement these gender affirming treatments as opposed to gender conforming treatments without following the evidence-based ethical process. These treatments have not been tested or studied in any rigorous way over time and hence are experimental. There is serious doubt that the motivation for the use of SP and SRS in the early treatment of GD, is medical rather than ideological.

Therefore, many health practitioners and other professionals have called for caution for the following inexhaustive reasons 1. 80-95% of dysphoric children will naturally desist at puberty, so why the early drastic medical intervention? 2. Although some relief is gained from distress, the underlying psychological problem is not resolved 3. There is no evidence of any long-term, large, randomized, controlled study which analyzes the outcomes, risks and long-term effects of the treatment 4. The fixation on one type of solution and one that has little scientific evidence for its long-term benefits is problematic 5. There is no evidence of true reversibility of the process if medication is not stopped before the end of puberty.[30] 6. Adolescents who undergo SRS are at risk of infertility and may never produce genetic children. 7. There is no standardized process of diagnosing gender dysphoria. Diagnosis is based only on what the child reports. 8. There is a double standard between how GD and similar conditions like BIID are handled[31] 9. Social factors seem not to be factored in. These may include peer pressure, parental upbringing, and cultural promotion of transgenderism. Little children are extremely prone to suggestions and

[30] Cretella, https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. Accessed December 12, 2018.
[31] Hall, https://sciencebasedmedicine.org/gender-dysphoria-in-children/. Accessed December 13, 2018.

do fantasize about all kinds of things they hear 10. The accepted age of competent consent for SP by children is worrisome.

Section Four: The Christian Ethical Implications of the New Trend of Transgender Children

Issues in Diagnosis of Children with GD

It is easier to proceed with a diagnosis of GD in adults whose observable behavioral patterns show persistence than in children. The DSM-V workgroup for GD recognized this fact by creating additional criteria for diagnosing gender dysphoria in children. According to the DSM-V, children are required to have experienced at least six symptoms for six months with associated significant distress or impairment in function using the phrases "strong desire, strong preference, and strong dislike."[32] All the criteria are largely subjective. It is unclear how the hierarchy of desire or preference can be determined in dysphoric children.[33] There seems not to be an independent physiological, neurological, anatomic or instrumental test that will aid in this judgment. Hence the diagnosis and prognosis of gender dysphoria in children hinge on the child's report about how he or she feels. The intensity of their incongruence based on their report is what determines whether the suspension of puberty will be commenced. For example, if a child threatens to commit suicide or inflict self-harm because he feels distressed about his biological sex, then the use of hormone therapy and sex change surgery will be recommended.[34]

This realization brings to question the competence and authority of a child to make such determination. The main problem with this approach is that the cognitive capacity of the child is

[32] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed; (2013), https://www.psychiatry.org/psychiatrists/practice/dsm. Accessed December 13, 2018.
[33] Harriet Hall, "Gender Dysphoria in Children," *Medical Ethics Neuroscience/Mental Health,* (September 11, 2018), https://sciencebasedmedicine.org/gender-dysphoria-in-children/. Accessed December 13, 2018.
[34] DSM-5, https://www.psychiatry.org/psychiatrists/practice/dsm. Accessed December 13, 2018.

known to develop fully over time. Studies in neuroscience conclude that "*Longitudinal neuroimaging studies demonstrate that the adolescent brain continues to mature well into the 20s. This has prompted intense interest in linking neuromaturation to maturity of judgment. Public policy is struggling to keep up with the burgeoning interest in cognitive neuroscience and neuroimaging."*[35] Although neurodevelopmental processes and adolescent behavior are not fully understood, the observed evidence of the link between the two in children is obvious. A growing child begins to get more conscious of privacy during adolescence, and tends to wean off from dependence upon parents (caregivers) as a self-sufficient adult. Therefore, it seems unethical to base a major prognosis on the feelings of a prepubertal child.

Case Study:

A story appeared in *The Telegraph* on January 28, 2007 titled, "Unhappy as a boy, Kim became youngest ever transsexual at 12."[36] The boy is said to have convinced doctors that he wanted to live the rest of his life as a female by having a sex change surgery. He was started on hormone treatment, and subsequently a sex change surgery. The basis of the diagnosis was that doctors and psychiatrists "concluded that his claims to be *'in the wrong body' were so deeply felt that he required treatment."* The article noted that the major issue Dr. Meyenburg (the head of the clinic) and other psychiatrists faced was how to distinguish a true transgender personality from a temporary gender identity disorder.[37] How they solved this problem is uncertain since the child's insistence that he is, and wants to be a girl for the rest of his life determined the diagnosis and prognosis. I do not think it is ethical to base the medical diagnosis on a persistent wish,

[35] Sara B. Johnson et al, "Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy, *Journal of Adolescent Health,* (September 2009), https://www.jahonline.org/article/S1054-139X(09)00251-1/fulltext. Accessed December 11, 2018.
[36] Bojan Pancevski, *The Telegraph,* (January 28, 2007), https://www.telegraph.co.uk/news/worldnews/1540842/Unhappy-as-a-boy-Kim-became-youngest-ever-transsexual-at-12.html. Assessed December 13, 2018.
[37] Ibid.

which could very well be a fantasy,[38] of any child under any circumstance. To remove the authority of determination from credible science (biological sex) and transfer it to the wishes of a child, who is legally and developmentally incompetent to make such decisions, is problematic. The ethical implication here is that children are being taken seriously in this one case, whereas they will not be trusted to make decisions in, say, getting married at the age of twelve.

Deception about Juvenile Competence in Certain Decision-Making

In a 2005 court filing in support of Roper vs. Simmons case, the American Medical Association argued that: *"[a]dolescents' behavioral immaturity mirrors the anatomical immaturity of their brains. To a degree never before understood, scientists can now demonstrate that adolescents are immature not only to the observer's naked eye but in the very fibers of their brains."*[39] This neuroscientific evidence is believed to have swayed the Court's decision to overturn the death penalty for juveniles.[40] It is surprising, however, to note that there is a double standard when the same science is logically applied to cases like adolescents making independent decisions for their gender or reproductive health.

Justice Antonin Scalia pointed this discrepancy out in a dissenting opinion on this case.[41] He referenced a 1990 brief filed in the Hodgson v. Minnesota case by the APA in support of adolescents' right to seek an abortion without parental consent. In the 1990 brief, the APA argued that adolescent decision-making was virtually indistinguishable from adult decision

[38] Jeremy Baumbach, Louisa A. Turner, "Female Gender Disorder: A New Model and Clinical Applications," in *Gender Dysphoria: Interdisciplinary Approaches in Clinical Management,* eds. Walter Bockting, Eli Coleman (Binghamton, New York: Haworth Press Inc, 1992), 111.
[39] American Medical Association AMA, American Academy of Psychiatry and the Law, American Society for Adolescent Psychiatry, American Academy of Child & Adolescent Psychiatry, National Association of Social Workers, Missouri Chapter of the National Association of Social Workers, and National Mental Health Association. Brief of amicus curiae supporting respondent, Roper v. Simmons, 543 U.S. 551 (No. 03-633). 2005.
[40] Haider A. Roper v. Simmons: The role of the science brief. Ohio State J Crimin Law. 2006;375:369–77. In Johnson
[41] Scalia A. Dissenting Opinion, Roper vs. Simmons. Supreme Court of the United States. 2005:03–633. [Ref list]

making by the age of 14 or 15.[42] To make their case, it seems that the APA bends the rules and interpretes science to fit a predetermined position. Arguably, scientific evidence cannot show that persons under 18 lack the competence to take moral responsibility for life-altering decisions in one case and not in the other. It is either they are competent, or they are not.

From a Christian ethical perspective, this inconsistency is nothing but a charade, a deceptive ploy to advance an agenda that is averse to Biblical principles. In the case of GD, it is alarming as the age at which children's decisions are taken seriously keeps being lowered to cut off parental consent completely. In 2012, the Associated Press reported that sex-change treatment for kids is on the rise. The rate has risen from four patients per year in the 1990s to nineteen per year in the mid-2000s. A report by Dr. Norman Spacks,[43] *"details 97 girls and boys treated between 1998 and 2010; the youngest was 4 years old. Kids that young and their families get psychological counseling and are monitored until the first signs of puberty emerge, usually around age 11 or 12. Then children are given puberty-blocking drugs, in monthly $1,000 injections or implants imbedded in the arm."*[44] The underlying ideology here is non-biblical, because although actual treatment begins at 11 to 12 years of age, gender-affirming psychological counseling is given to the child from the age of 4. Both the children and their parents are monitored and steered away from any gender conforming counseling or treatment within this period. This one-sided approach in treatment is akin to the method used by the now exposed Planned Parenthood abortion network, who only provides counseling that leads to

[42] Ibid.
[43] Norman P. Spack et al., "Children and Adolescents With Gender Identity Disorder Referred to a Pediatric Medical Center," *American Academy of Pediatrics,* 2012, http://pediatrics.aappublications.org/content/129/3/418. Accessed January 10, 2019.
[44] Associated Press and CBS News, "Sex-Change Treatment for Kids on the Rise," (AP February 20, 2012), https://www.cbsnews.com/news/sex-change-treatment-for-kids-on-the-rise/. Accessed December 14, 2018.

abortion for all their patients. Christian ethics demands ethical and balanced clinical practices where all possible alternative treatments are presented to parents who have children with GD.

Issues of Parental Consent

Also, the Bible teaches that the rights of a child are limited, in childhood (Galatians 4:1-2). A child is dependent on the parents to teach him right from wrong. Proverbs 22:6 and 15 state*: "Train up a child in the way he should go, and when he is old, he will not depart from it,"* and *"Foolishness is bound up in the heart of a child; The rod of correction will drive it far from him."* Other relevant passages are Titus 1:6, and Colossians 3:20. The Bible is clear that it is the responsibility of Christian parents to train their children up in a godly way. Therefore, transferring the authority to make important decisions for a child, from the parents to a child, undermines the clear teaching of the Bible.

The ongoing attack on the Christian ethic of parental responsibility is evident in a recent article opposing the state of Ohio and Delaware that are considering requiring parental consent before schools or government entities begin to treat dysphoric children. The author, in protest, stated: *"That means many transgender children spend over a decade in the custody of someone who may not support them, and who may try to enroll them in harmful conversion therapy programs to try to change their gender identity."*[45] This ideological statement is a defiant attack on Christian family principles and parental rights accorded by God to parents over their children. It is unethical to call evidence-based gender conforming medical treatments harmful and proceed with gender affirming treatments without parental consent.

[45] Samantha Allen, How 'Parental Permission' Could Destroy Transgender Kids' Privacy, https://www.thedailybeast.com/how-parental-permission-could-destroy-transgender-kids-privacy

Section Five: Conclusion

Statistically, less than 1% of children experience symptoms of GD.[46] Within this population, 80-95% will outgrow GD at puberty. That means that only 10 out of 1000 children will show symptoms of GD and that about 9 out of this 10 would not have GD after puberty without SP and SRS treatment. Results also show that when these 10 are subjected to SP and SRS just because they showed signs of GD, all 10 of them will end up as transgender adults. SP treatment, therefore, forces this 80-95 % who could have outgrown GD at puberty to adopt a transgender identity since 100% of children with GD who receive SP treatment end up requesting sex reassignment surgery.[47]

Puberty suppression is known to prevent the brains of these children from naturally maturing into a sense of their biological sex, which is normally completed after maturation of neurological brain development in the mid-twenties.[48] Puberty suppression could also cause an impaired increment of bone mass, interference with endocrine and metabolic development. These side effects show that the SP treatment is dangerous to the majority of the children. It is unethical to force all these children whose dysphoria would not have persisted, to undergo suppression of their puberty which will convert all of them to transgender adults.

Ironically, many supporters of SP and SRS treatment in dysphoric children cite beneficence as their ethical grounding. They claim that it is to the best interest of the children to grant their desires. This argument is weak because, helping children avoid the distress by suppressing puberty, evidently harms 80 to 95% of them who could have clarified their gender identity through the pubertal process and/or psychotherapy. In the guise of beneficence to the 1

[46] Cretella, https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children. Accessed December 12, 2018.
[47] De Vries et al, https://www.sciencedirect.com/science/article/pii/S1743609515336171. Accessed December 20, 2018.
[48] Johnson, et al, https://www.jahonline.org/article/S1054-139X(09)00251-1/fulltext. Accessed December 11, 2018.

out of 10 GD children who could have undergone distress but still have the opportunity of later treatment, 9 out of 10 of them are put at risk and even harmed by potentially irreversible processes. Coupled with the fact that some sex reassignment regrets have been reported after SRS,[49] it is only in the case of gender dysphoria that the preferred medical intervention does not cure a sick body. Instead surgery is performed to remove or alter healthy organs to conform to the wishes of the patient with the hope of adapting biological sex to a psychological anomaly.[50] This violates the medical ethics that prohibits doctors from performing unnecessary amputations. Just because it can be done does not mean it should be done. Surgery could lessen the patient's distress but fails to address the underlying psychological problem.[51] However, the progression of puberty and psychotherapy successfully addresses the psychological problem without hormones or surgery. It seems rational to make gender conforming psychotherapy the first line of treatment of GD because it is an evidence-based safe and successful procedure.

It is apparent that making SP and SRS the preferred treatment without enough study and evidence of the long-term effects to ascertain the potential risks, violates evidence-based medical principles and is potentially dangerous experimentation with children. Considering all the reasons outlined in this paper and weighing them against the claimed relief from distress that SP and SRS achieve in children with GD, it is certainly unethical to rush into routine use of gender affirming SP and SRS treatment in gender dysphoric children and adolescents as the primary, and in some cases, only option of treatment.

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[49] Walt Heyer, *Kid Dakota and the Secret at Grandma's House,* (Columbia SC), 211. http://www.sexchangeregret.com/. Accessed December 23, 2018.
[50] Hayes, http://dx.doi.org/10.18785/ojhe.1402.03. Accessed December 15, 2018.
[51] De Vries et al, https://www.sciencedirect.com/science/article/pii/S1743609515336171. Accessed December 20, 2018.

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Endnotes